

THE LEGACY OF MICHAEL BALINT

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ABSTRACT

Michael Balint's lead article, "Repeat Prescription Patients: Are They An Identifiable Group?" inaugurated the first issue of *Psychiatry in Medicine*, Vol. 1, No. 1, 1970. A few years later, this *Journal* would be renamed *International Journal of Psychiatry in Medicine (IJPM)*. Who is this author of over 165 papers, 10 books, practicing psychoanalyst from 1926 to 1970, director of the Budapest Psychoanalytic Institute from 1935 to 1939, consultant at the Tavistock Clinic from 1948 to 1961, President of the British Psycho-Analytical Society from 1968 to 1970, literary executor of Sandor Ferenczi, a foremost theorist of object relations, and international educator and statesman for general practitioners? We would like to review for you some of the formative experiences in Michael's life that wedded psychoanalysis and general practice, and how they contributed to his major educational commitment over 40 years to furthering the understanding and integration of psychosocial factors in the practice of primary healthcare as experienced by doctors all over the world. We would also like to highlight some of his major insights and see to what extent they are incorporated in contemporary medical education and practice. We believe that some of his major insights have been neglected and others have been further amplified and extended. Our intention is to speak not only to medical students who desire to pursue medicine related directly to patient care but as well to seasoned practitioners who continue on a daily basis to care for individual patients and their families.

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FORMATIVE EXPERIENCES OF MICHAEL BALINT

Mihaly Bergsmann was the first of two children born on December 3, 1896 to an Orthodox, Jewish, general practitioner in Josefstadt, Budapest, a German-speaking, largely Jewish quarter in Pest. Mihaly, as did many of his Jewish middle-class compatriots, changed his given name to Michael Balint and converted to Unitarianism to the marked displeasure of his father. However, at a very young age Michael accompanied his father on house calls. These home visits marked the beginning of his intimate contact with primary healthcare. Michael began his study of medicine in 1914. This study was interrupted for a time due to his induction into the First World War that led to service in Russia and in Italy. In 1916 a hand injury brought him home. He was still able to complete his medical studies by 1918.

A close friendship developed with Alice Szekely-Kovacs whose mother was a psychoanalyst, and, as the story has it, Michael fell in love with psychoanalysis and Alice at the same time. They married and began a very satisfying life together, both seriously studying psychoanalysis. Their first teacher was Sandor Ferenczi, who became the world's first university professor of psychoanalysis and had been elected president of the International Psychoanalytic Association. Social and political conditions in Budapest caused Michael and Alice to move to Berlin in 1919 where Michael successfully pursued a PhD in biochemistry, completed in 1924. In 1922, they both began two years of psychoanalysis with Hans Sachs before returning to Budapest where they resumed psychoanalysis for another two years with Ferenczi, and Michael continued his medical practice.

By 1926 Michael's professional identity made a decided shift from general practice to psychoanalysis and the papers that he and Alice wrote separately and together centered on psychoanalytic topics. However, he had not forgotten the general practitioner and wrote that same year a paper entitled, "On the Psychotherapies, For the Practicing Physician." Michael continued to feel that psychoanalysis had much to offer the general practitioner and decided on his own to gather general practitioners for a kind of seminar to study the psychotherapeutic possibilities and potentials in their practice. He began these seminars with a series of lectures which he later realized were not having their desired effect. He made several attempts at such seminars but with diminishing success. Plain-clothes policeman attended each of the sessions, taking copious notes, and a proper atmosphere for discussion could not develop. These early seminars in Budapest are the foreshadowing of what would evolve later in London at the Tavistock Clinic and Tavistock Institute of Human Relations into the GP Groups, later to be known as Balint Groups. By 1939 the Hungarian government resembled a racist, pro-Hitler state and it was apparent that Michael, Alice, and their young son, John, would need to leave. With the aid of Ernest Jones and John Rickman they emigrated to Manchester. Shortly after their arrival, Alice died unexpectedly due to a ruptured aortic aneurysm.

After arriving in England, Michael obtained credentials to practice medicine. By 1945 he had completed a Master of Science degree at the University of Manchester, writing his thesis on "Individual Differences in Early Infancy: A Study of Infant Feeding Rhythms." He then moved to London and was appointed director of Chislehurst Child Guidance Clinic. Michael became a British citizen in 1947 and in 1948 was accepted as a consultant by the Tavistock Clinic. He was first asked to assist Enid Eichholtz, a supervisor of social workers. She had organized a group for case presentations and discussion on a regular basis to better understand the social dynamics of conflicted, postwar families and how social workers might serve them more effectively. Michael was assigned to work with this group from 1948 to 1953. The group would be known as the Family Discussion Bureau; it provided the context in which the "case discussion seminar" was developed that proved successful in more effectively training the social workers. These seminars became the theoretical foundation on which the GP Group would be organized in 1950. These general practice groups were referred to as "research cum training" seminars. Enid Eichholtz in 1953 became Enid Balint, and together, they continued lifelong careers in both psychoanalytic practice and the psychological education of general practice physicians.

