*Experiences of a psychiatrist with post-graduate training of general practitioners in groups**

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It is fitting that an address in this Institute should start by a reference to the work of Boerhaave. May I then remind you that at the height of his career, in the first decades of the 18th century, Boerhaave, besides being Professor of Medicine at the University of Leyden, had the Chairs of Botany and of Chemistry as well. It is also worth mentioning that he was an outstandig teacher in all these three fields, but of course our concern on this occasion is his activity in medicine. He was a teacher of world-wide repute and not only students but also experienced doctors came from many countries to attend what to-day would be called his post-graduate courses. What he taught there was medicine.

All this, of course, is utterly impossible to-day. It is simply unthinkable that any authority would consider offering three University Chairs to one man, or that anyone would even dare aspire to be considered as a candidate for three Professorships simultaneously. Even the medicine that Boerhaave taught has ceased to be taught, or even to exist, but for its name. Medical training is no longer in the hands of general physicians but of specialists. I know it will be argued that this is only partly true. We still have chairs, clinics and departments of medicine, and general physicians as teachers of medicine. I readily admit that this is indeed so, especially in England where we still have not only general medicine but also general physicians. Unfortunately even in our country these are only names because they are very nearly the same as what on the Continent or in the United States would be called Internal Medicine and Internists.

Thus it has come about that when doctors would like to add something to their knowledge about the illnesses of the heart, they look to a cardiologist, or if about any other illness they turn to a neurologist, dermatologist, rheumatologist, orthopaedic surgeon, gerontologist endocrinologist, gastro-enterologist, and so on and so on.

This is such a well established and self-evident institution that the choise of the specialist is automatic. Indeed it would be nonsensical to ask a gastro-enterologist's advice when we are interested in the diseases of the heart, or an orthopaedic surgeon's opinion if the problem is about the justification of tonsillectomy. Of course, there are and always will be neighbouring or even overlapping fields in which two, three, or even more specialists might have special experience which is worth listening to, but this does not alter the general fact that medical teaching, both under- and post-graduate, is now in the hands of specialists.

Boerhaave's case reminds us that this is a fairly new institution, not yet 200 years old. On the other hand, it must be stated in fairness that the specialists well deserve their eminent status. It is mainly their efforts that have brought about the immense progress in medicine that has taken place since they assumed leadership.

This is the general background which had some influence on our work in the Tavistock Clinic, whether we liked it or not. The two professional groups that have been working together in our seminars, general practitioners on the one side and psychiatrists on the other, are both products of the same kind of medical training. It is understandable then that their motives for joining in post-graduate training will show up the influences of this common past.

Being a psychiatrist I think it is easier to start with my colleagues, the general practitioners. Their most important motive is perhaps their need for relief from the burden of responsibility. We know in theory that it is inevitable that everyone gets older, iller, and ultimately must die, but to see this happen to someone entrusted to our care who asks for help and has put all his confidence in us, is not always easy to bear. Moreover, the possibility that we might have committed a mistake either in our diagnosis or in our therapy, increases this burden considerably. To relieve it, ever since the beginning of history, doctors have resorted to the institution of consultation. Of course, the one consulted is thought to know more, to be a better doctor, and therefore more able to help. Nowadays this „better" doctor to be consulted is almost invariably a specialist.

It is roughly in this spirit that most general practitioners approach our seminars. First there is the general expectation (1) that their burden of responsibility will be made lighter. In particular they have encountered several puzzling problems in their practice and so they expect that they will be told „what is wrong" with their difficult patients, which will enable them (2) to diagnose them more precisely according to some new categories and, in this way,

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understand better the most important features of their illnesses. On the basis of this diagnosis they should be able (3) to decide which patients they can treat themselves and which they had better refer to a specialist, and lastly, (4) they want to improve their own therapeutic skills.

These four expectations (1) to (4) are general. These are the motives that bring any general practitioner to any of the refresher or post-graduate courses. The situation may be — though not necessarily is — somewhat different when they come to a course run by a psychiatrist. Behind these four, quite conscious, expectations, may be a fifth, which is usually rather vague. It stems from the disappointment that in a number of cases, in spite of the best possible specialist service and advice, they were not able to understand their difficult patients. This feeling, although rarely explicitly verbalised, is usually conscious, whereas the next step is usually not, although it is not very far from the surface. It runs somehow this way: something must be wrong with medicine; although my patient has been examined from every possible angle most conscientiously and meticulously and all the reports are there to instruct me on what is wrong with him, they do not add up to anything. It looks as if we — my specialist advisers and myself — are missing something, we understand every bit of this patient and yet we do not seem to understand either him or what is really wrong with him.

