WHO NEEDS BALINT ANYWAY?

At every GP congress, Stanley Levenstein, a Cape Town family physician, can be found flying the Balint flag. Most Balint groups around the country have folded. "Balint Bashers" abound in family medicine. Nonetheless many people often emphasise the part Michael Balint played in the resurgence of general practice and quote excerpts from his book *The Doctor, his Patient and the Illness*, first published in 1957.

One often gains the impression that his ideas belonged to that era and that in the modern holistic GP's armamentarium his concepts are an anachronism and we can quite happily say "Who needs Balint anyway?"

In order to address this state of affairs, we must first gain clarity as to what we mean.

Who or what was Balint?

Michael Balint was a psychiatrist who died in 1970. He was intensely interested in the psychological implications in general practice and published a book on his findings of his research into this area of medicine — *The Doctor, his Patient and the Illness.*

He conducted research seminars at the Tavistock Clinic in conjunction with a group of eight to ten general practitioners who met weekly for a number of years.

The problem they looked at was:

Why does it often happen that, in spite of earnest efforts on both sides, the relationship between the patient and the doctor is unsatisfactory or unhappy?

Their chief aim was a thorough examination of the ever-changing doctor-patient relationship, i.e. the study of the pharmacology of the drug, "doctor".

His book set out to describe certain processes in the doctor-patient relationship (the undesirable and unwanted side effects of the drug "doctor") which cause both the patient and the doctor unnecessary suffering, irritation and render efforts fruitless.

He described certain processes that occur in doctor-patient relationships.

Patients make offers

Some people find it difficult to cope with problems in their lives and resort to becoming ill. In the early stages of their illness, before they settle down to a definite or "organised" illness, these patients propose or offer various illnesses — they have to go on offering of proposing new illnesses until an agreement can be reached between doctor and patient.

The doctor's response

One of the most important side effects of the drug "doctor" is the doctor's response to the patient's offer. Doctors prefer diagnosing physical illness using tags learnt from their consultant teachers rather than diagnosing problems of the whole personality.

Balint's explanation of why doctors do this is as follows:

1. There is no terminology to describe personality problems of non-psychotic patients.
2. The belief that physical illnesses are more important than personality problems is widely held.
3. A "real" diagnosis leads to rational therapy whereas a diagnosis of personality problems hardly ever does.
4. Most doctors have a fear of missing organic disease.

The result of a doctor responding to a patient's "offer of disease" with this frame of mind is that when approaching a problem of diagnosis, he resorts to the elimination (of organic disease) by appropriate physical examination, in other words, if some patient presents with vague and nebulous complaints that are a result of a psychological stress or a personality problem, the organically-trained doctor is more likely to look for organic disease. Only once this was excluded would he, perhaps, address the underlying conflicts or problems.

This is the doctor's protection against missing an organic disease.

However, the price paid in adopting this approach is that a "ranking order of illnesses and patients" is produced.

Contrast the degree of importance that a doctor will attach to a patient with scleroderma as opposed to one with a tension headache.

Organising a disease

In the process of elimination by appropriate physical examination, there is a danger not only of missing a physical sign, but also of finding one.

The danger here is that in finding a positive physical sign or test, the organically-minded doctor can end up leading his patient to believe that his symptoms are in some way linked to this irrelevant finding and not to his underlying psychological conflict. This is the process of organising a disease.

Deeper diagnosis

Balint stated that it is advisable for a doctor to aim at a more comprehensive and deeper diagnosis. He should not be content with comprehending all the physical signs and symptoms but try to evaluate the pertinence of the so-called neurotic symptoms as well.

The dilution of responsibility

In difficult cases, general practitioners resort to help from specialists. The appearance of a consultant in the equation introduces new factors. When a patient offers a puzzling problem to his medical attendant, who backed by a galaxy of specialists, certain events are unavoidable.

The most important is the collusion of anonymity. Vital decisions are taken without anyone being responsible.

In every of case of collusion of anonymity (if the two doctors involved are a general practitioner and a specialist) another important factor comes into play: the perpetuation of the teacher-pupil relationship.

General practitioners who are trained by specialists are overawed by the successes of their teachers in their respective specialities. Once they have left medical school, specialist consultants to whom general practitioners may refer are the successor of the doctor's teachers.

By their standing they ought to (and often even do) know more about certain illnesses than the general practitioner. If this is not confirmed by events the general practitioner may feel highly critical and dissatisfied with the consultant.

However, the GP might feel helpless to change the situation because of the respect which he has learned to show towards the consultant in the context of the teaching hospital.

Some consultants are more than willing to preserve their "teacher's status" and some even feel obliged to appear to know more than they actually do. It happens frequently that the general practitioner and his consultant differ about the patient's diagnosis and treatment.

Devising ways and means by which the two partners (consultant and practitioner) can inform each other of their motives and aims, presents a thorny problem.

Consultants grumble about indolent general practitioners who write perfunctory or nonsensical requests for examinations. Many general practitioners do not dare state their desires with regard to the consultation. A general practitioner would be even less likely to instruct a specialist as to what he or she would like the specialist to do to the patient or how he or she would like the patient to be approached.

The result of this mutual evasion is a reinforcement of the collusion of anonymity.

There is also a lack of understanding of the patient's regressive tendencies in the triangle and his playing off of one doctor against

Dr Russell Kirkby, MBChB, MPraxMed (Medunsa), DA, MFGP, MSc (Sports Medicine) (Pret), BSc. (Hons) (PU for CHE), Principal Family Physician

the other.