In 1957 Michael published a book on his long-term research and training with the GP Group: *The Doctor, His Patient and the Illness*. Maurice Levine, in his foreword to the 1972 edition said, "In these seminars a psychiatrist and group of general practitioners tried to face the actual facts of medical practice and to study the practitioners' problems, their difficulties and their successes in their attempt to have a more comprehensive understanding of their patients and their use of a psychotherapeutic approach" [1]. John Sutherland, medical director of the Tavistock Clinic, said in Michael's obituary, that this was "... a book which not only pointed the way for the family doctor in acquiring new skills but which revitalized his old role as the primary caretaker of the health of the family" [2]. In 1983 on the 25th anniversary of its publication, Michael Glenn in *Family Systems Medicine* said, "No factor has influenced the evolving nature of family medicine more profoundly than its ties to the behavioral sciences. And no work has established this link more trenchantly than Balint's *The Doctor His Patient and the Illness*" [3].

Having reached the required retirement age of 65, Michael left the Tavistock Clinic in 1961 and took up a position at University College Hospital in London where he continued his work with general practitioners and also began to work with medical students [4]. By 1969 the general practitioners of those early GP Groups, called Balint Groups, founded the British Balint Society for the continued advancement of Michael's work. The International Balint Federation, developed in the early 1970s, was an outgrowth of the Balint societies of Britain, France, Belgium, Holland, and West Germany. Today there are 23 affiliated national societies, representing all of the continents, with individual members registered from Brazil, Iceland, Norway, Venezuela, and Canada. The American Balint

Society was founded in 1990. Several significant international figures, most certainly including Enid and Michael Balint, made long-term contributions to the formation of the American Society, an early history of which is profiled in the article, "The Balint Movement in America" [5].

BALINT'S MAJOR CONTRIBUTIONS

Harold G. Koenig, former *IJPM* editor, saw clearly the significant connection between the contribution of Michael Balint and the overarching goal of the *International Journal of Psychiatry in Medicine*.

The idea for the *IJPM* dates back to the 1950s with the work of Michael Balint, a British psychiatrist. Balint wrote *The Doctor His Patient and the Illness*, a book that describes the importance of the collaborative relationship between psychiatrist and general physicians in helping to provide better care for the patient. In a second edition of the book, Balint emphasizes that a psychiatrist as a consultant should train primary care physicians to manage most of the mental health problems of patients, while reserving the treatment of those with more serious psychiatric disorders to the psychiatrist. [6]

It was Don Lipsitt in 1970 who carried these ideas forward by establishing the journal, *Psychiatry in Medicine*, devoted to "facilitating education and research of the psychiatric aspects of primary care and enhancing cooperation between psychiatrists and general physicians" [6]. These ideas remain at the center of *IJPM*'s "Aims & Scope" in 2013.

The aim of the *International Journal of Psychiatry in Medicine (IJPM)* is to provide a forum where researchers, educators, and clinicians concerned with mental health, primary health care, and related aspects of medical care from around the world can educate each other and advance knowledge concerning psychobiological, psychosocial, biobehavioral, and social theory, methods, and treatment as they apply to patient care. [7]

We would like now to focus more specifically on the central concepts that Michael Balint introduced. We will define them concisely in Michael's own words and then reflect on them as they have been ignored, incorporated, or expanded upon in the contemporary practice of primary healthcare.

Deeper Diagnosis

"... If the doctor asks questions in the manner of medical history-taking, he will always get answers—but hardly anything more. Before he can arrive at what we called "deeper" diagnosis, he has to learn to *listen*. . . . The ability to listen is a new skill, necessitating a considerable though limited change in the doctor's personality" [1, p. 121]. There is an entire chapter in *The Doctor, His Patient and the Illness* devoted to "Level of Diagnosis." Michael notes that the general

practitioner has been training in a hospital with specialists who know how to cure illnesses and the limitations of their skills in that specific field. About the specialists he goes on to say, "... they are less concerned with, and one may even suspect they do not know enough about, the total personality of the patient. We must realize that in general practice the real problem is often the illness of the whole person" [1, p. 39]. We quote these lines because they describe the medical education dilemma still confronting the general practitioner of today in the early and formative years of their training, and throughout the remaining years of their training.

Sometimes the "deeper diagnosis" is referred to as the "overall diagnosis" or the "whole person diagnosis." While we would not want to propose a new term, we might suggest the words "contextualizing diagnosis." In other words, what we believe Michael was pointing to was an attempt to get the physician to view and experience empathically the patient's world and his or her situation within it.

More recently, an attempt to address this issue of establishing a deeper diagnosis came about through the establishment of a Multi-Axial Assessment:

I. Clinical Disorders, **II.** Personality Disorders, **III.** Gen. Medical Conditions, **IV.** Psychosocial and Environmental Problems (Problems with: primary support group, social environment, education, occupation, housing, economic, access to services, interaction with the legal system, psychosocial environmental problems), **V.** Global assessment of functioning.

Our clinical experience unfortunately finds that attention to these five axes usually happens only in completing business or legal forms and may, at times, be noted on a psychiatry intake interview. However, they do not seem to be thoughtfully reviewed in coming to a diagnosis of many patients in the outpatient or hospital setting. A sixth axis, or perhaps only a more careful discrimination within axis IV, is an assessment of the cultural/religious orientation of the patient, as our world becomes increasingly multicultural [8]. If, however, the multi-axis assessment becomes simply an extension of medical history taking, the physician will again be getting only answers to questions and not the empathic experience of the patient's lived reality.

