

From Balint to Square-bashing

Fifty years' experience of General Practice

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Our healthcare's increasing employment of complex technology is often accompanied by a disinheritance of our human complexity. This inverse relationship is undesigned but ever-more important. A personal history of the culture explains.

The truth is rarely pure and never simple.

– Oscar Wilder, *The Importance of Being Earnest* (1895)

Nearly fifty years, as a medical student, I chose to stay with a country town GP, Samuel, to experience General Practice. He was a subtly mannered man whose open intelligence and warm heart had found a welcome home in his work. What I witnessed, and what we then spoke about, roused the beginning of my own lifetime vocation.

Samuel urged me to read a recently published book that, he said, was greatly helping his work's sense of personal purpose and direction. The book was *The Doctor, his Patient and the Illness*. I had not heard of either the book or its author, an elderly Hungarian refugee and Psychoanalyst, Michael Balint.

Samuel described his understanding of the book and its history – how Balint had become interested in the inexplicit and unformulated personal aspects of illness patterns and behaviours, and how these were reflected in broader, recurring themes – in patients' lives, and then in the consulting room. Balint wanted to explore, with doctors, the personal experiences beyond designatory diagnoses and treatments: the realms of human meaning and understanding.

To fulfil this quest he captured the intellectual interest and then time commitment of a few London GPs, initially for a decade. They met weekly to describe, explore and understand their emerging human stories and experiences with patients. This was done through candid, though respectful, disclosure and exchange.

The result was unprecedented qualitative research of the human subtext of medical practice, often tracking therapeutic relationships over many years – territory well beyond the reach of established, academia and training: traditionally this had been almost entirely restricted to the explicit, the designated and the quantifiable. Balint's pioneering research had some fascinating contrasts to the kind of research that is now customary or requisite. It was never funded or officially sanctioned, endorsed, ratified or assessed. It was fuelled and guided solely by the intellectual interest and vocational conscience of its participants over a commitment of many years. If we read how 19th century scientists worked – say the electromagnetic physicists Maxwell and Faraday – we can see a likeness. This kind of research would be impossible – even illegal – today.

Although such research might now seem feral, it had sufficient endogenous sophistication and integrity to spawn a vibrant culture. A generation of thoughtful GPs – like Samuel, and then myself – found an increasing resonance with our patients and like-minded colleagues. ‘The Balint Movement’ – as it then became – widened and deepened our observations and speculations about our humanity: our attachments, personal interactions and the meanings we then confer. Few of us were academic but most became – in the most essential sense – philosophers. A kindly, unboundaried fraternalism developed: our humanly difficult and demanding work became more interesting and gratifying.

Thirty years ago this gently burgeoning cultural enlightenment seemed secure in its influence and growth. This was illusory: today that influence seems to have shrunk to a kind of sentimental peripherality and quirky irrelevance.

Our planners, managers and paymasters tell us we have much other important work to do.

What has happened?

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I am having trouble with my professional validation authorities. My documentation for reflective practice and my Professional Development Plan are deemed inadequate or incorrectly formatted.

I balk, demur and then protest. I point to already accessible and copious documentation: it all indicates very long-term and consistent excellence of clinical, personal and academic practice. So why do I now need to contrive, say, a Personal Development Plan? The appraising authorities’ answer is, basically: ‘because the Authorities are responsible for standards, and they decide what is required from everyone. Rules are rules. And we are here to administer the rules. That means we tell you, and you comply’.

What are the consequences of such rules, this *modus operandi*?

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In the 1950s I remember ex-servicemen talking with wry reminiscence of ‘square-bashing’. This referred to military rituals of command and compliance – often choreographed on a

barracks square – where groups of men are corralled and then ordered to obey simple orders immediately and with unified precision. *Quick March!*, *Eyes Right!*, *About Turn!*, *Attention!* are all familiar terms from the square-bashing lexicon.

Personal Development Plan! is a complex and late descendent of square-bashing. It is an involuntary prescription sheltering under the broad rubrics of ‘Governance’ or ‘Accountability’. Yet it feeds its own roots of authoritarian rhetoric, to define who is the definer: who will command and who will obey. It enables and displays the individual’s surrender to the group, and the group’s surrender to authority. It is a tool to *manage* others, not understand them. For any learning submitted to an authority is very different from that personally sought and aspired to.

This latter distinction was at the human heart of the Balint movement. But we have replaced that human heart with a mechanical one that can count but cannot value. As a youthful professional I was gently encouraged by a fraternal nexus; as an elder I am now commanded and inspected on a parade ground.

These personal experiences are also a microcosm of massive cultural changes in the last two decades throughout Welfare: we have thoroughly replaced the fraternal milieu of supportive guidance with managerial engines of forensic surveillance and command.

