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EMPATHY AS A HERMENEUTIC PRACTICE

ABSTRACT. This essay will argue for the centrality of empathy in the doctor-patient relationship – as a core of ethically sound, responsible therapeutics. By "empathy," I intend an explicitly hermeneutic practice, informed by a reflexive understanding of patient and self. After providing an overview of the history of the concept of empathy in clinical medicine, I discuss current definitions and the use of Balint groups in residency training as a way to develop empathic competence in novice physicians.

KEY WORDS: empathy, hermeneutics, Balint, interpretation, doctor-patient relationship, narrative, reflexivity

1. INTRODUCTION

More than a decade has passed since Jay Katz published *The Silent World of Doctor and Patient*, a groundbreaking study of the many obstacles to establishing mutually trusting, respectful relationships in medicine. The SUPPORT group's recent report on hospital care for patients at the end of life reveals that pervasive miscommunication among health care professionals and patients continues to impede delivery of responsible, responsive care. One of the great strengths of Katz's original study was his awareness that "unconscious and irrational determinants" inform the actions of both physicians and patients, undermining the possibility of mutual understanding, care, and respect.[1]

Empathy is central to establishing such mutually empowering therapeutic relationships. The following article discusses empathy as a form of clinical hermeneutics and describes the use of Balint groups to enhance residents' facility for empathic interpretation of patient narratives. Maureen Milligan and I have argued elsewhere for the ethical necessity of empathic attunement in the doctor-patient relationship[2]. Let me begin by defining empathy and elaborating on our claim.

2. EMPATHY AND CLINICAL MEDICINE

Although the concept of empathy originally was coined in the 1870s as part of the psychology of esthetics, it was soon appropriated for the fields

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of human psychology, Freudian psychiatry and, more recently, all clinical medicine.[3] In popular parlance it is commonly – and mistakenly – defined as a synonym for sympathy, pity, or compassion.[4] More recently, within the fields of critical social science, hermeneutics, and relational feminism, empathy is understood as a form of reflexive, interpersonal knowledge.[5] Perhaps Roy Schafer's definition best captures the resonant quality of empathic understanding in the doctor-patient relationship when he describes it as "the inner experience of sharing in and comprehending the momentary psychological state of another person."[6]

Over thirty years ago Robert Katz wrote of the importance of empathy as an underpinning to responsible patient care. Empathy establishes that "we are recognized and accepted for the particular kind of person we are ... When empathy is lacking our self-awareness and self-respect are diminished. We then experience ourselves more as objects and less as persons."[7] Katz was primarily considering the patient, but the same can probably be said for the physician. After all, how can the physician or other health care worker empathize with the patient's world, interests, values, and relevant past experience without a similarly well-developed insight into his/her own experience and values?[8]

Empathy begins with an openness to the patient, the ability to see, hear, and understand – the patient and oneself. It has been defined variously as "*knowing* what another person is feeling," and "*feeling* what another person is feeling."[9] Neither definition, however, captures the degree of self-awareness required for empathy. Nor do they acknowledge the limits of empathy. Empathic knowing yields a close approximation of the inner world of another person – but no more than that. As Lorraine Code has written, it is unconvincing to say "I know just how you feel."[10] Nevertheless, medicine's goals of competent, compassionate, just and fitting patient care require that physicians develop the ability to be empathically attuned to their patients' experience of illness. Iris Marion Young has written, "Justice begins in a hearing, in heeding a call, rather than in asserting and mastering a state of affairs."[11] That might well define the goals of medicine, too. It certainly points to the role of empathy in the accomplishment of those goals.

Empathy is sometimes described as the ability to imagine the other's inner world.[12] But this is only the beginning. To the extent that we can establish a coherent sense of another's interior world, we must turn imagination back on itself, reflexively seeking the sources of our reconstruction of the patient's world in our own past experiences. This hermeneutic process of reflexive interpretation involves a constant oscillation back and forth between observation of the patient, and of ourselves, allying

imagination, emotion, memory and cognition in the service of informed understanding.

