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Consultation skills and the work of Michael Balint

Many sources claim that Michael Balint revolutionized general practice just as it was beginning to establish itself as a speciality in its own right. Basing most of his concepts on theories of psychoanalysis, Balint set himself the task of finding a 'space' for general practice as a separate clinical discipline. Balint believed that it was the GP's ability to provide holistic continual care which stretched from cradle to grave that really separated general practice from hospital medicine. Balint developed many ideas and concepts around the doctor–patient relationship, all of which are still relevant to general practice today. Balint's theories depend heavily on three aspects of general practice: the personal qualities of the GP, the GP's skills and the wider socio-economic and political context of general practice. It is hoped that having an understanding of Balint's ideas and theories can improve the consultation for all GPs both new and experienced.

The GP curriculum, the consultation and Michael Balint

Curriculum statement 2: The general practice consultation lists the learning objectives for a GP to improve consultation skills. It states that the consultation is at the heart of general practice and that the GP should;

- Be able to communicate clearly, sensitively and effectively with patients and their relatives
- Have a commitment to patient-centred medicine
- Demonstrate commitment to health promotion, while recognizing the potential tension between this role and the patient's own agenda
- Understand the process by which patients decide to consult and how this can affect consulting outcomes
- Understand the need to share information with patients in an honest and unbiased manner, in order to educate patients about their health
- Have an awareness that consultations have a clinical, a psychological and a social component, with the relevance of each component varying from consultation to consultation

An introduction to Balint

Michael Balint had a very interesting medical career which is well described in an article in the *British Journal of General Practice* entitled 'Michael Balint—an outstanding medical life' (Lakasing, 2005). A brief timeline of Balint's life is displayed in Box 1.

Much of Balint's work was based around three key principles:

- General practice has an abundance of 'neurotic illness'
- Trivial and inexplicable complaints are the main ways these neurotic illnesses present to a GP
- The key to healing neurotic illness is the character of the doctor and the type of relationship established between them and the patient. This is the source of Balint's famous remedy 'the drug "Doctor"'

Box 1. A timeline showing key events in Balint's life

1896—Michael Balint is born in Hungary; his father was a GP.

1914–18—Balint studies medicine at the University of Budapest. He graduated at the age of 21 years despite serving in the Hungarian army during the First World War. During this time, Balint became interested in psychoanalysis and attended the lectures of the first professor of psychoanalysis, Sandor Ferenczi.

1924—Balint set up and ran support groups for GPs in Hungary in which they could discuss psychosomatic illness in general practice.

1939—Balint moved to UK and worked in a child guidance clinic in Manchester.

1945—Balint began working at the Tavistock Clinic where he met his third wife, Enid Eichholz, who was a social worker at the clinic.

1950—With the help of his wife, Balint restarts the GP support groups; he had begun almost 25 years earlier in Hungary. The groups, known as 'Balint Groups', encouraged GPs to reflect on cases to try and reveal the hidden meaning of emotions felt and behaviours exhibited by both GP and the patient.

1956—Balint publishes his book 'The doctor, his patient and their illness' which was based on his experiences at the Tavistock Clinic.

1968—Balint becomes president of the British Psychoanalytical Society.

1970—Balint dies on the 31 December. Even after Balint's death, his influential wife continued to expand the work, importantly she began to include non-psychoanalysists as Balint group leaders which further expanded the use of Balint groups.

1972—The International Balint Federation is founded with the aim of continuing to spread Balint's ideas and theories.

Balint believed that the key to an effective doctor–patient relationship was a complex dialogue held over time in an atmosphere of trust (Balint, 1956; Greenhalgh, 2007).

> I wish to state that the tool in psychotherapy—the counterpart to the surgeon's knife or the radiologists x ray apparatus—is the doctor himself . . . he must learn to use himself as skilfully as the surgeon uses his knife, the physician his stethoscope and the radiologist his lamp (Balint, 1956)

Balint, the personal qualities of the GP and the consultation

The GP's apostolic function

The attitudes and values of a GP are intensely linked to that doctor's apostolic function. This rather confusing term describes the doctor's beliefs about how a patient should behave and endure illness (Greenhalgh, 2007). This seems a rather paternalistic concept but in Balint's era, the consultation style was more paternalistic which may account for this. Nevertheless, it is still an important idea as it is believed that the apostolic function can influence the patient's behaviour, ranging from frequency of visits to compliance to treatment (Balint, 1956; Balint and Shelton, 2002).

Every doctor's apostolic function will be very different, being shaped by his or her own attitudes, values, models of illness and upbringing. For example, if, as a child, the doctor was encouraged to 'carry on' regardless of minor illness, he or she may have an unsympathetic attitude to patients who 'request' sick notes or present with very minor symptoms. Balint argues that doctors need to be aware of this process and how it can affect patients. If properly controlled, however, it becomes a means of patient education (Osborne, 1993).

