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An interview with Michael Courtenay by John Salinsky (2004)

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JS: May I take you back to your first meeting with Michael Balint. How did that come about?[1]

MC: I had written to him after first reading *The Doctor, His Patient and the Illness* and said I was interested in joining a group, so he wrote back with an appointment to go and see him at the Tavi. It was the most searching interview I've ever experienced. He seemed to penetrate one. He said 'how many children have you got?' (We had four at the time) and he said: 'four children!'. But he didn't seem to be very focused on what we were going to do. It seemed to me very personal; he was shining a searchlight on me as a person.

JS: You'd been in practice a few years by then?

MC: I'd been five years in practice then.

JS: And were you aware of some frustration with the way patients presented?

MC: I was aware of having no training that seemed to have any application on what I was supposed to be doing. The emotional side of ill-health certainly made itself known to me. I attempted to meet this by reading funny little books about 'anxiety' etc. But at least I knew that the deficiency was what went on in people but I couldn't find an answer.

JS: Did you have some background interest in psychiatry? Were you aware that there would be a lot of emotional stuff in general practice?

MC: No. Not at all, really. I had no idea what I was going into.

JS: So the book really spoke to you —

MC: Yes. I thought: this man knows the problems. And he indicates possible ways of approaching them. And I need this because otherwise I'm going to be thrashing about wildly as I've done for five years.

JS: So you arrived at your first group. Can you remember what that was like?

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[1] First published 2004, Vol. 32, *Journal of the Balint Society*.

MC: I do indeed. It actually took place in the drawing room on the first floor of 7, Park Square West. This turned out to be improper later on and the Tavistock Clinic rapped him over the knuckles and said we had to meet in the Tavi itself. But we met at Park Square West for a whole year, about eight of us. It was a beautiful room with some wonderful artefacts on the walls. It was an L-shaped room with one photograph of Balint as a young man on which someone had put on devil's horns! But we were, to start with, a totally ill-assorted crew. There was a Pole, who never spoke a word for the first three months — and then left. There was a lovely GP from Malvern who used to drive up. He was very go-ahead, he actually had a radio in his boot. He was simpatico and then there was Erica, who has since become a great friend. And there was another chap who had done some psychiatry, which was not the right approach, apparently. But there seemed to be no explanation, it was quite amazing. Apart from presenting cases, and —that was the thing — if you didn't have a case to present every week, you stood in awe of great wrath. Not that you heard eight cases but you had to have one ready.

JS: But he didn't pick on anybody to present a case...

MC: No, he'd just say 'Who's got a case?' and people would raise a hand - or not - but there weren't great silences. Because he made it terribly clear at the first meeting that you would have to have a case. And of course we pulled out notes and that was utterly forbidden. Put those away. Enid was the co-leader...

JS: So she was there from the beginning?

MC: Yes. And when he was at his fiercest, she used to protect the chicks a little bit. We were always terribly pleased with her interventions in our defence.

JS: What sort of fierce things did he say?

MC: He would be quite critical. Sort of: 'Why did you do that?' and 'What did you expect to gain from saying that?' It was pretty direct and pretty strong but

very rarely too strong. If he became too hectoring then Enid would sort of put up a shield for us.

JS: Were the sessions a similar length to nowadays?

MC: Yes, it was pretty strict. They were an hour and three quarters and at the end we just departed. In my case there wasn't a moment to lose because I had to go straight to surgery.

JS: Two cases in a session?

MC: Two cases pretty well always. If there were follow ups — he would sometimes say: `we'll do some follow ups next week'. So we might get three or four follow ups.

JS: And was it expected that you would have done a long session with a patient before presenting him?

MC: Yes. He would definitely presume that any presented case would have had a long interview. He never said, but everyone agreed that this took at least three quarters of an hour. Subsequent consultations were not so long but more than the average consultation time. Which was at that stage, you know '57, '58, pretty short.

JS: What sort of problems did people present on the whole?

