Analysis

Balint work and the flourishing practitioner

INTRODUCTION

Visiting a community clinic in China some years ago, we saw a room with seats placed beneath hooks in the ceiling. Seeking an explanation, the doctor reluctantly admitted that most people expected intravenous antibiotics for sore throats. She knew it was unnecessary, but if the clinic didn't do it people would just go to the hospital.[1] The doctors in this clinic were not flourishing. The doctor's unease illustrates the discomfort of practising primary care medicine in an unsympathetic context with the wrong tools, and without a culturally shared understanding that differentiates it from technical biomedicine.

Doctors in that clinic did not have the benefit of the long history, training, and esteem that generalist doctors have in the UK. But, in spite of these advantages, our UK discipline of general practice remains marginalised within the wider discipline of medicine. Whether in medical education, where GPs can still be seen as the doctors falling off the specialist ladder, or in everyday conversation, when the comment *'So you're just a GP?'* holds a sting with consequences for how we practise. For many GPs there is a lack of flourishing that goes beyond the current crisis of workforce, time, and money currently tearing at the substance of the NHS.

When Michael Balint started his groups for GPs in the 1950s, also a time when practices were poorly resourced and edging towards crisis, his idea of bringing a specialist service into the consulting room soon gave way to providing a meeting place for GPs and psychoanalysts to study the everyday work of general practice. By paying attention to unfolding, often difficult, encounters in the surgery Balint opened a window onto an additional approach to medicine that needed study.

Other commentators[2] have noted the challenge that Balint brought to the hegemony of biomedicine in Western culture. Muench[3] contends that Balint describes an alternative theory of knowledge, a *'countercultural epistemology'* for general practice, built on the demonstration that technical biomedicine is insufficient to understand the problems that patients bring to doctors.

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DEVELOPING THEORY AND PRACTICE

I want to expand these ideas, centred on the notion that the group-work done by GPs with Michael and Enid Balint, while apparently concentrating on the doctor–patient relationship, also furthered the theory of generalist medicine in two distinct ways.

First, through the shared experience in groups GPs developed a language and a set of shared theories about their everyday practice. An epistemology of practice was emerging. Many will know some of the phrases from the original book: *'the drug doctor'*, the *'collusion of anonymity'*, the *'mutual investment company'*.[4] These are theories describing the everyday work of doctoring. From these encounters the consultation emerged as the particular tool of general practice, worth teaching and study.[5]

The second way is related to the reflective focus possible within the group. The implicit norms of medical practice begin with student life in hospitals, but the particular attributes required by GPs are learned outside the hospital setting. Often these are first recognised and then developed through case-discussions, challenges, and reflective silence within a group.

Turning to Aristotle, these attributes are akin to the *'moral virtues'* (courage, honesty, generosity, and temperance), which he described as acquired character traits, or habits of behaviour, which lead to habitual good choices in life. Much of the expertise possessed by a skilful GP in their interactions with patients is derived from these moral virtues, and is acquired in a similar way: by apprenticeship, reflection, and regular practice till they become habitual. These virtues-for-practice can be thought of as part of the generalist doctor's toolkit.

This link between Aristotle's virtue ethics, with its focus on *'how should we live if we are to flourish'* and the attributes needed to flourish in medicine, is explored by Toon,[6] and contrasts with a consequentialist approach to ethics, which prioritises actions that maximise some valued outcome, such as longevity.

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THE GENERALIST ROLE AND WHAT IT REQUIRES

Barbara Starfield is well known for gathering worldwide evidence showing that a strong generalist presence within medicine is associated with better outcomes, a more equitable distribution of health in populations, and protection for patients from inappropriate specialist care.[7] However, this evidence is frequently crowded out by a resistance, rooted in the power structures of Western culture, which reinforce the dominance of biomedicine and the primacy of specialists.

For generalist doctors to flourish they need a suitable resource of vocabulary and concepts to build their own theory. They need to explore the interpretive, the hermeneutical, aspects of their discipline, and create a language to frame their professional activity. The importance of this can be illustrated with an example from outside medicine.

Before feminism, there was no vocabulary or concept — no ready-at-hand understanding — to articulate the distinctive social experience of sexual harassment. Perhaps men, who dominated the places where ideas are generated, but had little experience of sexual harassment, were not able to find the language and concepts. This emphasises the importance of peer-groups, freedom, and imagination

Box 1. Case history

Version 1

Imagine you are a salaried GP at a surgery that offers web-based consultations. That morning you are allocated one for 'elbow pain' from a patient seen twice in the last 2 years by his regular GP.

The form tells you he is a chef, and from the clinical questions you gather that for 6 weeks he has had pain on the outside of his right elbow, worse on picking things up.

Confident that this is a case of tennis elbow, you send him a link to a video of eccentric exercises, and an information leaflet. You sign off the email suggesting that, if his pain hasn't improved in 4–6 weeks, he should ring the open-access physiotherapy service for further advice.