For example, consider a school bus driver's request for a refill on narcotics and benzos for relief of pain and anxiety confronted daily in driving. She is single, obese, and speaks in a childlike voice. The doctor complies but is left feeling troubled because he knows that he has put children's lives in jeopardy, and also has not addressed the increasing jeopardy in which he is putting her life. The representing illness has been accepted and treated even though deeper diagnoses were latent and could have been addressed.

Did the biopsychosocial model (BPS) theorized by psychiatrist George L. Engel at the University of Rochester, and explored further by other physicians and psychologists that followed his thinking, contribute to developing a "deeper diagnosis" [9]? The biopsychosocial model became a kind of technical term for

what was more popularly called the "mind-body connection." The proposition was that health was to be understood in terms of a combination of biological, psychological, and social factors rather than in purely biological terms. This perspective generated many interesting and some significant new physiological and psychological concepts about the intimate connections of thoughts and feelings to bodily states and conditions. Whether this perspective brought primary care practitioners closer to understanding a patient in greater depth is questionable. The concept is not unsound but rather clinically unhelpful because it does not prescribe how the provider-patient relationship is to be changed to admit this new and broader knowledge in diagnosing and treating the patient. The biopsychosocial model is a concept, an attitude; it is not a skill. For example, knowledge of the assessment and treatment protocols developed by Masters and Johnson does not lead to effective identification or treatment of sexual problems of a patient when either doctor or patient individually, or together, are uncomfortable or avoiding approaching and exploring their own human sexuality. Sociologist David Pilgrim has stated that despite "scientific and ethical virtues," the BPS model "... has not been properly realized. It seems to have been pushed into the shadows by a return to medicine and the re-ascendancy of a biomedical model" [10].

Recently, a more diffuse movement in the healthcare and medical subculture called Complementary and Alternative Medicine (CAM) has caused a significant shift in our understanding of the term "diagnosis." It most certainly is focused on the whole person. Changes in DSM-V, ICD-10, the integration of multi-axes assessment, or the incorporation of the biopsychosocial model do not embrace or comprehend the whole person as postulated in many of the practices now represented in Complementary and Alternative Medicine. This has simply to do with the fact that some of the alternative medicines are more focused on prevention by treating the whole person so as to strengthen the immune system, to structurally align the body, to nurture the whole person through a more simple and diversified diet or to bring the whole person into a more mentally and physically relaxed or meditative state. Chinese medicine, Ayurvedic medicine, Naturopathic medicine, Homeopathy, and Native healing traditions would characterize some of the alternate, whole medicine, whole person systems. Manipulative body centered practices such as massage, chiropractic care, reflexology, Rolfing, therapeutic touch, or Reiki would characterize some of the modes of practitioner-patient contact in CAM. Appreciate that CAM is not focused so much on treating symptoms or disease by scientific techniques and technology. It is not negating allopathic medicine; it is "Complementary And Alternative." Michael's concern about attention to and empathic engagement with the whole person leading to a deeper diagnosis is a central part of Complementary and Alternative Medical practice. It is this personal, patient-focused care that has contributed in a large part to the growth of Complementary and Alternative Medicine. Deeper diagnosis now takes on still new psychological and physiological categories of meaning.

Let's return for a moment to the school bus driver. A Balint Seminar might explore how the doctor's need to be helpful induced him into the role of an enabler. This compromised his ability to see the patient more objectively. As a more objective observer, he might notice that the patient could have been neglected as a child and was conditioned to substances as a substitute for care. The physician's professional obligation is to establish a different kind of relationship in which trust is established without the prescription of substances. Through this trusting relationship the patient and doctor can then begin to explore a deeper diagnosis and more effective treatments for her illness.

Apostolic Function

"It was almost as if every doctor had revealed knowledge of what was right and what was wrong for patients to expect and to endure, and further, as if he had a sacred duty to convert to his faith all the ignorant and unbelieving among his patients. It was this which suggested the name of 'apostolic function'" [1, p. 216]. The apostolic function is manifest on a variety of levels where both moral and sophisticated clinical discrimination are called upon. Requests under rather bogus conditions for releases from work, or the requests for selected drugs that the patient claims to be the only choice that are effective to address her condition/pain are examples. In these conditions the physician must present his reasons for the way in which health and disease are to be understood and treated. It is as though the physician carried a template into which a patient must fit in order to receive care; there is a "Scripture" of disease and healing that patient and physician must follow.

"Naturally the doctor-patient relationship is always and invariably the result of a compromise between the patient's offers and demands and the doctors responses to them" [1, p. 217]. The doctor then must set the conditions under which calls will be received during the day and more specifically under what conditions would they be accepted at night or during holidays. What gospel of care does a physician feel called to follow in visiting the sick or assuming the role of a "father confessor," "comforter," or "granting absolution"? What is the quality and extent of care the patient is seeking: how very idiosyncratic is each doctor and each patient when it comes to addressing not only their disease, but also their illness?