Why and how have we done this?

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Our personal assumptions, expectations and value systems have deep roots in our society’s economy, ecology and technology – how we live. It requires great attention to achieve even a little separation from our embedding.

For example, we live with and through a myriad of industrially manufactured objects and commodities. To ensure their accessibility and our security we have devised ways to industrialise and standardise their manufacture, distribution, reliability and safety. We do this in ways that (in ‘advanced’ societies) also protect the welfare of the labour force that produces them – the workers’ ‘health and safety’.

These blessings of our industrial society are only possible through massive systems of technical plans, procedures, checks and regulations. All of this is essential to, say, the

manufacture of a car. Generally – as consumers – we are both unaware of, and uninterested in, the governing systems that provide us with safe and reliable accessibility. We assume that these considerations can be entrusted, on our behalf, to technicians, managers, lawyers and – increasingly – computers and robots. We pay for the object or commodity and presume the rest will follow.

This kind of consumerist thinking has leached widely and deeply through our mental and relational life: it has become a major determinant of how we now think about healthcare. So, we think, if we can design, manufacture and purchase a car that is accessible, safe, reliable and quality-assured, why can we not do this with *all* of our healthcare, and with doctors in particular?

Such seductive conflation of healthcare with industrialised commerce has easy appeal but proves to have very limited competence. This is because such a view cannot engage with the human heart of healthcare: relationships, attachments and meaning. Yet these human vicissitudes are crucial to our ailments and how we attend to them: they are hardly relevant to the manufacture of cars (though they are important in *marque* marketing – another, fascinating, subject).

The consumerist, car-manufacturing, approach to healthcare may do well with certain procedural aspects of healthcare (eg public health, screening, the treatment of acute circumscribed illnesses, vaccinations) – these can all be commissioned, pre-packed and manufactured. But it serves us much less well in the vast area where we want something else to enable our capacity for endurance, for new adjustment, for trust, for repair of recent or ancient traumas. Especially in our declines, our need is for comfort and recognition, for fraternalism. All of these – all healing and palliation – require bonds and understandings that can come only from genuine personal investment and interest. Such spirit and spirituality in healthcare can generate only from natural, and thus vernacular, growth. It cannot be successfully commissioned, planted or manufactured from somewhere else.

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Michael Balint and his cohort fifty years ago understood this very well and many were liberated by such insight.

For all their wisdom, though, their analysis and view were narrowly confined to the doctor-patient relationship: they did not look at the wider social context, and thus the

social change and gathering forces that would sweep away their substantial but fragile wisdom. The Balint era thrived in a world that had a far less developed consumerist mindset and systems of manufacturing governance. This world changed dramatically with the introduction, then hegemony, of computers. The language and thinking within our institutions then had to change because the language of computers is systems, and the raw material of systems consists of codes and numbers, data and categories. We humans had then to comply with the office machinery.

Another brief analysis is necessary here. Computers operate from binary elements: 0 or 1, Yes or No; so computers cannot contain or recognise ambiguous complexity. Yet, all those years ago, Balint was urging us to acknowledge and explore such complexity, helping us see that 'This is That as well as This'. But this kind of holistic sophistication cannot survive the computer's non-negotiable binary imperative: 'This is This, and That is That'.

The computer's requirements, repeated millions of times, become the human mindset. We engineer our machines, and then our machines engineer us.

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The world I inhabit is naturally and humanly complex. There are many who deny this. They seek to speedily relieve themselves and others of our burden: they offer many invitations to simple notions or remedies. Usually these are found to be specious in any longer test. Worse still, mixtures of simplicity and zeal often become dangerous.

Likewise there are many who wish to make healthcare simpler and thus more efficient by short-circuiting human vagary and complexity, by distilling it to some kind of simpler industrial governance and consumerist 'choice'.

Through a long working life my most testing yet rewarding encounters have often been with people who feel misunderstood or excluded by such institutional directives of simplicity. They have then sought my personal embrace of complexity. My encounters cleave to a demanding principle: it is often through our capacity to tolerate and contain complexity and ambiguity that our most helpful contact and understanding – of ourselves and others – can take root and grow. There are better and worse ways to do this; if we are both skilful and lucky they can be quick, but they are hardly ever simple.

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Samuel, so many years ago, talked of his gratitude and relief to share such notions with fraternal colleagues. A professional generation later I would benefit, too. But how will our current and future doctors negotiate their own and their patients' human complexity?

If I were the Chief Square-basher I would command: *About Turn!* and then *Eyes Left!*

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Conformity is the jailer of freedom and enemy of growth

– John F Kennedy, UN General Assembly,

September 25 1961

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