MC: Quite a lot of them were what would have been termed psychosomatic. Questions as to why someone who was asthmatic was having more attacks and this would be viewed from the point of view of it having a large emotional component. But the main thing really was whenever you got stuck with a patient and you didn't really know what was happening; if you found you were referring the patient repeatedly to different people or there was some obvious no progress sign. There was a wide spectrum of possibilities.

JS: And were the patients that were presented usually someone whom the doctor felt they really wanted to help? Because these days, especially with registrar groups, the patient presented is often someone the doctor feels fed up with

or annoyed with or bruised by, rather than someone he really wants to engage with.

MC: No, I think the boot was on the other foot. I think the feeling was that we, the doctors, were not meeting that patient's need and that we were sore because we felt we were professional failures, and not able to see which way to go. There were a few in which the doctor felt he had been rubbed up the wrong way, but they were rare. That was not the main focus.

JS: So it was very much 'how could I be doing this better'?

MC: Definitely. Here's a patient whose complaints don't make sense to me, I'm struggling to make sense of them and I need help there.

JS: Reading the book, *The Doctor, his Patient and the Illness*, although it's fascinating and you can see the way his ideas were developing, you don't really get a sense of what it was like to be in the group. Would you agree?

MC: I would. Actually, returning to the book, I found that even after a few years it was strangely old fashioned to read. It seemed to be quite different from the atmosphere of my first working group.

JS: Things had moved on, presumably.

MC: They had. It had been going seven years before I started which meant that it had probably run through a couple of groups. It was very sticky for the first three months, and then it got easier; it started to flow. The poor Pole disappeared and the rest of us had become more friendly. Perhaps the chap who had done psychiatry was not one's most close colleague, but it was treating emotional illness from a specialist's position which we didn't really feel. We still felt that we needed more time but there was a consensus from all but two that we were on the same train. Then we moved to the Tavi and we had two new members. For those who had been at Park Square West it was distinctively a sad move. And then in the third year we moved into the Tavistock Institute. That was actually better.

JS: Did you get a feeling that you were being trained to be GP psychotherapists?

MC: That was certainly the feeling. Quite early on, before the end of the three years, there was a sort of hint of rebellion from some of us about that. Partly because, well, speaking for myself, I was aware that I was giving time to a tithe of the patients who really stood in need, and it was actually one of the most painful things that I hadn't got time to give because I suppose I did long interviews on four nights a week. But four patients a week and you had to see them for some time. And as one became more aware of the problems, the more of the damn problems were visible. So it became increasingly agonising.

JS: How would a group in those days compare with a group at Oxford today?

MC: There's a great deal more freedom in the Oxford ones. You have to remember that that group finished in 1960 and we moved on to another group. But it was rather old fashioned. Christian names were not used.

JS: Christian names were not used in our group (1974-78) you may remember until about half way through.

MC: That's true. Perhaps that was part of the old tradition continuing. We were just doing as we had done before. I must say I find that quite horrifying. I totally accept that it's true. So it was much more formal. Having said that, the nature of the work soon broke down the formality so that after a year the group was behaving much more like an Oxford group. The Oxford group seems to start de novo in a weekend. I can't see that happening in those days.

JS: Was it more difficult in those days for GPs to be open with each other and trust one another with this kind of material?

MC: No, oddly enough, I don't think so. That was the reason, because we were all guilt laden and everybody admitted — with one notable exception — that we were a pretty hopeless lot. And we were all floundering about on the same floor.

JS: The kind of way of leading a group that my contemporaries learned from you and Mary Hare - I'm curious about where that came from; whether that was present in the original groups or whether it was more due to Enid's influence. I am thinking of the sort of thing where we would deflect a question back to the questioner.

MC: That was always present but Michael Balint would be given to passages of didactic teaching on a particular problem — which was very useful — but you wouldn't actually find in many groups now. The other thing is he seemed to be quite directive. I think the main thing was that the reflected question wasn't as common. He would make some remark about the presentation which would not be a spot diagnosis but a direction in which to pursue the discussion at your next interview. But it was an interesting duet between Michael and Enid. She would often disagree with him. She would definitely challenge him and they would have a semiprivate argument and in a way that was a great learning experience. Because there was a dialogue between people who presumably knew what they were talking about. It also was teaching you that you didn't have to take the directive statements if you didn't want to. It was when there was a good deal of cross discussion between group members about something and Michael would bring that to an end by some sort of rather bold didactic statement and Enid would then say 'Well, I'm not sure that's how I would see it! And what about —another way?' So there was in fact the model that there was always more than one way to see anything.