The most sophisticated level at which the apostolic function takes on quite a substantive form in primary healthcare has to do with what Michael calls addressing the "stage of an illness." Is it possible for the physician in diagnosing and treating a patient's illness to negotiate a treatment plan by which the patient and doctor are able to establish a protocol for care that brings a satisfactory resolution to an "unorganized stage of illness"? Here Balint is literally referring to an organ system where there is a resolution and not a recurring "organ recital." Michael then outlines the less happy scenario.

Here again the doctor is at the mercy of his common sense, for his training taught him only how to treat "real" physical illnesses. More often than not in his embarrassment he will prescribe a bottle—on highly insufficient indications—thus inflating the national drug bill. Still, some people get better on such bottles, though nobody—least of all the doctor—knows why. On the other hand as we saw in several of our case histories, the first bottle may set people off to "organize" their illnesses in a therapeutically inaccessible form. [1, pp. 225-226] (Might this be our bus driver?)

At this point you could say the doctor and patient together have scripted "the repeat prescription patient." So it is that the physician in primary healthcare plays a significant role in not only treating patients but also in cooperatively scripting the medical history of his patients. Had the physician felt more psychologically competent to prescribe a "long interview," at the end of certain clinical days, as opposed to prescribing a medication for addressing the illness, a very different medical history, and personal life history of the patient might have unfolded [11]. Are larger healthcare systems and health insurance corporations providing opportunity for selected, extended patient contact and if not are they equally responsible through individual physicians for "organizing" the diseases and illnesses of the populations they serve? How is the apostolic function of a physician formed by the organizations within which he or she practices? In Michael's words "... the doctor's response to the patient's offer, or to the presenting symptom, is a highly important contributory factor in the vicissitudes of the developing illness" [1, p. 36].

The Drug, Doctor

How is the primary doctor going to learn about his therapeutic, stimulating, or tranquilizing influence on the patient? What kind of a drug will he be? "In spite of our almost pathetic lack of knowledge about the dynamisms and possible consequences of 'reassurance' and 'advice' these two are perhaps the most often used forms of medical treatment. In other words they are the most frequent forms in which the doctor is administered" [1, p. 116]. With the significant social disruption and dislocation of extended and immediate families following the second world war, Michael was very sensitive to the experience of isolation that many patients embodied. Today individuals experience comparable disruption of extended and immediate families due to global military interventions and through the national and international relocation of businesses and factories. Early on in his book, Michael frames the physician's dilemma this way in receiving the patient's complaint:

In such troubled states especially if the strain increases, a possible and in fact frequently used outlet is to drop in to see one's doctor and complain. I have deliberately left the verb without an object, because at this initial stage we do not know which is the more important, the act of complaining or the complaints that are complained of. It is here in this initial, still

"unorganized" phase of an illness that the doctor's skill in prescribing himself is decisive. [1, p. 2]

For Michael to propose the doctor as drug, is to cast him in a far more intimately invasive and impactful relation to the patient than any textbook I have read describing how the doctor is to relate to the patient. He raises the question of just how the doctor "should administer himself": "Should he be a kind of authoritative guardian . . . ?" "Should he act as a mentor . . . ?" "Should he be a detached scientist . . . ?" "Or should he be an advocate of 'truth above all' . . . ?" [1, p. 228]. Taking quite seriously this metaphor of the doctor as drug, he then goes on to question the importance of the doctor learning what are his "side effects." "All these and many more problems contribute to what we have called the pharmacology of the drug 'doctor'" [1, p. 229].

Michael comments about the extent to which significant research surrounds the formulation and testing of drugs. He very strongly advocates that such research needs to surround the education and ongoing practice of the primary care physician. It is imperative that the general practitioner, the family doctor, maintains a caring and observant eye on himself as well as the patient. "Just as it is very difficult to operate with a blunt knife, to obtain sharp [x-ray] images with a faulty apparatus, to hear clearly through an unserviceable stethoscope, so the doctor will not be able to listen properly if he is in poor shape" [1, p. 228]. In introducing such a metaphor it seems apparent to us that there is an implied ongoing responsibility, and concomitant satisfaction for the physician to study and reflect upon the very particular ways in which he is relating to, "treating," patients. In other words, treatment is not to be summarily understood only by prescriptions or referrals written, hospital admissions, changes in patient laboratory profiles, or educational materials distributed, but as well by a mutual sense of satisfaction in the relationship as experienced both personally and professionally, by the physician and the patient. Are they working effectively and well together in the treatment of illness? "One of the most important side affects—if not the main effect—of the drug doctor is his response to the patient's offers" [1, p. 18]. When the drug doctor is effectively being prescribed, the apostolic function of the physician is being realized. It is in this growing pharmacological awareness of self that the physician begins to understand the meaning of a "considerable though limited" change in personality.