Version 2

Mohammed Aziz is on your list that morning. Calling him in you notice he is wearing a suit, and your imagination races, noticing the unfilled shoulders of his jacket and how he shrinks into the seat with an attitude that speaks of resignation.

You ask how you can help him, and he explains the details of his painful elbow, that he works in a restaurant, and repetitive work with the cooking pans must be the cause. He falls silent with a slight frown, which is clearly asking to be taken further. While examining his arm you try out a comment about whether he has lost some weight. And then he tells you about leaving his accountancy business in Pakistan, that his wife and family are not yet with him, and although he lives with relatives he is lonely and gets home too late for family meals.

You show him eccentric exercises for his epicondylitis, touching his scrawny arm in solidarity, and suggest he sees the social prescribing coordinator, who may have ideas about alternative work or other opportunities.

to build a satisfying explanatory theory to allow previously impoverished topics to become more culturally visible.

Alongside this need for theory, generalist doctors also require the reflective space to develop practical wisdom, Aristotle's *'phronesis'*. This is the ability to apply principles, or acquired virtues, in real-world medical situations that one could not have foreseen beforehand.

CHALLENGES TO FLOURISHING

In my view there are two longstanding trends in medicine that continue to adversely affect the development of relationship-based general practice. Both leave GPs with deficient or distorting explanatory resources with which to frame their professional activity.

The first trend is the *specialist paradigm*: a privileging of specialist medicine as more worthy of attention, funding, and status than generalist medicine. This tacit understanding leads to a neglect of generalism, and remains a contemporary problem.

Consider this quote from a study of medical students' views of general practice in 2016:[8]

'... the GP tutor we had, she was an absolutely amazing GP [...] *she just did it amazingly ... because there's a saying, isn't there, that it's easy to do the job badly, but it's hard to do it well as a GP.'*

This not only shows that the student intuitively recognises the well-done job of this GP tutor, but it also demonstrates the difficulty of articulating the elements of this excellence.

The imbalance of interpretive resource-for-articulation between generalist and specialist contributes to a reluctance of students to take up general practice, and to the relative poverty of explanatory theory applied to the everyday work of GPs. Miranda Fricker is a philosopher who has explored epistemic injustice, which is the concept of injustice related to a disparity of knowing. She writes:[9]

'... relations of unequal power can skew shared hermeneutical resources so that the powerful tend to have appropriate understandings of their experiences ready to draw on as they make sense of their social experiences, whereas the powerless ... [have] *at best ill-fitting meanings to draw on in the effort to render them intelligible.'*

A second challenge to flourishing is the *bureaucratic*, or *managerial*, paradigm. Bureaucratic medicine is scientific, relying on biomedical knowledge and bureaucratic in the sense of relying on rule-based implementation: *'one way best'* of doing things; a *'single answer'* to any clinical problem. This trend aims to gain control over the traditionally uncertain, situated, co-constructionist relationship between doctor and patient. It requires the conceptual commodification of the outputs of medical care, such as the Quality and Outcomes Framework (QOF). In general practice this is also seen in the trend towards stratifying patient activity into product lines to improve access and efficiency. Organisational efficiency is laudable, but a primary focus on access and segmentation subtly introduces new conventions that describe *'how things are'*. The process of commodification can become normalised, or internalised — hence GPs may come to see QOF performance, or similar metrics, as the key measure of quality in practice.

This process is illustrated by the case history in Box 1.

The second description shows the doctor using technical skills as a bridge to move from an instrumental role in providing a plan for his patient's epicondylitis, into a relational role in seeing his disappointment at the direction of his life, and accepting the role of witness to his predicament. His arm pain and his life course are inextricably linked, and the doctor can engage — at the patient's pace — in renewing a painful narrative.[10]

These two trends, with the specialist recruiting the explanatory resources and the managerial project crowding out the context-laden knowledge of the doctor–patient relationship, can alter the conception of what it is to be a doctor. Without resistance these processes can loosen and dismantle much of the interpretive understanding of the practice of a good generalist doctor.

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SUPPORTING RELATIONSHIP-BASED CARE

The practice of medicine includes knowing a set of abstracted rules and guidelines.

But the work of a skilled GP cannot be substituted by the mechanical application of a list of rules — however long. The capacity to recognise, and make, *situated judgements* rooted in the context of the individual, is learned by reflecting on actual cases seen in practice. A good place for this to happen is in a professional group.

Focusing on the doctor–patient relationship, work within a classic Balint group remains close to the doctor's everyday world. Changes in perception brought about by attentive listening to other group members, occasional insightful links to deeper issues, and the nudging by group leaders to stay on task creates a template for future reflective practice. Such groups are places where development of the necessary virtues-for-practice can be supported. Each doctor has an apprenticeship built around their own casework with patients. By necessity each generation of doctors needs to retake similar ground, make similar mistakes, and learn the same lessons. A goal of this training should be to ensure that these distinctive virtues-for-practice become more explicit. They should be widely recognised as part of the necessary toolkit for practice.

