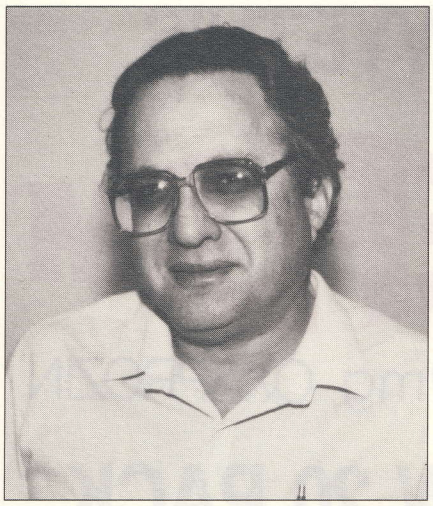
Balint Work in Developing Countries*

– Dr S Levenstein



Dr Stanley Levenstein
BSc, MBChB, MFGP(SA)
Rooms 24/25
Medical House,
Central Square,
Pinelands
7405

Curriculum vitae

Dr Stanley Levenstein is a general practitioner practising in Cape Town. He is currently National Vice-Chairperson of the SA Academy of Family Practice/Primary Care and was Founder President of the SA Balint Society. He is also a member of the National Council of the National Medical and Dental Association (NAMDA). He has authored numerous publications and papers relating to general practice, and has received several awards for his contribution to continuing medical education for general practitioners, among the most recent being the 1988 Boz Fehler Fellowship and the 1989 Academy Writer's Award. Dr Levenstein has been closely involved with developments relating to Vocational Training in General Practice and Community-based Medical Education (CBME). He is currently leading a vocational-trainee Balint Group in Cape Town.

Summary

Balint principles could have an enormous influence on the health care of the developing South Africa, and need to become an integral part of the health care strategy. This feature article explains the need for better health services in isolated, black areas and how Balint-training would help towards this goal.

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Health care in developing countries is characterised by certain common problems. These include:

(i) a shortage of trained medical personnel;

(ii) a *maldistribution* of doctors in favour of urban centres, as against rural and heavily-populated peri-urban areas;

(iii) an acute shortage of funds for the provision of adequate health services;

(iv) a comparative over-emphasis of tertiary, curative services, mostly city and teaching-hospital based, at the expense of preventive and promotive services. (This, like the other points mentioned, could be attributed partly to the colonial legacy of the countries concerned.)

**Talk given at a Plenary Session of the 7th International Balint Conference Aug 1989 Stockholm*

All the above factors apply in the South African setting. However, the situation is further complicated by its unique political set-up, which has resulted in health care being fragmented along racial lines (there are currently no less than 14 Ministers of Health in South Africa!) with black patients for the most part receiving comparatively less adequate health care, and in certain parts of the country receiving no health care at all!

What has been the response of the medical profession to this state of affairs? Rather variable, and impossible to discuss adequately in such a short paper. It has to suffice to say that in spite of the efforts of a few concerned medico-political and academic bodies, it has thus far not been possible to make very much impact on the situation which has been described. It has to be said that the medical schools in particular have tended to continue producing what could be described as first-world doctors trained to practice first-world medicine on first-world (ie mainly white) patients in first-world (ie mainly large city) areas equipped with all the best in sophisticated modern technology in the form of investigative and in-patient hospital facilities.

General practitioners involved in promoting academic general practice in South Africa have recognised the gross inadequacies of the present system. They have emphasised the need for vocational training in general practice and have attempted to establish vocational training projects in under-doctored rural and peri-urban areas with the aim not only of training general practitioners to perform their work more competently, but also to address the health needs of the country by attempting to establish a permanent

medical presence in these areas. (The experience in countries like Australia has been that when vocational training programmes for general practitioners are established in rural areas, the doctors who are trained there, tend to remain there permanently, thus helping to resolve the problem of the shortage of doctors in such areas.)

Where does Balint work fit into all of this? When Balint-work first began in South Africa in the mid 70s, its main exponents were white, city-based GPs with mainly white practices, who were favourably impressed with the developments that had been taking place in academic general practice, and Balint-work in particular, especially in the UK. Fortunately most of these GPs were also involved in the broader academic general practice movement in South Africa and were able to influence it in such a way as to make it recognise the enormous contribution that Balint-work could make to the practice and

Medical Schools are training first-world doctors to practice first-world medicine on first-world patients in first-world areas

teaching of general practice. Thus it was that the concepts of Balint-work came to feature in the implementation of vocational training programmes for aspiring general practitioners in South Africa from the very start. Wherever possible, Balint group training was recognised as an integral part of the training process.