Thus it comes about that after having listened to a whole galaxy of eminent specialists, the doctors turns to the psychiatrist in the — usually not quite conscious — hope that the psychiatrist will be able to tell him what is really wrong with his patient. This is the fifth of the expectations.

There is, however, a sixth. This may be conscious or unconscious but is hardly ever admitted openly at the beginning of our work. It originates in a feeling of inadequacy in the doctor. It does not originate from any mistrust in his own knowledge or skill but in a kind of uneasiness about his sensitivity. They feel either that they are not sensitive enough to spot what is wrong in their patient or, on the other hand, that they are hypersensitive and become much too easily and much to deeply involved in their patient's problems. In any case they feel that all this interferes badly with their „practice of medicine" beyond what comes under (1) to (4) and they hope that the psychiatrist will help them to overcome this difficulty.

This last expectation has, of course, a very complicated under-structure. In the rare moments when we dare to be really sincere with ourselves we may admit that all of us have some doubts about whether we are really as healthy as we would like to appear. Another form in which this nagging doubt might be consciously expressed is the question: how far are we neurotic or, in a milder form, what sort of oddities, idiosyncracies and peculiarities we may have, how all this influences our practice of medicine and, in particular, our ways of handling these difficult patients who are a problem to us? Implicit in this question is the uneasy feeling that most likely this influence upon our technique will be a bad one.

I think it is important to stress that most of this understructure or even the whole of what I called expectation (6) might be more or less unconscious. In spite of this my experience is that these unconscious expectations make themselves felt and each doctor seems to know when he is not getting what he needs from the course or the seminar. As just said, all this is largely unconscious, that is, in contrast to expectations (1) to (4), the doctor cannot express it in words. He merely feels that he has been let down, that what has been offered to him was disappointing but, because of the unconscious nature of his needs, this failure may be attributed to some secondary rational features of the seminar, such as not enough theory, insufficient leadership etc. These criticisms may be justified, it is their intensity and bitterness that betray their origin in irrational emotions.

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Now let us turn to the other group of professionals, that is, the psychiatrists. You must forgive me if my analysis of our expectations will not be as ruthless and penetrating as in the previous case. The reason is obvious. Whether he likes it or not, agrees or disagrees with it, the psychiatrist is unquestionably a specialist. Being a specialist means in the setting under examination that he does or, at any rate, is supposed to know more than his colleagues, and that he must behave accordingly. This is only a half-truth; he actually does know more when he is doing his own job in his own setting, that is, psychiatric diagnosis, psychotherapy or consultant work. But he will not know more about the general practitioner's job — except, of course, if it is agreed that general practice is a watered-down form of proper medicine as it is practised, say, in teaching hospitals. My experiences have taught me that this is very far from being true. Therefore in my opinion the superior knowledge of the specialist is a somewhat hypocritical half-truth and the psychiatrist in particular should be careful not to be seduced by it.

Though this is said on many occasions in so many words in each of my groups, and though it is good-humouredly accepted by each of them, time and again we get undeniable proofs that it is not believed. This is bad enough but it is still worse that in spite of my convincing past experience, time and again I catch myself out playing the role of the omniscient mentor-specialist. This means that I demonstrate how to make a psychiatric diagnosis or advise therapy along the lines which I would use in my own setting, while forgetting that all this has only a limited application and may be utterly out of place between a general practitioner and his patient. This shows that one of the psychiatrist's expectations — conscious or not quite conscious — is to excel, to shine, to show off his superior knowledge and skill, irrespective of whether they will be

useful or even possible in general practice or not.
Loosely linked with the previous expectation is the next, which might be described as being reassured that one's ideas about illnesses and their therapy are correct. It is rather difficult to obtain reliable objective evidence for the comparative efficiency of any psychotherapy, or the correctness of a particular piece of psychodynamic theory. Most of the evidence that we have is based on an intelligible connection between the symptoms and the changes brought about by psychotherapy; this in ultima analysi means subjective understanding. In consequence the more people view their therapeutic problems in the same way as we do, the more reassured we will feel that we were not far from the truth, the more people have different opinions, the more uneasy we will be. Thus leading a seminar, in fact all teaching, is an expression of what I call the psychiatrist's apostolic function, and his expectation is that he will be able to convert all the unbelievers and heathens among his colleagues to his faith.