MUTUAL INVESTMENT COMPANY

It is on this basis of mutual satisfaction and mutual frustration that a unique relationship establishes itself between a general practitioner and those of his patients who stay with him. It is very difficult to describe this relationship in psychological terms. It is not love, or mutual respect, or mutual identification, or friendship, though elements of all of these enter into it. We term it—for want of a better term—"a mutual investment company." [1, p. 249]

Through years of acquaintance, the physician gains an intimate knowledge of the patient's background, members of his or her family for several generations, the type of people who are his friends, coworkers at a factory or office, the place where he works, and the street on which he lives. The physician may indirectly hear from other patients how this particular patient is viewed, something about his work record, something about his wife and children, and still more importantly how he thinks about his health and his care of himself. The physician has had first-hand experience with:

... the common experiences in health and especially in sickness, how often and with what sort of complaints the patient comes for medical advice, how he behaves when something unexpected happens, when a member of his family falls seriously ill or dies, or when he has a minor or major illness. In the same way the patient learns how much and what kind of help he can expect from the doctor. Obviously it is of paramount importance that these capital assets, the result of persistent hard work on both sides to gain the other's confidence... should be used in such a way as to yield an adequate return to both patient and doctor. [1, p. 250]

Michael considered these commonly shared medical behaviors a most important domain for research "which medical science has neglected." This domain of research most certainly involves objective data generated in clinical practice, and also a wealth of subjective data relevant to both doctor and patient. A significant focus of contemporary medical research has been the objective data in clinical practice in an attempt to assess the potency of treatments prescribed as measured by improvements in the patient's laboratory and radiological reports and the efficiency and effectiveness of the doctor's prescription of same. However, little or no attention has been given to the patient's subjective experience of improvement or sense of resolution of his or her illness and the doctor's sense of satisfaction with having effectively understood and addressed the patient's illness. In other words, there has been little attention paid to the "capital assets" of the "mutual investment company." What has sustained the empathic, caring relationship of doctor for the patient and the confident, trusting relationship of the patient for the doctor has been, by and large, ignored. This is a history that needs to be written. Today we recognize that trust is a necessary ingredient in patient satisfaction and adherence to management plans.

Gayle Stephens notes that the physicist is really not concerned with the behavior of a single electron as long as the behavior of electrons in general can be predicted. He then goes on to say:

With human beings, however, the physician is concerned with the single one, the individual who can only be understood in terms of the sequence of his experiences; i.e., his history.

Family practice properly belongs among the historical sciences and, therefore, is subject to the rules and methods of historical research. Testimony, an account of personal experience, is a primary data of the family

physician's work. . . . We know about the vagaries of memory and the vicissitudes of affect on perception, but we do not often study these. We need to recognize, as historians long have done, that history is not only discovered but is also invented by the historian. [12]

If the capital assets of the mutual investment company are to be redeemed, primary care practitioners will need to record carefully their own history with discriminating attention to the ways in which their thoughts and feelings are responding to the unique offering of the patient immediately before them. The whole patient in his or her immediate and historical context needs to be recognized. The depth of that insight is extended through the various scenarios that other physicians in the Balint seminar bring to the case discussion of the day. It would be fair to say that the Balint seminar itself invests in creating a larger mutual investment company for the presenting physician and his patient. The Balint seminar is a creative process of learning through one's personal clinical practice; it is learning the art of medicine. The Balint seminar is itself a mutual investment company in the case of the hour: clinically plausible, alternative scenarios of doctor, patient, and their relationship are "invented." Here the art of medicine and the art of relating have a foundation in an otherwise scientific and technologically monopolized curriculum. Here also the isolated practitioner examines with his colleagues the everyday lived reality of attempting to care for patients where science and technology have reached their limit and have left the physician in professional, existential suspension.

The Offer of an Illness

"One is caused by a fact, not always taken seriously enough, that every illness is also the 'vehicle' of a plea for love and attention" [1, p. 276]. In elucidating the "apostolic function" and the "doctor as drug," we spoke about the critical significance the doctor's acceptance of the patient's offer of an illness had, both immediately and over time, in the effective treatment and management of the patient. Acceptance, as Michael conceives of it, is not some naïve generosity of spirit, but rather a carefully discriminating response, alert to the posture the patient begins to assume. The physician must be:

. . . on the watch to prevent the patient from organizing his illness around an unimportant and accidental physical sign, thereby sapping in a futile and sterile manner both his own energies and those of his medical attendants. General practitioners will have learnt when it is essential to treat a "clinical illness" offered by a patient and when to disregard it and make a bee-line for the underlying "conflict." [1, p. 287]

What might be the patient's hidden agenda, or actual reason for the visit? Such discrimination must be a part of every medical student's training! Interviewing skills may not disclose the patient's hidden agenda.

In attempting to cope with the illness being presented, the doctors are faced with what Michael calls "technical difficulties." "One of the problems is how much regression, i.e., returning from an adult to more primitive, childlike behavior, should be permitted to the patient, and when. . . . The opposite problem is how much maturity should be demanded from an individual, how fast, and at what point." How will the doctor exercise his apostolic function and in what ways will he be prescribing himself? Both of these factors directly speak to the way in which the patient's offer of an illness will be accepted. How are love and attention judiciously and empathically modulated in caring for patients?