Empathy thus requires a self-conscious interplay between feelings and cognition. Martin Hoffman describes the process by which empathic knowledge is initially received, a process that depends on many sources of information including, "verbal and nonverbal expressive cues ... situational cues, and the knowledge one has about the other's ... experience beyond the immediate situation."[13] But for empathy to be closely attuned, it must incorporate a process of introspective analysis in which one's own inner life acts as a touchstone to the initial interpretation of the patient's inner world. Such introspection also acts as a reminder of one's own subjective presence within the interpretive process. One tests and modifies an initial empathic hypothesis by seeking further observations, additional conversation, deepening one's knowledge of the patient's narrative. Again one cycles back, reflexively considering the coherence of the modified empathic hypothesis and, finally, its meaning for the patient. In this way empathic knowledge transforms its subject, moving her/him from understanding to responsible action. A definition that comes closer to acknowledging the reflexive nature of empathy is given by Alexandra Kaplan. She writes, "Empathy is the capacity to take in and appreciate the affective life of another while maintaining a sufficient sense of self to permit cognitive structuring of that experience."[14]

The foregoing description and definitions of empathy differ in significant ways from earlier discussions which located empathy under the rubric of "detached concern." As described by Renee Fox, detached concern "entails the ability to bring objectivity and empathy, equanimity and compassion into a supple balance."[15] The concept of "detached concern," originally formulated by Harold Lief and Renee Fox, depicted the empathic physician as "sufficiently detached or objective ... to exercise sound medical judgment and keep his equanimity, yet he also has enough concern for the patient to give him sensitive, understanding care."[16] Empathy as I understand it does not stand in opposition to objectivity; it is not an attitude such as sympathy, compassion, or concern. Rather, it is a form of relational knowledge. Its manifestation is not "concern" but "presence." The empathic physician is neither objective nor subjective, neither detached nor identified, but dialogically linked to the patient in a continuing cycle of reflexive interpretation that integrates the objective and subjective.[17] The physician is *present* with the patient.

3. BALINT GROUPS AND DEVELOPMENT OF EMPATHIC COMPETENCE

Given the indispensability of empathic awareness for responsible clinical practice, some effort has been made to develop the skill in physicians. One of the more useful approaches resulted from work begun by Hungarian-born British psychoanalyst Michael Balint at the Tavistock Clinic in London following World War II. Balint's research led to an approach now utilized by significant numbers of generalist physicians in England, on the Continent, in North and South America, and in Israel. As of 1990, sixty-six out of 381 family practice residencies in the United States alone employed Balint groups as part of their curriculum.[18] By now the number has likely increased.[19]

Balint initially was interested in training "non-psychiatrists" to incorporate psychiatric methods into the standard medical interview to improve general practitioners' ability to identify and treat their patients' "emotional problems."[20] Balint's best known description of his work, *The Doctor, His Patient, and the Illness* (1957), emphasized three main concepts: 1. the placebo-like, healing powers of the physician's personal presence (what Balint termed "the drug doctor"); 2. doctors' largely unintended choices of interpersonal style with patients (their "apostolic function"); 3. the powerful effects of the phenomena known as transference and countertransference within doctor-patient relationships.[21]

By the mid nineteen-sixties, however, Balint had begun to doubt the wisdom of teaching generalist physicians a "watered down" version of psychoanalysis. Instead he and his successors focused on developing physicians' greater sensitivity and competence in dealing with their own responses to the patient, what Balint referred to as the "doctor's countertransference to his patient."[22] As Paul Ornstein wrote, "the physician has to be able to make contact with the *person* in the patient. To achieve this the physician must develop his potential for empathic observation, empathic listening, and introspective self-awareness . . . These are some of the key functions of the physician as a 'therapeutic instrument.' "[23] One goal of most Balint groups is learning to re-frame the "problem" in non-biomedical terms. Second, they attempt to develop in young physicians and residents a greater awareness of their emotional responses to patients insofar as these can preclude empathic attunement and interfere with delivery of compassionate, competent, and respectful care.

Surveys of residents' attitudes toward their patients support this change in direction away from analytic interviews of patients by non-psychiatric physicians and toward developing greater insight into the doctor-patient interaction. When asked what circumstances triggered most discomfort,

residents cited psychosocial and sexual issues, and disparities in social class, behavior, or values. Situations involving "death and dying, family problems, psychosomatic issues, noncompliance, chemical abuse, domestic violence, chronic illness, culturally distinct families, fear of AIDS, psychosis, pregnancy and childbirth, and the need to deliver bad news," all ranked high as triggers for troubling emotional responses by physicians.[24] That is, physicians reported feelings of confusion, frustration, anxiety, anger, depression, and humiliation when treating patients perceived to be "different" from the physician. Patients who elicited a sense of "otherness" in their doctors were experienced as more difficult. Unable to establish a sense of mutuality, physicians experienced anxiety with their patients and failed to establish a therapeutic alliance.[25]