I really do not know whether the next expectation to be mentioned is a general as the other two or is only a peculiarity of mine, so allow me to describe it using the first-person singular. I am a highly critical man, never content with what I know or with what I can do. In consequence I have an unquenchable thirst for new knowledge, new experiences, which perhaps might shed a little light on one or the other of my many problems. I learned early in my academic career that whenever two hitherto unrelated sciences could be brought together to study the same problem, it nearly always resulted in exciting discoveries. As history shows, in most of these instances the two sciences worked side by side, neither of them subordinate to the other. This is then my third expectation, that provided we can remain equal partners we may encounter exciting new facts.
And lastly there is a general need — present I am sure in all doctors — which could perhaps be described as a wish to be a good helpful doctor. The specialist, too, wants to feel that he has given something good, contributed something valuable and his colleagues who asked his advice and assistance have become thereby better doctors themselves, better able to understand and to help their patients. In return he expects to be appreciated for his work.
To sum up, these are the expectations brought along by the two groups. The general practitioner wants (1) to be relieved of some oppressive responsibility, he wants to learn (2) how to diagnose his difficult patients more precisely, (3) on what basis to decide which of them should be referred to specialists and which he can treat himself, and (4) how to treat those whom he ought to take care of. Further (5) he hopes to learn from the psychiatrist something about human beings suffering from ill-health, and lastly, (6) about the reasons and the effects of his own emotional involvements in his patients.
The psychiatrist, as any other specialist, expects (1) to excel, to shine, (2) to be reassured that his ideas about illnesses and their treatment are correct, (3) perhaps to make some new discoveries, and lastly, (4) to be appreciated for his knowledge and valuable help. Now let us see how these two sets of expectations interact, what sort of methods of training emerge out of this interaction, and what sort of satisfactions and disappointments are created by the various methods.

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Before starting out on this survey I feel I have to explode a conviction which is hardly ever stated explicitly. Everyone of us — and I must admit that in the beginning I did so too — in a way believes that there must be a correct method which will satisfy everybody or, at any rate, everybody's justified expectations. My experiences have taught me to accept the sad fact that this method is only a wish fulfilling phantasy. We must realise that whatever method we adopt it will satisfy some, will not make any impact on others, will irritate yet others, and will disappoint still others. This hard fact must be borne in mind when devising any method. Fortunately, on the basis of our experiences it is possible to predict which method will satisfy, or antagonise, what kind of doctors. It has to be added that this holds true for general practitioners as well as for psychiatrists.
I know that my description of the various methods will be considerably biased by my predilections, convictions and experiences. The same will be true, however, of all of you, no matter whether you intend to take part in the discussion on this paper or not. Even our experiences are not beyond every doubt. All of us live in a world partly created by ourselves, that is, we try hard to avoid experiences which might contradict or refute our convictions and seek out such that will conform with them. The not so peaceful coexistence of these various individual worlds makes progress in psychiatry extremely difficult. The only solution that I can see is to try to understand the argument and the man who uses it together. May I ask you to bear this in mind while listening to my survey.
The traditional method of post-graduate courses develops if we allow free reign to expectations (2) to (4) of the general practitioner and expectation (1) and (4) of the psychiatrist. It will depend then on the psychiatrist's skill, knowledge and pedagogical ability whether he will succeed in impressing his group or not. If he does, the group will develop respect and admiration for their excellent teacher and in due course he will get some satisfaction for his expectation (2). As a result the doctors will learn from him up to a point. This point can be raised considerably if the seminar is taken by a „modern" psychiatrist who will endeavour to satisfy expectation (5) of the general practitioners, namely, to tell them „what is wrong with the patient". In modern language this is called explaining the psychodynamics of the case or, alternatively, supplying the doctors with a theoretical framework which will

enable them to conceptualise their experiences with their patients. This is a most attractive and fairly successful scheme and is widely used in the United States. A well known example of this kind of training is Dr. Grete Bibring's psychiatric service at Harvard. A further reason for mentioning this is that I saw it working and also had the opportunity to talk to a few doctors participating in it, both psychiatrists and other specialists. I think it will be a fair assumption that the other schemes based similarly on psychodynamics and on conceptualisation will have similar structures.