JS: I think pairs of leaders nowadays are very afraid of disagreeing with each other.

MC: I think you are right. The group that you were in which was led by Mary and myself was post the so-called Tuesday Group, the one that produced *Six Minutes for the Patient.* That was a major shift in technique. Michael and Enid's idea was to change the culture. I see that as the watershed. Because

he then no longer was training us to be psychotherapists, he was no longer insisting that we spend 45 minutes with a patient... it was a sea change.

JS: What brought that about?

MC: I think he came to realise that a lot of us were probably not competent to be psychotherapists! I mean he didn't actually say that, but having that long interview requirement meant that a lot of patients were being neglected. And he also realised that so many 'ordinary' general practice consultations which have a strong somatic element might be just as important. I remember one of his things was: 'Can't somebody present a case with a cough?' Poor Aaron Lask was the sacrificial lamb: he produced a case. Balint appeared to be extremely angry and was really rather cruel. We all bled with poor Aaron. Michael said `I'm fed up with these long cases which get nowhere! What about the ordinary case, the real, the case you see every day, lots of them, what about them?' So that was the crunch. Then, we'd been invited to Aberdeen for a weekend. The professor of psychiatry in Aberdeen at that time was Colin McCance. So we all went up on the night train, drinking whisky and then we had this amazing weekend. In which the idea of a short case really was cemented. It had happened before. The week before, Jack Norell had presented a woman with acne and that was the first ordinary case. It was amazing. It was like peeling off layers of opaque material. In Aberdeen we had a whole spate of these cases, they weren't all**n**acne but they were all ordinary. This was in the mid-1960s. And the group absolutely changed. Then we knew we didn't have to spend 45 minutes with all the patients we then presented. I think Christian names came in then. I think it was moving.

JS: Well, you'd been together a long time by then, hadn't you?

MC: We had. We'd been together four years. But that was the great change in my opinion. And he became far less didactic. He was still piercingly acute — he

would say something that you had never remotely thought about that. But it was a different thing. There was much less teaching, much more encouragement to be bold.

JS: What about the emphasis on the doctor's own feelings? Was that there from the beginning?

MC: Not in my first group at all. It was about the doctor-patient relationship, but not the doctor's feelings, standing alone.

JS: Well, even the doctor's feelings as induced by the patient?

MC: Yes, that was there. You know, curiously enough, it wasn't such a democratic feeling of exchange as it became later on. It was a question of an invitation to say what was going on between A and B — rather than what A feels or B feels. It was a little bit more distant.

JS: Because when we are leading groups we quite often say to somebody, how would you feel if this was your patient?

MC: Yes. I don't ever remember that in the first group. Although it just so happened that at the end of three years the person appointed to lead the group couldn't do it and Bob Gosling stood in. I presented a long and impossible case, a 'pregnant nun'. He sort of looked at me and said: ' I know you have had quite a lot of experience but why have you presented this pregnant nun? And he was absolutely right. If only I'd remembered that at Oxford when that Italian doctor presented: if only I had done a Bob Gosling with him; that's what I should have done. Then we had a young leader who was very warm and simpatico, who had quite a different technique. That was leading on to a much less charged atmosphere in the group. With Bob there was a bit of a Spartan feeling. He was very good, but it wasn't comfortable.

JS: Like being with a classical psychoanalyst?

MC: Absolutely! That's right. You've hit the nail on the head. But the other chap was more avant-garde, more relaxed. I think his name was Harding. He was

a protégé of the Balints and he worked at the Tavi, I think he was a senior registrar. There were people from two other groups welded on to our group of whom at least 50% remained, which was rather odd. And we definitely had to negotiate for a few months.

