Balint work and the Flourishing Practitioner

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 practicing primary care medicine in an unsympathetic context with the wrong tools, and without a culturally shared understanding which 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 practice. For many GPs there is a lack of flourishing which 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 general practitioners 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.

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, 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 practise 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 which maximise some valued outcome, such as longevity.

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 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 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*', which is the ability to apply principles, or acquired virtues, in real world medical situations which one could not have foreseen beforehand.

Challenges to Flourishing

In my view there are two longstanding trends in medicine which 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 student views of general practice in 2016. [8]

'*the GP tutor we had she was an absolutely amazing GP, because I saw from her that you can…….because there is a saying, isn't there, that it is easy to do the job badly, but it's hard to do it well as a GP.*

This shows 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 general practitioners. As Miranda Fricker, a philosopher who has explored epistemic injustice, the concept of injustice related to a disparity of knowing, says: [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 experience, whereas the less powerful ….have at best illfitting 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, coconstructionist 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 Fig.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 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 patients' 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 interpretative understanding of the practice of a good generalist doctor.

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.

Focussing 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 doctorpatient 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 which 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 which 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 continuityof-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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