Expectations (1) to (4) of the doctors — in Dr. Bibring's set-up these are not psychiatric specialists — are definitely satisfied. All the doctors I had the opportunity to talk to were unanimous on this point. Equally there was no question that expectations (1) and (4) of the psychiatrists were amply satisfied; everyone of my contacts expressed his appreciation for the help he received from them. This, of course, amounts to a satisfaction of expectation (2), that is, corroboration of the psychiatrist's ideas. However, as Dr. Bibring and her staff frankly admitted, they had some failures which they could not understand. The only explanation they could offer was a reference to general resistances present in every unanalysed doctor.

In my opinion failures of this kind are due to disappointments in expectations (5) and (6) of the general practitioners and (3) of the mentors, which gradually reach an intensity which is incompatible with any further work. In these cases, as a rule, there is no sudden break, the warning symptoms are a gradual slackening of interest and enthusiasm; to everybody's great surprise the participants who were so enthusiastic when they departed for a break, either do not reasemble for the new term or have completely lost their interest. One of the most famous examples of this kind is the Minnesota experiment by the Commonwealth Fund.

An obvious and often-heard explanation of these well known observations is that naturally every doctor's curiosity and receptivity has a limit and when he has had enough there is no reason why he should ask for more; or in other words: the doctor came because he found that both his knowledge and skills were wanting, he got what he needed, he does not feelthe need for more. Undoubtedly this explanation may fit the case of a number of participants. They feel that they have learned a great deal, not only that they understand their patients better, but they can see and avoid pitfalls of which they had not been aware hitherto. They know and say readily that they learned all this from the psychiatrist and that they are grateful for it. To illustrate this atmosphere may I quote my experience with a Senior Surgeon who was trained in this way by psychiatrists. For more than half an hour he quoted case after case, all of them highly impressive, in which he received most valuable help. Being what I am, I could not resist asking him towards the end of our talk: considering how much he had learned from the psychiatrists, had it ever occurred to him to enquire whether the psychiatrists learned anything from him? A somewhat surprised pause followed, after which he admitted that he had never thought of this possibility and in fact he doubted whether they did. To avoid possible misunderstandings may I add that the question was not whether the psychiatrists had learnt anything about specialist surgical techniques, but about special experiences open only to a surgeon who has a unique relationship with his patients, inaccessible to any other specialist.

Another story illustrating a different side of the same problem comes from a teaching hospital in which a highly enviable close co-operation exists between internists and psychiatrists. Each border-line case is discussed by a Conference, presided over jointly by an internist and a psychiatrist. Here too the internist was full of praise of how much valuable help he and his department received from the psychiatrist. Then he stopped, looked at me, and after a pause added „everything would be all right if only the psychiatrists would not lay down the law".

These two anecdotes might help us to understand what sort of doctors, with what sort of characters, will appreciate this kind of training. I have mentioned already that the burden of responsibility that a conscientious doctor has to carry is considerable. For some it is a great relief to know that there are people with superior knowledge above them — like the psychiatrists — who can tell them what to do and what not to do. Since a good psychiatrist will of course know more than his non-psychiatric colleagues, he can help them to that extent. This help will be of the same nature as the surgeon's help to his non-surgical colleagues. If these colleagues do not want to learn surgical skills this is exactly the help they need. For some, however, as the story about the internist shows, this kind and this amount of help are not satisfactory.

To sum up the results of this type of training in which the emphasis is on diagnosis and assessment based on clinical psychiatry with some — not very much — psychotherapy, it relieves the burden of responsibility. The doctor will know more and will be more confident about deciding which patient he should not touch. These results can be considerably deepened and the doctor's understanding and handling of his patients made still more reliable if the teaching is extended to cover the field of psychodynamics. However, in my experience, this much will satisfy only those doctors who for some reason or other do not want to go beyond this point, but it will be disappointing to those who want to do more than keep up a sympathetic distance between themselves and their patients.