We feel that these are significant issues that the mastery of scientific information or technical procedures leave unaddressed in contemporary medical education. Teaching interviewing and counseling skills, which are given passing attention, do not address the underlying issue of how the student or resident will use themselves in caring for as well as "treating" the patient. Interviewing is an operator dependent function. Outside of the Balint seminar, no systematic attention is being given to the feelings and thoughts evoked in students or residents by the patients they are caring for on a regular basis. The classical prescription for maintaining professional distance and avoiding discussing thoughts and feelings that surface in the immediate patient encounter are to be avoided. The more experienced clinician will likely have learned some effective skills in managing many patients, and yet, is subject to encountering a new patient, or an established patient confronting an unanticipated change in her medical condition which may cause the physician to question just how effectively he is treating them. Unless this clinician maintains a personal diary, or is the member of a Balint seminar, he or she will not be dictating, as part of a medical record, their subjective clinical experiences. Consequently, self or peer reflection is displaced in keeping up with the next appointment.

Collusion of Anonymity

"... when the patient offers a puzzling problem to his medical attendant, who, in turn, is backed by a galaxy of specialist, certain events are almost unavoidable. Foremost among them is the 'collusion of anonymity.' Vital decisions are taken without anybody feeling fully responsible for them" [1, p. 76]. Michael continues by saying, "Another example of disagreement masking the collusion of anonymity occurs when the general practitioner and his consultant differ fundamentally about the therapeutic method to be applied in a particular case" [1, p. 86]. Consider the patient with persistent abdominal pain who remains inconsolable in the face of negative imaging, endoscopic exams, and an abdominal hysterectomy. It is only at the end of the chapter entitled, *The Collusion of Anonymity*, that Michael introduces what we judge to be another significant player in this collusion of anonymity. "The collusion of anonymity rules the situation not only as far as the doctors are concerned, but the patient has her full share in it, too. Everybody

is trying hard, is expending his energies in a futile way, but nobody can be held responsible for the management—or mismanagement—of the case” [1, p. 80]. This seems to us equivalent to saying that the real problem, both in the patient and in the system, has not been identified.

This collusion of anonymity would look familiar to therapists who work with family systems. That is, one or several members of a family agree upon the “identified patient,” and how she needs to be treated for their illnesses. However, for the therapist there is no doubt that the entire family maintains its homeostasis by keeping the identified patient in her “sick” role which allows the remaining family members to preserve their “healthy” roles. Consequently, the contemporary general practitioner must be sensitive to the fact that the collusion of anonymity involves the patient, various consultants, himself, and as well the medical community and hospital structure of which they are part. In other words, the final treatment protocol that may be agreed upon for the patient is most likely to be one that satisfies the needs and values of the subculture in which the patient is being treated. The primary care physician, specialists, and laboratory personnel are all induced to play their role in maintaining hospital and clinic homeostasis. In some cases this may, in fact, serve the patient better than a negotiated treatment plan simply between the doctor and the patient. In other cases, however, it may result in a treatment protocol for the patient that has completely missed diagnosing the patient’s real problem. Hospital and clinic homeostasis will be preserved: financial solvency will be maintained, everyone’s job has been secured. However, imagine the effects of this wasteful spending on the national healthcare budget.

A commonly used electronic medical record system operational among general practitioners and specialists may in some ways clarify how each specialist is diagnosing and is disposed to treat an individual patient. However, the issue that Michael raises is still present: who is finally going to be responsible for judging what treatment protocol should be followed? As in the past, so in the present, the patient most likely, in the long term, is going to be followed by her primary care physician. It is this physician who should assume responsibility for that judgment. It is most certainly the case that the patient will be returning to that primary care physician. Her problem will have been appropriately identified and treated, or the patient will continue to register chronically her complaints, continuing to offer a more organized illness that is disguising the real problem.

Basic Fault

We now approach the deepest diagnosis.

If I am right, psychoanalysis is about to develop a new conception which may be called “basic illness” or perhaps “**basic fault**” in the biological structure of the individual, involving in varying degrees both his mind and his body. The origin of this basic fault may be traced back to a considerable discrepancy between the needs of the individual in his early formative years

(or possibly months) and the care and nurturing available at the relevant times. This creates a state of deficiency the consequences of which are only partly reversible. . . . the vestiges of his early experiences remain, and contribute to what is called his constitution, his individuality, or his character makeup, both in the psychological and in the biological sense.

Should this theoretical approach prove correct, all the pathological states of later years, the "clinical illnesses," would have to be considered symptoms or exacerbations of the "basic illness," brought about by the various crises in the individual's development both external and internal, psychological and biological. [1, pp. 255-256]

The Basic Fault is in fact the title of a major book which Michael wrote in 1968, some years after the publication of *The Doctor His Patient and the Illness* [13]. Michael initially proposed this idea in the 1930s. "It was central to his thinking over most of his career and is a unifying principle in his work on the doctor-patient relationship" [14]. According to psychologist Thomas Klee, the term was never intended to be pejorative. It is, in fact, a geological term and not a biological or ethical term, and in that sense descriptive of a basic formation of the earth's crust just as Michael had intended it to be a description of a basic formation of personality. We view the basic fault manifest in character disorders and impaired executive functioning. Such conditions contribute manifestly to the overuse of medical services. Patients with a basic fault often have thick charts and engender sinking feelings in the doctor, and are the most frequent presented cases in a Balint seminar. Our two case examples were both presented to a resident Balint seminar.