How do Balint groups address the need to develop empathic attunement in physicians? Typically Balint groups include anywhere from six to twelve participants as well as one or more group leaders to facilitate discussion. Leaders will commonly begin by establishing some ground rules. First, respect and confidentiality for each participant are required. Second, group leaders try to preserve "the dignity, the independence, and the mature responsibility" of the doctors who have agreed to participate. Thus, Balint groups do not try to analyze what Balint called the "private countertransference" or "hidden motivation" of physicians struggling with a difficult case, in contrast, for example, to group psychotherapy. Rather, the participants are urged to address the "public countertransference" of the physicians, i.e. those issues acknowledged in the case report to the group.[26] In this way a sense of mutual trust and the opportunity to experience empathy can be nurtured among the group members.

A revealing array of emotions and attitudes will emerge during a physician's case presentation. As Balint once observed, "The way the doctor reports about his patient with all the holes, unfolds in the history, with all the ommissions, second thoughts, later additions and corrections, etc., including the sequence in which these are revealed, all tells a tale . . . "[27] Leaders model skills such as listening carefully, being non-judgmental, tolerating uncertainty and lack of closure, while also setting limits for the sake of purposeful discussion. Participants are asked to consider their own (and their patients') emotions and behaviors, what they meant, and whether the meaning of the case can be re-framed in ways that reflect these new insights.[26]

Participants use the occasion of a case presentation in several ways: first, through empathic resonance with the presenting physician, they reflect on his/her state of mind; then, by a reflexive process of internal reflection – consciously or not, they draw on their own similar experiences, gaining

insight into their own emotions. In the final stage of empathic processing, they consider the presenter's case self-consciously in the light of the feelings and thoughts they experienced during the case presentation. Balint groups thus offer the opportunity to learn empathy by experiencing it – both as the subject empathically considering patients and colleagues, and as the object of empathy from one's colleagues.[29]

4. BALINT WORK AND EMPATHY: SOME CASES

For the past two years, the Department of Family Medicine at the University of Texas Medical Branch, Galveston, has run a Balint group for second year residents. The group meets once a week for sessions lasting between one and one and a half hours. Last year I was invited to join the group as a co-facilitator along with two Family Medicine faculty members with many years of experience as Balint group participants and leaders.[30] This group, consisting of all the second-year residents, was made up of about fifteen physicians. The participants were mostly of anglo and hispanic ethnicity, with several members who were of Asian or Indian descent. The group contained neither African Americans nor Native Americans. Some of the participants were more experienced than others; they chose to enter the Family Medicine residency after having spent several years in other specialties such as obstetrics-gynecology or pathology. Their ages ranged from their late twenties to their late thirties. About half were married. Most significant, however, was the group's gender-homogeneity: there were no women in the second-year residents' class. Yet the gender composition of cases presented for discussion (reflecting the department's patient population as whole) was overwhelmingly female: after the first six months, fourteen of the eighteen cases discussed at length concerned women patients. Finally, as one would expect in a state-supported medical school, the majority of the patients discussed by the residents had no private health insurance, had no personal physician, and would be classified as belonging to the lower socio-economic strata of American society.

Many cases thus proved to be a significant challenge to the empathic competence of the group. Yet, within six months their self-awareness and insight into the emotional worlds of their patients began to deepen markedly. At the year's first case discussion, for example, a resident presented as a problematic patient a woman he described as "flirtatious." This resident said he was afraid of incurring a lawsuit, and hoped the group would support his request to transfer the case to a female physician. When one of the group leaders asked the others how they imagined this resident was feeling, no one ventured a reply. In subsequent refer-

ences to Balint's concept of the "drug doctor," residents interpreted the term to mean patients' inappropriate dependence on physicians rather than the therapeutic effects of the doctor-patient relationship. At least on the surface, the group's base line for empathy stood close to ground zero.[31]

Over the next few months, however, the group's facility for self-understanding and mutual trust slowly increased. Their growing ability to empathize with each other provided the experiential matrix for enhanced empathy for their patients. Exactly two months after the session described above, the residents began entering into case discussions in much greater numbers than at any point before. In addition to the predictably reassuring effects of the passage of time, two factors seem to have precipitated their increased participation: the case concerned a set of emotional issues with which all the residents were contending; and, the resident who presented the case gave an unusually vivid recreation of the patient during his presentation. In fact, role playing provided an effective tool for drawing out residents' emotional responses to presentations in many subsequent sessions.