Balint also proposed a utopian medical scenario for general practitioners. In Balint's Utopia, general practitioners would resent being classed as indifferent, indolent, totally uninterested dispensers of drugs — a person who knows about twenty prescriptions and the addresses of about thirty consultants.

In Balint's Utopia...

... a general practitioner would not be happy to write letters that say, "Heart. Please see and advise."

... general practitioners would take responsibility for their patients.

... they would make more in-depth diagnoses.

... they would be more aware of the offers patients make to them.

... they would be more aware of the dangers their responses to these proposals have on the health of their patients.

In Utopia, general practitioners would be less impressed by the expertise and skill of his consultants. This involves no disrespect to the latter. The specialist's skills would be used far more appropriately in Utopia.

The utopian GP would not fear the dreadful faux-pas of missing major organic illness and thus would conduct an appropriate physical examination.

The utopian GP would guard against establishing a ranking order of illnesses in his patients.

He would try to prevent his patients from organising their illness around around an irrelevant clinical finding and he would try to help his patients uncover the major conflicts or problems in their lives.

Those were some of Michael Balint's thoughts and suggestions in 1957. Are they now outdated and irrelevant to our modern day practice?

Who needs Michael Balint?

Chemical pathologists, radiologists and probably anaesthetists might, but I wonder if there are any clinicians who can safely say, "Who needs Balint anyway?" ●

AN UPDATE FROM SASPREN

Now that the South African Sentinel Practitioner Research Network (SASPREN) is functioning well as a surveillance network, the committee has been able to give more of its attention to purely research considerations. The committee has recently addressed core research issues such as: the design of research suitable for implementation on such networks; consent and confidentiality relating to information disclosed by patients to reporting doctros during consultations; and linkage with other networks.

An assessment will be conducted of the validity and generalisability of SASPREN-generated data to South Africa as a whole after an intial pilot survey has been completed for the Western Cape. In compliance with its obligations to the Health Systems Trust (HST), SASPREN has completed a Research Report which will be submitted for publication. SASPREN is in a phase of positive growth and consolidation and expects to be able to provide health information for both provincial and national health planners.

The Western Cape branch of the South African Academy of Family Practice has assumed financial responsibility for the maintenance of the network whose treasurer will in future administer SASPREN's financial affairs.

– DE Whittaker,
for the SASPREN
Steering Committee

SAFP: INSTRUCTIONS FOR AUTHORS

- The *South African Family Practice* accepts manuscripts prepared in accordance with the Vancouver Style[1] and any papers that conform to that style will be considered.
- All material submitted for publication is assumed to be submitted exclusively for the *South African Family Practice* unless otherwise stated.
- All authors must give signed consent to publication. Manuscripts should bear the name and the address of the author to whom proofs and correspondence should be sent.

Language policy

Articles in all eleven official languages will be considered for publication. All articles not written in English must be accompanied by an English summary.

- Manuscripts will be acknowledged; letters will not be, unless a stamped addressed envelope is enclosed.
- The Editor retains the right to stylise and, if necessary, shorten material accepted for publication.
- Any article may be submitted to outside peer-review, statistical assessment and evaluation by the Editorial committee. This should take six weeks but may take up to ten weeks.

Manuscript preparation

Copy should be neatly typewritten with double spacing and wide margins. Pages should be numbered.

- The manuscript must be submitted in triplicate. If the paper is rejected these will not be returned. Authors should keep one copy of their manuscript for reference.
- Scientific articles should conform to the conventional structure of abstract, introduction, methods, results, discussion and references.
- The abstract should be no longer than 150 words and should set out what was done, the main findings and their implications.
- Original articles should be 2000 words or less with no more than six tables or illustrations.
- Letters should normally be no more than 400 words.
- Abbreviations should preferably not be used. When used, they should be spelt out when first used in the text and thereafter used consistently.
- Tables and illustrations should be submitted separately from the text of the paper and legends to illustrations should be typed on a separate sheet.
- Tables should be simple and should not duplicate information in the text of the article.
- Tables should carry Roman numerals, thus: I, II, III etc. and illustrations Arabic numerals, thus: 1, 2, 3, etc.
- Photographs (in duplicate) should be glossy, unmounted prints.
- When identification of a patient is possible from a photograph, the patient must submit signed consent to publication.

References

References should be numbered in the order in which they appear in the text. The full list of references should give the names and initials of all authors (unless there are more than six, in which case only the first three should be given followed by *et al*).

The authors' names should be followed by the title of the article; the title of the journal, abbreviated according to the style of *Index Medicus* (consult the January issue of *Index Medicus* (No. 1 Part 1) for these details); the year of publication; the volume number; and the first and last page numbers. Titles of books should be followed by place of publication, publisher, and the year of publication:

Stott NCH, Davis RH. *The exceptional potential in each primary care consultation.* J.Roy Coll Gen Pract 1979;29:201-5.

Stott NCH. *Primary Health Care: Bridging the Gap Between Theory and Practice.* Berlin: Springer-Verlag, 1983:43-7.

Authors must verify references against the original documents before submitting the article. Scientific measurements should be given in SI units with two exceptions: Blood pressure should be given in mm Hg and Haemoglobin in g/dl.

Editorial address

The Editor,
South African Family Practice,
P.O. Box 2731,
Rivonia, 2128

[1] International Committee of Medical Journal Editors. *Uniform requirements for manuscripts submitted to biomedical journals.* Br. Med J 19X2; 2X4: 1766-70.