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Editorial: The Doctor, his Patient and the Illness - revisited

Michael Balint's book, The Doctor, his Patient and the Illness, was first published in 1957. This is the book that introduced Balint groups to the world. Everyone in family medicine has heard of it and we in the Balint movement speak of it with reverence and respect. We recommend it to our students and our registrars. But how long is it since we read it ourselves? If we read it again, we will approach it with a new curiosity. New questions will arise. How does Michael Balint's 1950s group compare with the ones we have today? What was he really trying to do, or in the language of narrative medicine, what story was he trying to tell?

In the introduction, Balint tells us straight away of his discovery that the most frequently prescribed 'drug' is the doctor in person. A lot of important things are going on psychologically between the GP and the patient that only the GP can observe. But the GP doesn’t quite understand what is happening because he is not psychologically trained. In order to further the research, Michael had to train the doctors in psychotherapy and find a way to do this.

What did the 'training' consist of? This is not explicitly stated, but one of the first things he must have done was to encourage the doctors to get the patient back for a long interview. Once that begins, the floodgates are opened and the patients pour out their personal stories for the first time. Nowadays we rarely do long interviews and Balint himself changed his mind about them. In the later book Six minutes for the patient, he declared that the long interview was 'a foreign body' in the heart of general practice. Many GPs were relieved because they now felt free to apply the method to
all their patients and not just selected ones. But in the 1950s, the long
interview was essential. Balint also says that the doctors had to learn how
to listen; in a way that would involve 'a limited but considerable change in
personality'. How did this happen? It seems, from the text and from
appendix 1 on Training, that this was largely taught by example. He
listened attentively to the doctors as they presented their cases and they
were given a model to use with their patients. There were no lessons in
interviewing and communication skills. And definitely no videos.

The book contains 28 case histories that give us a historic picture of what
life was like in north London in the early 1950s. One has the impression
that the patients' lives are rather sad. Most people are very poor and there
isn't a great deal to do. Rock and Roll has not been invented and Swinging
London will not arrive till the 60s. The shadow of war still hangs over
everyone. Some patients had been injured in the war or had become
prisoners. There is a great fear of tuberculosis. Parents are strict and the
young are sexually frustrated. The chief source of entertainment seems to
be the cinema, which is mentioned surprisingly often.

What sort of illnesses did the patients present to their doctors? Balint
observes that people who are unable to express their emotional distress
will convert it into a series of physical symptoms, which they offer to the
doctor. The doctor turns down the first few offers by saying: 'I can find
nothing wrong with you. Don't worry'. But of course, this reassurance
doesn't work and the patient tries again. Finally, the doctor accepts an
offer, an illness is agreed and the two of them settle down to treat it over
the next few years. Specialists are called in but they are all useless. Often a
referral ends up with the famous 'collusion of anonymity' where the patient
is passed from one specialist to another with nobody taking responsibility
for the whole person.

When the doctor offers a long interview, there is spectacular change. The
patient releases all the details of his or her unhappy life and begins to feel
better. At last, there is someone who will listen! The doctor is excited but
apprehensive. Suddenly he has turned into a psychotherapist. But what
happens now? He is like a trainee pilot who has managed to get the plane
off the ground but isn't at all sure how to fly it. Most worrying of all, he has
no idea how he is going to land safely. The book has chapters called 'How
to begin' and 'When to stop' to deal with these questions. Some of the
doctors are only too eager to keep flying. Some report spending an hour a
week with the patient, in one case on a Saturday afternoon! The more
ambitious ones make bold interpretations, just like they imagine an
analyst would. Balint seems unperturbed by their clumsiness. But he does
warn them not to go too fast, not to interpret before the patient is ready and
not to be too intrusive. There are some successes and some failures. 'Dr H',

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who seems to be the only woman in the group, does some of the best therapeutic work. She is not only bold and brave but sensitive, and is able to cope with a male patient who has sexual fantasies about her. It is a little ironic that a book called the 'Doctor His Patient and the Illness' should have a woman doctor giving an object lesson to the men.