Since the basic fault occurs at a preverbal level it, has to be approached or addressed at an experiential level conveyed through an empathic relationship between doctor and patient. Consequently, the physician with experience begins to sense that the illness he is offered is likely a physical site or condition that the patient has unconsciously chosen to represent a more basic illness, the basic fault. However, that physical site or condition is not summarily dismissed. It is treated as though it may be a disturbed biological site or physiological process representing the same basic illness. To attempt to make this a rational, diagnostic judgment on any initial encounter, or prematurely in a developing relationship, would be unfounded. It is the developing relationship that will treat most directly and effectively the basic illness; it is the drug doctor that is to be prescribed to attend to both the body and the mind.

Although there is an unmistakable line running through the "illness offered" to the "conflict" and, deeper still in the direction of the "basic fault, I do not think it will prove possible within the framework of general practice to reach the "basic fault" and still less to redress it in any seriously ill patient." [1, p. 289]

To understand the basic fault is to understand more completely what a deeper diagnosis means and of what the illness of the whole person consists. Think back

to our incorrigible patient with persistent abdominal pain. Might the deeper diagnosis here involve a basic fault? Michael has suggested that this greater depth of diagnosis is approached, you might say, passively, by learning to listen. The basic fault is not the result of some series of experiences where words were attached to a person or persons who were intimately threatening, vaguely present, or remote and inaccessible; nor were words associated with sensations or identifiable needs. To understand the illness offered, the conflict presented, or the basic fault is to expand the scope of one's awareness of all of life, both in the patient and in the physician. This requires a considerable though limited change in the personality of the physician, what Michael was hoping to accomplish in the seminars. In other words, something more than objective clinical knowledge of pathophysiology, disease processes, pharmacology, or psychopathology must be acknowledged in helping the physician more sensitively receive the patient's offer of an illness. The physician must learn and trust a communication through presence, not simply the verbal exchange of information. If the physician would keep in his mind that some basic fault is still struggling for a better resolution in this patient's life, a new kind of listening could be acquired leading to a new depth of diagnosis, one that is more inclusive and accurate. When the physician is truly present and open to hear, the patient will be more fully present and able to speak.

SUMMARY AND CONCLUSION

We have presented some of the central concepts of Michael Balint's thinking as it relates to the psychological education of the primary healthcare provider and what is necessary for him to learn in providing more effective, patient centered healthcare. The vehicle for this learning was the GP Group, Balint Seminars, that began at the Tavistock Clinic in London the Fall of 1950. The research that summarized the results from the first six years of seminars was presented in Michael's book, *The Doctor His Patient and the Illness*. It is from that text that we have quoted in elucidating his concepts: 1. Deeper Diagnosis, 2. Apostolic Function, 3. The Drug, Doctor, 4. Mutual Investment Company, 5. The Offer of an Illness, 6. Collusion of Anonymity, and 7. Basic Fault. *The Doctor His Patient and the Illness* exists in print in nine languages, most recently in Chinese. Consequently, we used it as a meaningful and accessible anchor for readers of an international journal. Other relevant books that Michael edited, co-edited or that discuss the development of his work have been consulted [15-20]. Most all of Michael's extensive writings in psychoanalysis have not been referenced.

Hopefully our elucidation of these seven concepts leaves you with, first of all, the understanding that Michael saw the primary care physician in a key position to help prevent the "organization of an illness." To do this, the physician, as operator, was going to have to do something more than "rule out disease" and doing this something more was going to require a slight but significant change in his personality. This something more could be spoken of as understanding the

pharmacology of himself as the drug to be prescribed or to deliver the appropriate "message." These metaphors are saying that a broadening of self and interpersonal awareness would facilitate an empathic engagement with the patient. Such an engagement would allow the physician to see through, or beneath, the illness that the patient was offering, to the deeper diagnosis, the more accurate diagnosis that should be made. It is through this empathic engagement that the mutual investment company is formed. It is within this mutual investment company that doctor and patient, together, begin to form a relationship that approaches a treatment of the basic fault as well as other problems that must be addressed and treated.

In other words, it is the relationship that becomes the bridge to healing. Interviewing techniques or skills, and scientific medical knowledge may certainly be elements of that relationship; however, they do not constitute the foundation of the relationship. Counseling skills or scientific medical knowledge may be acquired without a change in the physician's personality. Medical treatment without the person of the physician has objectified the patient and the physician; person-centered care involves taking the perspective of the patient. This has been discarded. A change in the physician's personality results only from the direct experience of continual observation and reflection on actual, personal, physician behavior exhibited with patients. It is this behavior that becomes the focus of attention in the individual case study of the Balint seminar.

We do not believe that the evolution of biological, biochemical, or medical engineering research is attenuating. And likewise, we believe that it will continue to have much to offer in the way of improving healthcare delivery. However, it seems also to be true that patients will continue to seek from the physician more in the treatment of their illness than simply identifying and ruling out disease. It also seems to be the case that physicians, as much as patients, desire the experience of a mutual investment company: the cultivation of a working relationship in which satisfaction can be achieved by seeing growth, the restoration of health and an improvement in general well-being. In the contemporary world, it is not unusual to see physicians pulling out of their affiliation with medical corporations or hospital acquired practices to create their own community of patients with whom they will establish a more intimate, available and caring relationship. They are truly establishing a mutual investment "company."