With this we have arrived at the doctor's expectation (6), namely, that he will be able to understand better his emotional involvement with his patients, and on this basis develops a more reliable psychotherapeutic technique. The question is what can the psychiatrist do to satisfy this demand? As you all

know, psychoanalytic training demands as the first step a thorough study of the candidate's mental and character structure in the form of personal analysis. Since the introduction of group techniques some psychiatrists thought that a somewhat attenuated form of group therapy might be the right answer to this demand. For quite some years the Tavistock Clinic experimented with this mode of training, in particular in the case of psychiatrists, social workers, psychologists and various people in industry who had responsibility for personnel management. I was one of the last who acted as leader of such groups in our Clinic. I am not sure whether I ought to be proud or otherwise, but it was largely due to my influence that this kind of training was eventually given up.

Since I think that this is an important question I propose to spend some time on it. Every group discussing psychodynamic problems in which the members of the group are personally involved — as is the case when doctors report about their own patients or the psychiatrist leader about his own work — functions up to a point as a therapeutic group. The practical problem is where this point should be. In my experience if the psychiatrist-leader uses interpretations freely a therapeutic atmosphere will eventually develop in which highly intense and rather primitive emotions will be stirred up and ultimately transferred to him. Although this creates certain difficulties these can be dealt with in the normal way but, and this is the point I wish to make, at a price. A good example is psychoanalytic training in which the first few years — one to three, even in the course of a normal candidate — must be spent as therapy. This of course would be impossible in a post-graduate course for general practitioners and furthermore it would be unfair to most participants who, after all, came to the Clinic asking for training and not for therapy. True, in some cases this demand was only a cloak for the wish for therapy, but in my opinion and experience these can be spotted in an initial interview and should be diverted from the course. All of us being more or less neurotic it may be argued that some therapy would not harm any group of doctors, certainly, not those who are interested in neurotics and in psychotherapy.
The real trouble however is that this kind of training-cum-therapy can never be sincere and so defeats its own aim. It would only demonstrate to the participants a technique so superficial and insincere that in fairness they ought to be advised at every step not to learn it. Thus we were faced with the dilemma, either to undertake a therapy for which there was not enough time and we had not enough staff, or to demonstrate a technique which we knew full well was wrong. When we reached this point the only thing to do was to give this method up.
It was replaced for the whole range of the Tavistock Clinic's activities by a method devised jointly by Enid Balint and myself. As we have described elsewhere, it is centred on the close study of the doctor-patient relationship as it is reported by the doctor to the seminar, and the seminar's reaction to this report. In this way these two relationships (a) between doctor and patient and (b) between the doctor and the rest of the group, are those that are examined continually; although both of them have some primitive features, essensially they are relationships in which the doctor himself is a mature man. In our opinion the always present and highly dynamic doctorgroup leader relationship should as far as possible be left alone. If the situation is such that this relationship must be interpreted in order to avoid some calamity, then in our opinion the interpretation should be restricted to what we call „public transference". By this we mean a reference to facts which the whole group had ample opportunity to observe and become aware of. Any reference to subjective emotions and still more to any unconscious phantasies or motives, must be avoided if at all possible. Interpretation of the public transference results, as a rule, in smiles or even in laughter, whereas anything going beyond that produces a hushed silence and eager expectation for more. Our technique in these cases is to stop immediately, admit the mistake, and return to the normal training work.

Here I can rely only on our own experiences since I am not familiar with the training methods in other centres. In my early groups this resulted in some frustration. Time and again the group, led by one or the other member, unanimously proposed that we should turn into a therapeutic group forthwith. Though the arguments advanced were fairly convincing, in every case I simply refused and I am certain that all my colleagues at the Tavistock Clinic did the same in similar conditions. The great majority of the participants remonstrated but accepted this fact. In the last few years, at any rate in my recently started groups, the hankering after therapy has been conspicuously absent. I do not know yet whether this is due (a) to the institution of an initial interview which enables a number of doctors to withdraw their application, (b) to our growing experience and improving techniques, or (c) to the not yet sufficiently long period of observation.