In this particular case, a resident I'll call Dr. A. began by describing feelings of being "overwhelmed," "frustrated," and "manipulated." The patient, a middle aged female who scheduled appointments with the resident every few weeks, "rambles on aimlessly," according to Dr. A. She described her sexual relationships "in detail," including a history of sexual abuse as a child. At every visit she requested a pelvic exam: "Doc, would you just take a look?" Dr. A. was growing desperate. "How many times do I have to do a pelvic on her?" he plaintively asked the group. His presentation incorporated a full performance of the patient's speech patterns and mannerisms. For the first time, the other residents began asking probing questions: "Did you feel like turfing her to someone else?" "Do you feel she is using you to reenact her earlier traumas?"

Ideally, Balint group discussions move on from questions directed at the presenter to descriptions of the emotions elicited in the other residents by the presentation. These reflexive insights can then lead on to insightful understanding of the presenter's experience. Several more months passed before the group began to achieve this deeper, more open, involvement in the process. Of course Balint work does not always proceed smoothly. At least once, the three facilitators made a major misstep, as we later concluded, by ignoring a basic convention of Balint work. By addressing a resident's private countertransference rather than focusing on the public emotional dilemmas he had invited us to consider, we trespassed beyond his comfort level. We were not empathically attuned to his excruciating sense of embarrassment. We compounded our mistake by making it rela-

tively early in the group's history, before an adequate sense of trust was established within the group as a whole.

In this instance the resident, Dr. B., presented the case of a white, married woman in her thirties, the mother of two children. The patient, who presented with a productive cough, nasal congestion and possible upper-respiratory infection, previously had been diagnosed with obsessive-compulsive disorder. She was phobic about germs and disease. At this visit, she was found to be in her first trimester of pregnancy. Dr. B. described to the group his patient's ambivalence about her pregnancy, her marriage, and her husband's family, but noted that her greatest fears focused on her possible respiratory infection. Dr. B.'s central concern, confusion, and anxiety, however, initially focused on the patient's marital situation rather than on her phobias. With evident sympathy, he described her husband from the wife's point of view. He expressed concern that she might be thinking of divorcing him although, "she shouldn't be thinking of divorce during pregnancy ... I can understand her anger, but ... " In the mind of the group, Dr. B. had become a partisan on behalf of his patient – *against* her husband.

Yet, he was also profoundly distressed that his patient "goes off on her own to see other doctors so I don't know what's going on ... I do like her; trust her to some extent. I don't think of her as a nut." Another resident wondered if Dr. B. felt that his patient "doesn't have confidence in you?" The presenter then disclosed more of his own concerns than he may have intended: "Well, I've told her she has to choose her doctor. I'm afraid I'll be a co-conspirator in the dissolution of her marriage." At this juncture, one of the group leaders asked, "Would I be off the mark if I speculated that she's attracted to you?" The remark hit uncomfortably close to home. Dr. B. replied, ambivalently, "The countertransference isn't there." When another resident directly suggested that Dr. B. had made an alliance with the patient (and against her husband), Dr. B. resisted this analysis: "No, I think you're wrong." The discussion yielded no further insights that day.

Three weeks later, while reporting on the follow-up to this case, Dr. B. now referred to his patient as "the somaticization disorder." He made no mention of her marital qualms, nor to his own prior ambivalence toward her. From then on, he evinced little overt compassion, empathy, or insight toward this patient. Indeed Dr. B. now expressed the opinion that she was just "using" her husband; following her pregnancy, he speculated, she would "disgard" him. In response to our intrusiveness, Dr. B. had retreated behind his defenses.

About six months into the course of the group, however, the participants were noticeably better attuned to each other's emotional styles. The

following discussion moved forward in three stages from an initial lack of resonance between the group and the presenter, to the accurate perception and mirroring of his concerns, to a final stage in which the group disengaged from the resident's feelings to cognitively reflect on the situation and gain insight into it. The resident, whom I'll name Dr. C., described several months during which he followed the pregnancy of a hispanic woman in her mid-twenties. She had had one previous child, a boy, who was born following a rape two years earlier. Her current, live-in boyfriend had fathered the child she was now carrying to term. At her first prenatal visit, when Dr. C. wished to do a pelvic exam and pap smear, the patient "adamantly refused" because of her previous bad experience during an exam following her rape. Dr. C. explained that her chart showed some cellular changes that might be the early signs of cervical cancer. Yet she refused. Even after several visits to the departmental psychologist to begin working through unresolved issues related to her sexual assault, she would not consent to be examined.