A GP's confidence and ability to manage risk can also affect the content and outcome of a consultation. Risk adverseness can be altered by life experiences and knowledge and this innate tendency may be overridden by compliance with research guidelines or advice. This is linked in many ways to the apostolic function as perhaps a more 'risk taking' GP will be less likely to investigate patients with vague or 'uncharacteristic symptoms'. For example, a risk taking GP may confidently reassure an older woman that symptoms of vague abdominal bloating are simply irritable bowel syndrome and nothing to worry about. Whereas a more risk averse, GP may investigate further to rule out more sinister disease.

The collusion of silence

Balint recognized that to allow for a 'comfortable evolution' of a trusting doctor–patient relationship, it may be necessary for the doctor and the patient to exclude certain 'personal areas'. Some areas which may be 'out of bounds' include sexual relationships or substance abuse (Balint and Shelton, 2002). Balint referred to this as 'the collusion of silence' (Balint, 1956; Balint and Shelton, 1996). It is possible that the size and content of the 'collusion of silence' will depend on the GPs own values as well as their confidence in asking difficult questions. The collusion of silence can alter and affect the content of the consultation dramatically. Leaving difficult questions unasked may mean missing vital diagnostic information to help the patient. Interesting comparisons can

be drawn between Michael Balint's collusion of silence and Elizabeth Kubler-Ross' 'conspiracy of silence' which is discussed in her book 'Death; the final stage of growth' (Kubler-Ross, 1986).

Transactional analysis

Eric Berne was a Canadian psychiatrist who developed a model of the human psyche known as 'transactional analysis'. He stated that the human psyche has three different 'ego states' which everyone can switch between in different situations: the parent, the adult and the child (Berne, 1970). This theory relates well to general practice consultations and the doctor–patient relationship. Berne states that both doctor and patient are in particular ego states at all times during a consultation. If a patient is worried when they see the doctor, for a troublesome headache for example, they may assume the 'child role' which can then have a 'reciprocal effect' on the doctor in assuming a parental role (Berne, 1970).

This type of transaction is common in consultations because of the caring role of doctors but this is not always positive. This reassurance could reduce the stress and hence the number of headaches. However, the doctor assuming the parent role can lead to exhaustion by constantly trying to 'make it better'. It can also cause a sense of failure when things do not go according to plan. Patients assuming the child role may lead to overdependence on the doctor by enjoying the 'parental attention' received from the GP (Berne, 1970).

The ego states assumed by doctors will depend on values and attitudes which may in turn depend on their upbringing or life experience. They will affect the doctor–patient relationship and may challenge the 'trusting' connection between the doctor and patient that Balint believed was so important.

GP's skills, Balint and the consultation

Forming a trusting relationship with a patient is one of the most important skills for a successful consultation. However, every GP knows that they 'click' better with some patients than they do with others. Liz Moulton is a director of postgraduate general practice education in Yorkshire and an advisor for the Department of Health. In 2007, she published a book on consultation skills in primary care entitled 'The Naked Consultation'. In her book, Moulton discusses skills which can help develop a good doctor–patient relationship. She discusses simple measures such as arriving on time and having the room set up correctly before discussing 'the golden minutes'; the first couple of minutes at the beginning of a consultation where an effective relationship can be made or broken (Moulton, 2007).

These theories link very clearly to the ideas of Roger Neighbour discussed in his book 'The Inner Consultation'. Neighbour describes a widely taught consultation model in which the final 'stage' is housekeeping. In this stage of the consultation, GPs are encouraged to reflect on the previous consultation, acknowledge the effect that it may have had on themselves and prepare for the next consultation (Neighbour, 1986). Clearly, GPs, who arrive late, feel rushed and need to 'catch up' will find it much more difficult to connect with patients. They will be much less likely get to the bottom of the 'neurotic illnesses' which Balint believes are so prevalent in primary care. An example of this is given in Box 2.

Box 2. An example of how the outcomes of a consultation could be altered by the 'timekeeping' skills of the doctor

A patient arrives requesting a repeat sick note for back pain.

Doctor A, who arrived late, may be glad of a 'quick consultation' in order to catch up. Whereas Doctor B who has arrived in plenty of time may be more likely to further explore both the symptoms and the patients' job etc.

Doctor B is much more likely to uncover a patients 'hidden agenda' or neurotic illness'. Perhaps, the patient is being bullied at work? Is depressed? Or has problems at home that need attention?

The 'active listening' skills of a GP are vital in discovering what is wrong with a patient and perhaps to finding a hidden neurotic illnesses. According to Moulton, active listening means 'taking an active role in the process of another person talking to you'. Some doctors will be better at this than others, but it is possible to improve these skills by paying attention to body language and posture, echoing the patient by repeating bits of what has been said and asking both open and closed questions (Moulton, 2007). Research has shown that active listening increases patient satisfaction and consultation outcomes (Lang *et al.*, 2000).

One of Balint's most central beliefs is that the doctor, inevitably, acts as a kind of drug upon his patients. He thought that the very persona of the doctor was a vital 'instrument of treatment' in general practice (Balint, 1956). Believing this, Balint postulated that GPs should learn to use their own personalities in the best way possible, by what he called 'limited but fundamental changes in their personality'. Balint and his wife used their famous 'Balint Group' to help facilitate these changes in personality (Osborne, 1993).