Lastly, there is the third group of training methods in which the chief attention is focussed on the doctor's subjective involvement with his patient and the psychiatrist tries to satisfy what I call expectation (3), his thirst for new discoveries. This is the standard adopted for the Tavistock seminars and we try to measure our results by how far we were able to achieve it. Let us now examine this method and the satisfactions and disappointments resulting from it, starting with its negative features which I find easier to describe. The most conspicuous of them is the lack of systematic teaching. Hardly any theory is given, only as little as is unavoidably necessary

for the understanding of the particular case under discussion.
In consequence very little theoretical frame work is taught to the participants who have to rely on their own ways to describe their experiences. Nearly every guest psychiatrist who visited a group for a few sessions only was impressed by the poor conceptualisation and commented adversely on it. We are fully aware of this fact but after ten years of experience and experimenting I, for one, still think that it is not a high price to pay for the advantages connected with it.
I have already mentioned the irritation caused by our refusal to accept therapeutic responsibility, that is, to satisfy fully expectation (6). Presently we shall discuss to what extent we satisfy this expectation.
The last negative feature is our failures. This, as I described in my book, was alarmingly high in our first years. Since the introduction of our initial interview our drop-out rate has fallen to about 10-15 percent per annum, which compares favourably with other post-graduate courses, especially in view of the fact that the usual course lasts only a few weeks, whereas ours lasts several years. A more pertinent comparison would be with some post-graduate training course such as in pediatrics, surgery, psychiatry, etc. in which case our figures are quite acceptable. This does not mean that we intend to rest on our laurels, but the discussion of the possible causes and remedies of our failures is beyond the scope of this address.

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Now about the positive features of our method. Foremost among them is the condition that the doctors participating in it must report about live cases, that is, patients who are under their care at the present. In this way their next meeting with the patient allows them to test any theoretical or practical conclusion, any technical suggestions that were made in the previous seminar. This turns the seminar into a research since its work is under constant scrutiny. If we fail to understand the patient's problems and devise the correct approach to them, this will be shown up mercilessly by the development of the case. On the other hand, the constant pressure of therapeutic responsibility compels the doctor, even if he does not report about his case, to use in his own practice this or that bit of what he heard in the seminar. In the long run he will not be able to resist bringing up in the discussion his successes or failures, whichever the case may be. Unfortunately this condition imposes an unwelcome limitation on us. At our own expense we have found that it is practically impossible to train by our methods doctors who have not an ongoing responsibility for patients, such as doctors on leave, in administrative occupation, and so on.
A consequence of the previous condition is the second positive feature of our method, which is that the doctor must remain fully in charge of his patients. Nobody is allowed to interfere with this relationship. When I introduced this condition I did not realise its full implication, but now I think this is one of the most important features of our method. On the one hand, some psychiatrists insist on visiting the doctor in his surgery to see how he works with his patients; on the other hand, it is quite customary that patients are presented to a Conference when everyone, and in particular the leader, is allowed to get in touch with them, ask questions, and so on. Apart from very rare and exceptional cases, no such thing happens in our course. This means a nearly absolute disappointment of expectation (1), easing the burden of responsibility, and especially in the beginning I had some trouble in enforcing it. Now the tradition has been so firmly established that it is accepted without much trouble by new groups, which shows that even long-established customs and prejudices can be changed.

The result of this institution is a gradual change in the general practitioner's relationship to all specialists, including psychiatrists. To quote one of my cliches, the general practitioner, instead of looking up to the psychiatrist-leader as an omniscient mentor, uses him as an expert assistant, highly valuable but only in his limited field. Not everyone is capable of this change. As mentioned before, there are a number of doctors who need a superior authority above them who knows better and can tell them what to do and what not to do. For these doctors the responsibility to use and to give instructions to an expert assistant is too much, they prefer it the other way round. They are the second source of our failures, but in their case we have some idea how to satisfy their needs. We have found that what they need is an on-going contact with a psychiatrist who will relieve them of part of their responsibility by advising them in concrete cases how far they should go and when they should stop. Provided this can be arranged, these doctors can offer their patients psychiatric help of a very high standard. It has to be added that some specialists, including psychiatrists, do not suffer gladly to be used merely as an expert assistant; they possibly feel it as being demoted from their status of superior specialist and certainly as a frustration of their expectation (1). It is to be expected that they will find our method unacceptable.
Closely connected with the previous two is a third feature of our training scheme which I would like to call being prepared for new and exciting discoveries, which is expectation (3) of the psychiatrist. This expectation in my case has been fully gratified by our method. A number of our discoveries were published in my book: „The Doctor, His Patient and the Illness", and at present we are planning a monograph series to keep pace with them. The participating doctors, too, have similar experiences. Potentially every case reported may turn out to be a source of some new discovery, as our aim is less to conceptualise the observations into psychodynamic

formulas than to allow them to act upon the doctors as fresh and alive instances of particular human relationships. With some exaggeration one could say that we aim not so much at recognising something familiar as seeing a well known phenomenon in a new light.