So many of the critically important professional behaviors that Michael has defined are preempted by the educational establishment/hospital in which primary care physicians are trained/educated. Business policies, security practices, and the medical protocols of various specialties straitjacket and preempt the medical student from experimenting with most of the issues we have raised as key concepts in the functioning of a primary healthcare physician. What constitutes a medical history and appropriate bedside manner is modeled by an attending physician on expeditiously timed rounds. Family medicine residencies reduce in some respects the administrative policies and medical protocols, but not entirely. Residents are required an increasing number of half days spent in their "own clinic" over their

three years, and still in their third year are up to no more than five half days. However, for months at a time throughout their three years they continue to rotate on specialty services where patient treatment protocols are to be followed and the attending physician models the specialty's "standard operating procedures."

Nevertheless, it is these family medicine residency sites that became the beachhead for establishing Balint seminars in United States. Survey studies from 1990 (19%), 2000 (48%) and 2010 (54%) show an increasing number of Balint seminars in these residency programs [21, 22]. The frequency with which these seminars meet, the composition of their membership, the longevity of their group life, the quality of their leadership, and whether or not attendance is required or voluntary are all factors among these residencies that vary greatly. In a few sites around the United States, Balint Seminars are also occurring in other medical specialties. So there is a growing attempt on the part of the American Balint Society to realize Michael's legacy and provide new generations of physicians with the knowledge and experience to dispense themselves more empathically and effectively in caring for their patients.

REFERENCES

1. Balint M. *The Doctor, His Patient and the Illness* (rev. ed.). New York: International Universities Press, Inc., 1972.
2. Sutherland JD. Obituaries: Michael Balint (1896-1970). *International Journal of Psychoanalysis* 1971;52:331-333.
3. Glenn ML. Balint Revisited: On the 25th Anniversary of the Publication of *The Doctor, His Patient and the Illness*. *Family Systems Medicine* 1983;1(1):75-81.
4. Tredgold RF. Michael Balint and Medical Students. *Psychiatry in Medicine* 1972; 3:385-388.
5. Johnson AH. The Balint Movement in America. *Family Medicine* 2001;33(3): 174-177.
6. Koenig HG. Editorial: Exploring Psychobiological, Psychological, and Cultural Aspects of Patient Care. The *International Journal of Psychiatry and Medicine* in the 21st Century. *International Journal of Psychiatry and Medicine* 2000;30(3):195-202.
7. *The International Journal of Psychiatry in Medicine (IJPM)*. Freedy JR, Aclierno RE, editors. Retrieved July 11, 2013 from <http://www.Baywood.com/journals/previewJournals.asp?ID=0091-2174>
8. American Psychiatric Association. Appendix 1: Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes. *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, DC: American Psychiatric Association, 1994: 843-849.
9. Engel G. The Need for a New Medical Model: A Challenge for Biomedicine. *Science* 1977;196(4286):129-136.
10. Pilgrim D. The Biopsychosocial Model in Anglo-American Psychiatry: Past, Present and Future. *Journal of Mental Health* 2002;11(6):585-594.
11. Salinsky J. *The Last Appointment: Psychotherapy in General Practice*. Sussex, England: The Book Guild Ltd., 1993.

12. Stephens GG. *The Intellectual Basis of Family Practice*. Tucson, AZ: Winter Publishing Company, Inc., 1982:202.
13. Balint M. *The Basic Fault: Therapeutic Aspects of Regression*. London, UK: Tavistock Publication Limited, 1968.
14. Klee T. The Function of Balint's Levels of Mind in Balint Groups. Reprinted from *The Journal of the Balint Society*, 2008. Available at <http://www.drklee.com/balintarticle.htm>
15. Balint E, Courtenay M, Elder A, Paul S, Julian P. *The Doctor, the Patient and the Group: Balint Revisited*. London, UK: Routledge, 1993.
16. Elder A, Samuel O. *While I'm Here Doctor: A Study of Change in the Doctor-Patient Relationship*. London, UK: Tavistock Publications, 1987.
17. Balint M, Balint E, Gosling R, Hildebrand P. *A Study of Doctors: Mutual Selection and the Evaluation of Results in a Training Program for Family Doctors*. London, UK: Tavistock Publications, 1966.
18. Balint E, Norell JS, editors. *Six Minutes for the Patient: Interactions in General Practice Consultation*. London, UK: Tavistock, 1973.
19. Stewart H (with chapters by Elder A, Gosling R). *Michael Balint: Object Relations Pure and Applied*. London, UK: Routledge, 1996.
20. Haynal A. *The Technique at Issue: Controversies in Psychoanalysis: From Freud and Ferenczi to Michael Balint*. London, UK: Karnac Books, 1988.
21. Brock C, Stock R. A Survey of Balint Activities in US Family Practice Residency Programs. *Family Medicine* 1990;22(1):3-7.
22. Johnson A, Brock C, Hamadeh G, Stock R. The Current Status of Balint Groups in US Family Practice Residencies: A 10-Year Follow-Up Study, 1990-2000. *Family Medicine* 2001;33(9):672-677.

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