But most of the doctors do not have ambitions to be therapists. Many are content with the gains that follow the first long interview. Some find further opportunities to listen and to help. Balint refers to what he calls 'the special psychological atmosphere of general practice'. By this he means the way in which the ongoing relationship allows the doctor to stop being a therapist when the patient has had enough, and to go back to being an ordinary doctor. He may later treat the same person for a cough or a painful back or even deliver her baby. But if the patient wants to talk about herself and her feelings again a few months or years later, the doctor is again available to be a therapist. A psychiatrist can't do this. When it's over, it's over. Some GPs, instead of being therapists, rely on what Balint scathingly calls their 'Apostolic Function'. He explains that all of us have firm ideas about how people should live their lives and manage their illnesses and some of us are unable to resist trying to convert the patient to our point of view. Balint says this is like using 'common sense' and is therefore useless. However, he has to admit that sometimes it seems to work. One doctor tells a patient's husband that he must allow his wife to have a baby because it is her right as a woman. The husband accepts that he must change his attitude, the baby is born and the wife feels much better! Another doctor is able to convert some of his patients to his belief in the psychosomatic nature of their symptoms. Whatever the doctors do, Balint always has an open mind. He is willing to learn as well as to teach by example.

How does all this compare with the world of 'Balint' today? If the Michael Balint of the 1950s were to come back to pay us a visit, would he recognise the groups that carry his name? Would we accredit him as group leader or would we say: 'Sorry, Michael, you are going to need further training'?

The first difference that stands out is that we no longer try to turn GPs into psychotherapists. The long interview has all but vanished. But we still value good listening. In the book, we don't find the leader asking the doctors about their feelings. Nor to imagine how the patient might be feeling. The word 'empathy' does not occur. Balint does say in one place that it's important to be aware of the feelings that come from the patient but it does not seem to be a regular part of his technique. There is also no mention of the group having a supportive function for its members or helping to protect them from burnout. We attach great importance to this nowadays, and many old group members have confirmed that they did.
appreciate the support and believed that without the group, burnout would have overtaken them.

What would the group have been like? Could we have survived in it? I think you had to be pretty tough. Michael doesn’t say anything about protecting the doctors from aggressive questioning or criticism. Perhaps Enid’s influence was important in the development of the group process and the emotional climate of the group. Michael Courtenay who was in their group in the 1960s says that she would intervene ’to protect the chicks’ if Michael was getting too abrasive.¹

Should we still encourage our students to read The Doctor, the Patient and the Illness? I definitely think we should. They should read it firstly because it’s a classic: a book that changed general practice forever. It has influenced not just people like us who are involved with Balint groups but everyone who works in primary care. It was the first book to study and describe the process of consultation. It was the first book about patient centred medicine. And it laid the foundations for what we are doing now. Balint work and Balint groups may have changed but some of the most important ideas are there in the book. They include learning to listen; being curious about the patient as a person with feelings and a life story; the difficulties of dealing with psychosomatic symptoms; not trying to go too quickly; and the need to be tenacious and to keep trying.

It is also fascinating to trace the development of Michael Balint's thought as the book progresses. Towards the end, in the two chapters on the 'The Apostolic Function', he seems to acknowledge that all doctors are different and that he is not going to produce a standard model of a GP psychotherapist. One can imagine him thinking: 'I've shown them how to listen but after that, they might as well be themselves. They will all do their own thing anyway and that's how they will get results.' Then in chapter XX ('General Practitioner Psychotherapy') he says that the doctor can take risks but he should never forget that he is a family doctor and not an amateur psychiatrist. He also stresses the importance of the Mutual Investment Company: the store of experiences that doctor and patient build up together over a period of time. We really need to be able to stay with our patients to do this kind of work. One can only hope that governments and health planners will recognise how vital it is for patients to have continuity of care from the same doctor over a period of many years if they are to receive the benefit of this kind of treatment.

John Salinsky
