TRANSFER OF CLINIC PATIENTS TO PRIVATE PRACTICE *
Discussion on Paper by Caroline Polmear Et Al

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I am delighted to be asked to respond to this presentation and to have an opportunity to congratulate the five authors for a very vivid account of some of the issues arising from the transfer from Clinic auspices to private practice.

Although pin-pointing the reactions to the change of setting, the loss of an external authority and the problem of private fee-setting, the authors have also raised many broader questions, such as the charitable status of the Clinic and the considerable neglect in our affairs of any serious study of the meaning of money in the psychoanalytic relationship.

When Freud wrote that "Money matters are treated by civilised people in the same way as sexual matters - with the same inconsistency, prudishness and hypocrisy", he might have added "and secretiveness".

What I particularly liked about the paper was that the authors, although showing the problems surrounding the transfer, also see it as having been a very rich learning experience. They do not suggest we change the system by, for instance, abandoning our charitable status, charging more realistic fees from the start or having no Clinic and no Clinic Director and obtaining training cases in other ways, as happens in many other Societies.

I can only elaborate some thoughts on a few points raised by the paper. Firstly, do the patients deceive the clinic with regard to finances? It is undeniable that this happens because, as the authors say, the over-riding task is to find patients for the students, rather than to collect money. Our legal advisers say that, as a charity, we must never say that we charge fees, but only that we accept whatever contribution the patients can afford. This, for many patients, creates an irresistible temptation to lie. To add to that, there is an anomaly, since similar training organisations, all Registered Charities, have for years charged set assessment and set session fees. Puzzled, I asked 'why' of the Institute's Solicitor, when I became Director in 1985. He explained to me that we were the first such organisation in this country, and we should therefore have higher and purer standards. I was pleased that we were seen as superior to the newer institutions, though this anomaly has bothered me ever since. To return to the dishonesty about financial resources, my impression is that men conceal more often than women, although it may be the case that the usual shortage of male cases plays a part in that the consultant at assessment, and later the analyst, may turn a blind eye to their deceptions. It is probably also often the case that men (most men and not only Clinic patients) avoid being seen to be deceptive by managing to have only a vague idea, or even no idea at all, what resources they've got, what they earn or what they owe. This impression is based on clinic data, and confirmed by a report of a study in the U.S.A. by accountants and tax officials showing that women were three times more moral than men financially!

Students and supervisors sometimes say that the Clinic Consultant was remiss in not exploring the patient's resources at the assessment interview. Indeed I have said so myself, noting that they only discuss the Consultation contribution. But there are two reasons for this (1) Detailed contribution discussions before any decision on suitability is taken may give the impression that the patient is already accepted and (2) If the patient is rejected detailed financial discussion at the assessment may lead him to believe that his proferred contribution was the reason for his rejection. We now come to the Charity status. It means we are tax exempt. In other words it saves us a lot of money. But what does it mean psychoanalytically that we are a Charity? It is highly relevant to reflect on this because we offer patients a Charity 'home' for a few years, and then we evict them. But to the prospective patients what impact does it have and how do we understand it analytically? We proclaim our charitable status on nearly every letter. Everyone working for the Clinic likes the feeling of being a Charity. Who would not wish to be on the side of the Angels? But our virtuousness does not always provoke grateful responses.

A young City whiz-kid, made redundant, faced financial ruin and 'phoned to enquire about Clinic analysis. Told by me we are a Charity he rang off saying - 'my situation is desperate, but not so bad I must accept charity.' Just before Christmas, we send out a simple financial form to each patient just at the time that all the Charities make their appeals. We ask if their income or overheads are changed, and if the patient can increase his contribution. The reality purpose if straightforward (1) to encourage the patient to make a more realistic contribution which benefits the analysis and (2) to try to move up the contribution so that the analyst is not carrying a very low fee case after transfer to private practice. But the question on the form that says "The Clinic is a Registered Charity which relies on patients' contributions. Are you able to raise your contribution - yes/no" is not always well received. To some, it will be very persecutory; the

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financial form handed by the Analyst will seem like the rattling of a Collection Box, saying "The Charitable Mother relies on her children to look after her." Some patients refuse to complete the form or even to accept it. I believe Charities are respected, loved, distrusted, feared, or even hated. Very much the variety of responses evoked by the breast. Our reasonable financial form has about it more than a hint of blackmail, exasperating to patients whose mothers were adept at provoking guilt.

Some students strongly dislike discussion of the contributions with their patients, or presenting the financial review form, believing all this should be the clinic's responsibility, so that the analysis could be free from the disagreeable subject of money.

A student reported to me that his patient tore up the financial form and threw it on the floor. During the War when I was a Charity Assistant, I had to take a food voucher to each of about 30 families in slum tenements, which I did after school. Afterwards I felt very good - saintly even! Most of the families were grateful, but not all; some tore up the voucher and shouted abuse. At that time I did not appreciate how persecutory a good object could be.

Patients react to the Clinic as a Charity as if we were an Oxfam shop. There are many for whom our charitable status is completely irrelevant; we are a shop like any other. Some think of us as a latter day Pawn Shop, where go the poor, and to be avoided; yet others see us as an altruistic shop wherein very good treasures can be obtained at bargain prices. Finally there are those who see us as presenting a charitable face, to hide the ultimate lucrative private practice goals. I base this on various angry - and very grateful, letters I have received, and on what students and newly qualified analysts have told me. The value of our system is that it brings into analysis the question of money and fee setting, and I am sure the authors are right when they say that the question of fees is hardly ever written about, and may even go unanalysed. It is probably the case that the higher the fee the less likely it is to be analysed. The courageous struggles of our students, and of the authors in bringing this topic before us, are reminders that our charitable status, conceived probably as no more than a Tax avoidance measure, opens up many of the elements surrounding contributions to Charities and the setting of fees in general in private practice.What of the International scene? A few years ago I circulated a questionnaire through the I.P.A. to establish the incidence of Clinics as against a system of finding training cases from supervisors or in other ways.Out of 31 replies, 16 had a Clinic and 15 not. Only two, in Europe, have a Clinic. Twelve in North America have clinics, the rest in South America. Some countries, like France, had once had a Clinic but had given it up because of discontent with the clinic's choices of patients. One country in Europe, two in South America and one in North America, who had given up Clinic were taking steps to re-open one. Societies with Clinics had far greater interest in analysablity and were keen for opportunities to discuss it. There seemed a lot more dissatisfaction with the ways patients for candidates were found in some countries in Europe and South America with sometimes the supervisor, and perhaps the analyst, overtly or covertly involved in the referral. Several people overseas have said they hoped I would not propose having no clinic in London. Borrowing from the theme of the last International Congress "Chaos or Petrification", one young visiting analyst said to me there "In my country the Clinic was abolished because people thought it stood for Petrification, but I can tell you having no Clinic has led to Chaos". Her country is considering re-establishing a Clinic. I hope tonight's paper can reach the international psychoanalytic community by way of an appropriate journal, so that there can be some interchange on the organisation of clinical training in the component societies.