JS: Another thing leaders do today is to represent the patient: to say, if I was this patient I would be feeling so-and-so...Which can often get the group going again.

MC: Yes, Michael would have said: Now, the patient is in the room. The doctor is the patient. So he would invite the rest of the group, saying: you heard the story, but that's only part of the story. He is presenting the patient as a person. That would be his centre of gravity.

JS: So how did these subtle changes come about, do you think?

MC: Michael Balint had been wooed by the Family Planning Association with whom he started these psychosexual seminars. And that I think made him apply less rigidly the pure psychoanalytic approach. I joined in the second wave of those. But we were actually more psychotherapeutic in that. He felt that was reasonable because we didn't have to choose between patients. We had relatively long interviews in the marital difficulties clinic. He was interested in testing the possibilities of focal therapy. But when it came to the FPA wanting more leaders, he was prepared for GPs like myself to go and be leaders of that group because that was limited scope and we probably wouldn't be dangerous!

JS: How did the move to the presentation of shorter consultations begin?

MC: Well, those seminars made him think because a lot of the non-consummation papers had come out of quite short interviews, twenty minutes or so, in someone coming for contraceptive advice. And that's why he started off in the Tuesday group wanting to hear about ordinary length GP consultations and we all resisted it, we were all set in our ways. But he broke us down,

courtesy of Aaron and Jack. But the amazing thing was, once that was broken down, the flood gates opened and we were all producing lots of cases and he didn't seem to be inhibited at all about the different level.

JS: What would he think today, if he were to come back?

MC: I think he would have approved of what we do. He was never satisfied with where we'd got to. I think he would have been very disappointed if we hadn't moved. The hardest thing to swallow would be his feeling about the qualifications for leaders. But the fact that he changed that for the FPA groups makes me feel that even that - he would have been rigorous as to selection, but Tom Main was perfectly agreeable to the GPs as long as he knew who they were and what they were doing.

JS: I remember something he said at the second London International Conference that printed in Philip Hopkins' book *The Human Face of Medicine*, Tom Main's line was you have to do what you have to do. And if you haven't got any analysts then you have to use GPs —

MC: Absolutely. He was pragmatic. I mean you've got to get the best you can. Better to have second best than none at all. Because otherwise the work can't go on. But I think Michael would have been pleased that the group that Enid led, the one that you were in when she became ill — I think he would have been very pleased with that group [the group that produced the book [*While I'm here, doctor*] and I think he would have been pleased with our last group [*What are you Feeling, Doctor?*]. He would have been critical, but constructively critical. Perhaps he would have said, we ought to have looked at the defences in a more psychological way. But I think he would be `chuffed' that the work still goes on. Very much so.

JS: And what would he think of the fact that there are so few analysts involved in this country, compared with say, France or Germany?

MC: I can see him shrugging his shoulders. I mean there wasn't any difference in his day. Psychoanalysis has not taken well to British soil, let's face it. With some notable, notable, exceptions. But I don't think that would have bugged him. He had sort of learned to live with it. These damn Brits! Although he was more British than the British, in some ways. I think he would have been sad, but not surprised.

JS: What was the attitude to Balint work and Balint doctors among GPs in general when you were doing it in the late fifties and sixties?

MC: Pretty negative. I used to go out and give talks and that sort of thing. By and large, a wall of rather cold semi-hostility towards these people looking at their own navels. I think Michael would be very pleased with the involvement of GP training. He would think that was a major positive outcome of his work. But I've had some pretty chilling experiences, talking to non-Balint doctors over the years.

JS: So we get more respect nowadays?

MC: We definitely do. I think after a rather chilly downturn, I think there has been a resurgence. The fact that we have had citations, I think we are taken seriously. Maybe disagreed with, but that's fine.

JS: They may not want to join us —

MC: No but we are seen as genuine research workers. It's a point of view with which you can agree or disagree, but you are not damned. The great joy of my own in Balint work now is that you can be utterly free with colleagues or patients. The openness of communication in medicine, which was not there when I entered it in 1952.