Counter transference was another common theme that Balint discussed in terms of the consultation. This describes a process in which the patient influences and changes the emotions or feelings of the doctor. Therefore, the doctor asking himself 'how am I feeling at this point in the consultation?' may give useful insights into how the patient is feeling. This may be a skill which some GPs are better at than others, but, if GPs are able to recognize this process, it may help them to develop a better relationship with a particular patient (Heimann, 1950; Balint, 1956; Moulton, 2007). The counter transference skills of a particular doctor could easily influence the outcome and content of a consultation; it may be possible for the doctor to uncover a patient's 'hidden agendas' by keeping in touch with his or her own feelings and therefore the feelings of the patient. An example is given in Box 3.

Box 3. An example of how counter transference could help in a consultation

A patient may present to the GP with a long list of trivial or general symptoms that seem to have no connection at all. If the GP were to ask himself 'how am I feeling?', emotions such as frustration, getting nowhere or going round in circles may come to mind.

This may be exactly how the patient is feeling. The patient may be suffering with an endless list of complaints with no answers or cures being offered to her. If the GP could acknowledge this, it would certainly help the doctor–patient relationship and perhaps make the patient begin to feel as if she is being understood.

Communication and consultation skills are important for all GPs in training. These skills are assessed in the Clinical Skills Assessment (CSA) examination. One of the main aims of the CSA is to assess 'a doctor's ability to communicate effectively with patients'. In each station of the examination, 'interpersonal skills' carry as many marks as information gathering and clinical management skills (RCGP, 2011). It is hoped that by having knowledge and understanding of the theories of Michael Balint, GPs in training can improve both their consultation skills and the doctor–patient relationship.

Barriers to Balint

Throughout Balint's work, he talks about the doctor and the patient building up a trusting relationship over a long period of time but has the modern NHS helped or hindered this process? In a recent report, Lord Darzi discusses the formation of 'Polyclinics' or 'GP-led health clinics' (Darzi, 2008). Could these larger practices prevent patients seeing the same doctor and thus, stop them developing the trusting relationship discussed by Balint? Have you noticed any differences in doctor–patient relationships and consultation styles when working in large practices compared to a smaller ones? Similarly, do rotating shift patterns and shorter contracts for GPs affect the patient's ability to build up a trusting relationship over time? How do you feel the European working time directive and the 'new deal' for GPs have affected doctor–patient relationships?

The development and implication of the Quality and Outcomes Framework (QOF) into primary care may also have had an impact on the content and 'aim' of consultations (British Medical Association / NHS Employers, 2011). How should QOF be incorporated into modern general practice? Do you feel that QOF has any effect on the content of consultations? An interesting example which is often the subject of debate is the use of the Patient Health Questionnaire (PHQ-9) in depression. This questionnaire has nine questions and is recommended by QOF as a tool to assess the severity of depression. It is often printed off the computer and handed to the patient to fill in. One could question if this time would be better spent enquiring into the home life of the patient? Or asking about possible triggers of the symptoms that he or she is presenting with?

A recent qualitative study looked at both doctors' and patients' views around the use of the 'depression severity questionnaires'. It found that while some GPs found benefits from using the questionnaires, such as allowing a more methodical approach to history taking, all stressed the importance of holistic care and many were sceptical about the use of a questionnaire which they felt 'detracts from the human element of patient care' (Dowdrick *et al.*, 2009).

GP-led health centres and QOF are just two of many potential barriers to Balint's theory within modern day general practice. These barriers could prevent the building of an effective doctor–patient relationship and therefore miss the neurotic illnesses that Balint believed were so prevalent in primary care.

Conclusions

At his death, Balint was president of the British Psychoanalytic Society and his contribution to British general practice was enormous. But if his name is of some importance within psychoanalysis, it is even more so among GPs (Moulton, 2007). A recent *BMJ* article has asked the question 'Are we all Balintians?' (Holmes, 2008) and an editorial in the Journal of Royal College of General Practitioners stated that 'We believe that what Freud has become for psychiatry, Balint will become for general practice' (Editorial, 1972).

This article has discussed how Balint's theories and ideas are still very relevant to general practice today. Several studies have documented the benefits of Balint groups for GPs. One qualitative study published in Sweden found that participation in Balint Groups increased the GPs' competence in patient encounters and allowed them to find 'joy and challenge' in their relationships with patients (Kjeldmand and Holmstrom, 2008). Another interesting article documented the experiences of psychiatry trainees who attended a Balint group as part of their training. The authors concluded that despite their negative feelings at the start, they all enjoyed the group and 'wished that it could have continued longer' (Das *et al.*, 2003). It is worth noting that Balint groups run in all areas of the UK and may benefit the learning and reflection process for all GPs and GPs in training.

Key points

- Balint believed that there is an abundance of neurotic illness within primary care
- An awareness of Balint's theory of how the doctor can act as a 'drug' through his consultation skills can provide outcomes for patients in primary care
- An awareness of what Balint called the 'collusion of silence' can help to unearth a patients hidden agenda in the consultation
- Learning through reflection and continuous 'research' in to ones own consultations can aid learning and improve future consultations
- Being on time and prepared for each consultation can help the GP develop an improved relationship with the patient

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