In the context of a developing country, the relevance of Balint work to the country's health needs had to be clarified. It became important to realise that Balint training was not merely a worthwhile endeavour to help prospective doctors to relate more effectively to their patients (a particular pressing issue given the

Balint-trained doctors are less likely to prescribe unnecessary drugs or investigations - a great saving for the country

stresses and strains of South Africa's complex, tense and conflict-ridden society), but that it might also offer certain other more concrete advantages as well. For example, if it is true, as those of us who are involved in Balint-work believe, that Balint-trained doctors are less likely to prescribe unnecessary drugs or order unnecessary investigations due to a greater willingness to prescribe themselves ("the drug doctor") then what might not be the potential cost savings to a health system of such training? As mentioned earlier, cost of health services is a particularly crucial consideration in developing countries. I will cite a practical example from my own recent experience:

I am currently leading a Balint-group composed of young vocational trainees in general practice, most of whom are currently working in medical officer positions in a hospital in Cape Town. One of the patients who was often presented when the group first began to meet, was a diabetic male, who repeatedly arrived at the hospital with his blood-glucose out of control, necessitating fairly prolonged hospitalisations. (This patient had required no less than 18 hospital admissions in the previous 3 years, for durations ranging from 3-5 days to 2 months.) This vexed and annoyed the presenting doctors until discussion in the group helped them to discover that the patient was using the hospital as a refuge from an intolerable home situation. When the matter was taken up with the patient, he welcomed the opportunity to discuss it on an out-patient basis. At a recent meeting one of the group members commented "Since Mr R has been in the group, he hasn't once been in hospital!" (In the 10 month period since the patient was first presented to the group, he had only had occasion to attend the hospital twice outside his routine appointment times, and on both occasions it was possible to discharge him after brief treatment in the Casualty Department.) Apart from any other considerations, the savings to any health budget of un-utilised hospital beds are enormous.

The initiatives which have been taking place in vocational training for GPs form part of the efforts that are

Balint-trained doctors have a greater willingness to prescribe *themselves* . . .

being made to implement community-based-medical-education (CBME) in South Africa. CBME is being presented as an alternative to existing hospital-based medical education, as it is believed that it holds the potential for helping to address the real hitherto unmet

health needs of our country. The National Medical and Dental Association (NAMDA) took the initiative in promoting CBME in South Africa and bodies like the Academy of Family Practice/Primary Care in which most of the senior members of the SA Balint Society are actively involved, have backed the concept.

The Balint movement in South Africa is active on a number of fronts. There are several ongoing groups in various centres, as well as a vocational trainee group in Cape Town. There are annual Balint workshops, which are attended by many GPs, some of whom are not experienced in Balint work. Some of these are GPs working in rural areas, and a number of these have been black doctors who reported that they found the experience to be most valuable whether working with black or white patients. (This addresses the query that has been raised about the European "cultural bias" of Balint work).

> The Balint plant has its roots in Europe, but should successfuly be transplanted into African soil

The problem of Balint Group leadership training is a particularly thorny one. At the 6th International Balint Conference in Montreux, Switzerland, I reported on the method of Balint-group leadership training via supervision of tape-recorded, typed transcripts, by Mrs Enid Balint. I am pleased to say that this method is still being successfully employed, and that it is moreover being taken a step further by my attempting to pass on the training I have received from Mrs Balint, to prospective Balint-group leaders in South Africa, by scrutinising and supervising transcripts which they forward to me.

Those involved in Balint work in developing countries need to be particularly aware of the effects of social and political circumstances on their patients. Thus, for example, my own experience in Balint work has also come to my assistance in the area of counselling of ex-detainees, for which there is a particularly strong need in the South African setting.

It can thus be seen that in order for Balint-work to be viable in developing countries, it has to prove itself to be no mere esoteric exercise for the wealthy, but on the contrary, an integral part of the developing health care strategy in such countries. It may thus be that developing countries provide the ultimate test of the versatility of Balint-work. With the necessary foresight, flexibility and commitment, there seems to be good reason to believe that the Balint plant, while having its roots in Europe will increasingly prove itself to be a durable and adaptable transplant in Africa.