Dr. C. revealed that his anguish over the case stemmed from two issues: first, even after he successfully delivered her second child, she never returned for a pap smear; second, she seemed neglectful of both her children. The older son seemed starved for affection whenever they came in; he was very protective of his new baby sister, but their mother seemed uninterested in holding either child. Since their last visit, Dr. C. related, "I tried frantically to get hold of her. [Her phone was disconnected.] It's eating at me. It's been three years since the aplastic cells were first seen . . . I don't know what else I can do. Maybe I pushed too hard at the beginning. As for the son, there's just something that doesn't seem right. He ran right up to me to be held even at the first visit. He was right by my side during the entire time. It doesn't seem right for a two year old. Usually at that age they run to the other side of the room or to their mothers and start screaming. Did I miss something?"

At first the group had little to say. One of the facilitators commented, "It seems the group is having trouble connecting with this case." After more unfocused questioning by the others, another facilitator commented to Dr. C., "I imagine you still have a nagging, hangover-ish feeling about the case. But I still don't know how you're feeling about you." The group was groping for an accurate take on Dr. C.'s feelings, but did not yet have it. Slowly, though, the residents began to process their own emotional responses to the narrative. One resident asked, "Who do you feel sorry for? *I* feel sorry for the boy." Dr. C. replied, "I felt sorry for the boy, too." Another participant commented, "I *feel* this as a case where I identify with

the son and therefore get angry with the mother. I picture us as always moving forward toward her, and she's always receding back from us ... "

Dr. C. verified that he, too, felt as we were then feeling. Another resident, of hispanic ethnicity like the patient, drew deeper from his own experiences as he commented, "I think cultural factors may be important... Personally, I think if my wife was raped she might kill herself. Did you find out anything from the psychologist?" Dr. C. revealed that the patient was found to be "depressed and even suicidal." He recalled that the son might have been the product of the rape. Several participants nodded, and one commented insightfully, "That would explain a lot about her shutting him out." This insight also illuminated the dynamic of the resident's relationship to the patient.

5. CONCLUSION

After meeting for more than seven months, many of the residents began to look forward to seeing the very patients whom they previously had dreaded. As Dr. C.'s case suggests, the reflexive interpretive skills developed through Balint work can enhance physicians' ability to "read" the doctor-patient relationship and their own contributions to it. Through development of empathy, they deepened their understanding of the patient's narrative and a commitment to become more responsible for the part they play in the dialogue. In this way empathic knowledge can move from understanding to responsible action.

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NOTES

[1] Jay Katz, M.D., *The Silent World of Doctor and Patient* (New York: The Free Press, 1984), p. 122; SUPPORT Principal Investigators (Alfred F. Connors, Jr., M.D., et al.), "A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients," *JAMA*, 1995, 274: 20, pp. 1591–1598.

[2] Maureen A. Milligan and Ellen Singer More, "Introduction," in Ellen S. More and

Maureen A. Milligan, ed., *The Empathic Practitioner: Empathy, Gender, and Medicine* (New Brunswick, N.J.: Rutgers University Press, 1994), pp. 1–15.

[3] Ellen Singer More, " 'Empathy' Enters the Profession of Medicine," in More and Milligan, ed. *The Empathic Practitioner*, pp. 19–39, esp. pp. 19–22.

[4] *American Heritage Dictionary*, 3rd Edition, 1992, cf. entries for "Empathy" and "Pity."

[5] Increasingly the term "hermeneutics" has encompassed not only the act of interpreting texts to establish meaning, but also the recognition of the reflexivity of the interpretive process and the role of the interpreter. Cf. Paul Rabinow and William M. Sullivan, "The Interpretive Turn: A Second Look," in Paul Rabinow and William M. Sullivan, ed., *Interpretive Social Science: A Second Look* (Berkeley: University of California Press, 1987), pp. 1–30; More, " 'Empathy' Enters the Profession," pp. 21, 31 – 34; Lorraine Code, *What Can She Know?* (Ithaca, N.Y.: Cornell University Press, 1991). For an earlier use of the concept of hermeneutics in clinical practice, see Byron J. Good and Mary-Jo DelVecchio Good, "The Meaning of Symptoms: A Cultural Hermeneutic Model for Clinical Practice," in Leon Eisenberg and Arthur Kleinman, ed., *The Relevance of Social Science for Medicine* (Dordrecht, Holland: D. Reidel Publishing Co., 1981), pp. 165–196, esp. n.3.