As practices get larger and busier we need fresh approaches to ensure space for the doctor–patient relationship to flourish. The individual work of doctors — the focus of classic Balint work — is easily crowded out by the demands of complex organisations. Nowadays a patient can get lost in the round of consultations within a practice, with no one apparently taking control, suggesting that the *'collusion of anonymity'* has migrated out of the hospital.[11] Remaining attentive to these broader practice needs might involve group-work, whether a classic Balint group or one with a focus on the dynamics of organisations. Such groups can clarify organisational purpose, validate activity, and loosen defences that develop when a practice feels it is working in a hostile environment.

RESEARCH FOR RELATIONSHIP-BASED CARE

The research undertaken by early Balint groups are valuable examples of medical ethnography. These monographs, set in the social context of their times, provide detailed observations that illuminate the stages of discovery in our interactions with patients and group members.[12,13]

The research needs of today are different. In facing the growing demands of complex multimorbidity in an ageing population, we need to re-examine some broader factors in health systems that can affect the delivery of relationship-based care.

Two examples serve as illustrations. The triadic relationship in the consultation between the doctor, the patient, and the computer has been studied by Swinglehurst. She found that GPs spend about 40% of their time interacting with the computer. A silent but consequential voice, the computer produces a dilemma of attention between the immediacy of the consultation and the demands of the electronic record.[14] She concludes that the computerised record creates new forms of order, and new work. It frequently privileges institutional views of the patient over the individual account, requiring skill and effort in the consultation to redress.

The second example is from the growing body of research on the clinical benefits of continuity of care.[15] Longitudinal continuity is a necessary condition for relationship-based care, and frequently reported as a factor making a GP's work rewarding. Measuring continuity across all practices in a health district demonstrates a threefold variation in rates, reflecting important — but unexamined — differences in organisation and culture.[16] With clear benefits for patients and health systems, supporting continuity and learning from high-scoring practices should be part of health policy.

CONCLUSION

The history of general practice in the UK provides hope in challenging times, demonstrating how GPs have worked to build theory and correct the distortions regarding their professional activity. These reflective processes need support from practising GPs as well as those in professional and academic organisations, so that the self-understanding of general practice continues to be effectively renewed.

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REFERENCES

1. Hull SA. Lessons from the intravenous room in Hangzhou. *Br J Gen Pract* 2007; **57(542):** 754.
2. Barnett BR. Balint, the doctor, and the fear of being unscientific. *J R Coll Gen Pract* 1979; **29(206):** 520–524, 528–529.
3. Muench J. Balint as a medical counterculture. In: *Proceedings of the 22nd International Balint Congress*. Brussels: Belgian Balint Society, 2022: 87–94.
4. Balint M. *The doctor, his patient and the illness*. London: Pitman Publishing, 1957.
5. Royal College of General Practitioners (RCGP). *The future general practitioner: learning and teaching*. London: British Medical Journal, 1972.
6. Toon P. *A flourishing practice?* London: RCGP, 2014.
7. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q* 2005; **83(3):** 457–502.
8. Nicholson S, Hastings AM, McKinley RK. Influences on students' career decisions concerning general practice: a focus group study. *Br J Gen Pract* 2016; DOI: https://doi.org/10.3399/bjgp16X687049.
9. Fricker M. *Epistemic injustice: power and the ethics of knowing*. Oxford: Oxford University Press, 2007.
10. Hull S, Hull G. Recovering general practice from epistemic disadvantage. In: C Dowrick, ed. *Person-centred primary care*. London: Routledge, 2017: 1–23.
11. Elder A. Balint at the cutting edge: contributing in a changing world. *Journal of the Balint Society* 2013; **41:** 14–23.
12. Salinsky J, Sackin P. *What are you feeling, doctor? Identifying and avoiding defensive patterns in the consultation*. Abingdon: Radcliffe Medical Press, 2000.
13. Balint E, Norell JS. *Six minutes for the patient: interactions in general practice consultation*. London: Tavistock Publications, 1973.
14. Swinglehurst D. Challenges to the 'self' in IT-mediated health care. In: C Dowrick, ed. *Person-centred primary care*. London: Routledge, 2017: 54–76.
15. Pereira Gray DJ, Sidaway-Lee K, White E, *et al*. Continuity of care with doctors — a matter of life and death? A systematic review of continuity of care and mortality. *BMJ Open* 2018; **8(6):** e021161.
16. Hull SA, Williams C, Schofield P, *et al*. Measuring continuity of care in general practice: a comparison of two methods using routinely collected data. *Br J Gen Pract* 2022; DOI: https://doi.org/10.3399/BJGP.2022.0043.