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Perhaps the most important of all our discoveries and the one which explains best why it is so important that the psychiatrist should give up his traditional role as a superior mentor and join his colleagues as an equal, was the discovery that there are two different medicines, one which is practised in pure form in the teaching hospitals and might be called hospital or scientific medicine, and the other which might be called general practice. Of course, there are many similar or identical features between the two but there are also fundamental differences. One of them is the setting. In the hospital there is a hierachy, each rank having a somewhat different function and responsibility for the same patient, in consequence of which the patient relates much more to the rank than to the individual doctor. It is tacitly assumed that the treatment is adequate and correct if it is given by a doctor of equivalent status and rank, for instance, after one Houseman or a Registrar has left, the successor. In general practice there is no hierachy. Whenever the patient comes he will meet the same doctor, that is, *his* doctor. The other fundamental difference is the duration of contact and with it of the follow-up. A hospital, especially in the in-patient service, sees a patient for a few weeks or a few months, then the contact is broken. If the patient has another kind of illness it is more likely than not that he will be seen by another department, in which possibly his files will be the same but certainly not his doctors. In general practice the contact is lasting and whatever the symptoms are the same patient is seen by the same doctor. This means that the methods proved valuable in the setting of the specialist and tested out during the contact characteristic of hospital medicine, may not necessarily have the same effects under the conditions of general practice. This discovery imposes an obligation on the specialist. Instead of assuming that his ideas and methods are unquestionably valid in general practice and, because of their better „scientific" foundation, may overrule any contradictory evidence, he must start out on a research in which he must accept his colleagues from general practice as his equals. This is a serious disappointment to expectation (1) which, as I can testify, is not quite easy to bear. It means that the psychiatrist must give up his expectation to excel, to teach, and accept that he is in bad need of learning. However, the general practitioner is faced with the corresponding problem. He applied for the course in the hope that he would be taught something simple and useful, that the psychiatrist, so to speak, would take him by the hand and show him the right way. Instead he is now expected to start out on his own, report honestly about his many stumblings, accept fair but unfailing criticisms of them, and the only thing he is promised for all his trouble is that he will make some new discoveries. Some of them do not find it easy to believe that this is the only way by which they can learn something about their own peculiarities, why they are insensitive in some cases and hypersensitive in others, why they get so easily involved with one kind of patient and why they are so indifferent to others, and how all this will result in the acquisition of psychotherapeutic skills. As the seminar proceeds and more and more reports are presented, the doctors begin to become aware that the difficulties that any doctor experiences are connected with his personality. First this is recognised mainly with regard to his colleagues, but soon he cannot escape seeing his own case, and with it begins the „limited though considerable change of personality" which is the unconditional prerequisite of any psychotherapeutic skill.

Not every doctor is capable or willing of undergoing this change. This inability may be a transitory phase only but, if lasting, it may lead to considerable irritation and to a decision to discontinue the training. We have to admit that these cases are due to our mistakes since we ought to have spotted them in our initial interviews as unsuitable for our methods. The fact is that our criteria for selection have not yet been firmly established and we think it a wiser policy to accept some doubtful cases than to exclude possibly promising ones by a too stringent selection.

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To conclude, allow me to return to Boerhaave. Most historians agree that the most important of his achievements was his influence on medical education, the structure of which in principle has remained the same as it was organised by Boerhaave in Leyden. It is also worth remembering that it was he who devised the word „physiology" and elevated it to the real centre of medical thinking. Looking at his achievements from another angle, one might say that he was receptive to everything that could be used for the understanding of illnesses and their treatment and his system of medical education truly reflects his encyclopaedical knowledge. However, as far as I know, he did not use or refer to psychology. True, his Ph. D. thesis of 1689 bears the title „De distinctione mentis a corpore" but to my regret I have not been able to find out whether this led him to the acceptance of any psychology — in any case, I doubt it. Had, however, Boerhaave lived at present, I am quite certain he would be in the first ranks of those who fight for the cause that physiology and psychology should be the two main pillars on which to base present-day medicine.