[6] R. Schafer, "Generative Empathy in the Treatment Situation," *Psychoanalytic Quarterly*, 1959, 28: 3, pp. 342–373.

[7] Robert L. Katz, *Empathy: Its Nature and Uses* (London: The Free Press of Glencoe/Collier-Macmillan, 1963), pp. 7, 8, 144.

[8] Judith V. Jordan employs the term "self-empathy." Cf. Jordan, "Empathy and the Mother-Daughter Relationship," in Judith V. Jordan, Alexandra G. Kaplan et al., *Women's Growth in Connection* (New York: Guilford Press, 1991), pp. 29, 30; R. Schafer, "Generative Empathy in the Treatment Situation," uses the term "intrapsychic empathy."

[9] Robert W. Levenson and Anna M. Ruef, "Empathy: A Physiological Substrate," *J. Personality and Social Psychology*, 1992, 63:2, pp. 234–246, esp. p. 234.

[10] Lorraine Code, " 'I Know Just How You Feel': Empathy and the Problem of Epistemic Authority," in More and Milligan, ed. *The Empathic Practitioner*, pp. 77–97.

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[13] Martin L. Hoffman, "Empathy, Its Limitations, and Its Role in a Comprehensive Moral Theory," in William M. Kurtines and Jacob L. Gerwitz, ed., *Moral Behavior and Development* (New York: John Wiley and Sons, 1984), pp. 283–302, esp. pp. 286, 287.

[14] Alexandra G. Kaplan, "Male or Female Psychotherapists for Women: New Formulations," Judith V. Jordan et al., ed., *Women's Growth in Connection*, pp. 268–282.

[15] Renee C. Fox, *The Sociology of Medicine: a participant observer's view* (Englewood Cliffs, N.J.: Prentice-Hall, 1989), p. 85.

[16] As quoted in Ellen Singer More, " 'Empathy' Enters the Profession of Medicine," in More and Milligan, ed., *The Empathic Practitioner*, p. 31. Also see Jodi Halpern, "Empathy: Using Resonance Emotions in the Service of Curiosity," in Howard Spiro, Mary G. M. Curnen et al., ed., *Empathy and the Practice of Medicine* (New Haven, CT: Yale University Press, 1993), pp. 160–173, esp. p. 172.

[17] Cf. Robert C. Solomon, "The Philosophy of Emotions," in Michael Lewis and Jeannette M. Haviland, ed., *Handbook of Emotions* (New York: Guilford Press, 1993), pp. 3–15, esp. p. 12.

[18] Clive D. Brock and Ronald D. Stock, "A Survey of Balint Group Activities in U.S. Family Practice Residency Programs," *Family Medicine*, 1990, 22: 1, pp. 33–36.

[19] Cf. J. Norell, "The International Balint Federation: past, present, and future," *Family Practice*, 1991, 8: 4, pp. 378–381.
[20] All quotations from Michael Balint, "Psycho-analysis and Medical Practice," *Int. J. Psycho-Anal.*, 1966, Vol. 47, pp. 54–62, esp. pp. 54, 57, 60. Also see E. Balint and J. Norell, *Six Minutes for the Patient* (London: Tavistock, 1973).
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[22] Balint, "Psycho-analysis and Medical Practice," pp. 54, 57, 60.
[23] Paul H. Ornstein, M.D., "The Family Physician as a Therapeutic Instrument," *J. Family Practice*, 1977, 4: 4, pp. 659–661.
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[25] Leifur Dungal, M.D., "Physicians' Responses to Patients: A Study of Factors Involved in the Office Interview," *J. Family Practice*, 1978, 6: 5, pp. 1065–1073.
[26] Michael Balint, "Psycho-analysis and Medical Practice," p. 60.
[27] Balint, ibid., p. 60.
[28] Lee Scheingold, MSW, "A Balint Seminar in the Family Practice Residency Setting," *J. Family Practice*, 1980, 10: 2, pp. 267–270; idem., "Balint Work in England," pp. 316–317.
[29] Cf. C. D. Brock and J. V. Salinsky, "Empathy: An Essential Skill for Understanding the Physician-Patient Relationship in Clinical Practice," *Family Medicine*, 1993, 25: 4, pp. 245–248.
[30] The two principal group leaders are Drs. Donald Nease and Jeffrey Steinbauer.
[31] This author requested, and received, permission from the other group members to draw on group discussion for this article. In all such case discussions, the identities of both resident and patient have been disguised to insure anonymity for patients and to preserve the confidentiality of the group's proceedings.

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