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Remoteness and Liveness: Thoughts on the Consultation in Current Primary Care Practice

Balint Society Essay Prize 2023 Winner

Will Brook[1]

[1] GP Partner, East London, UK: william.brook@nhs.net

Six years ago, I took a break from my GP work in the UK to arrange a work placement in Japan, where I would observe primary care clinics. I offered to give a presentation by way of giving something back and I decided to speak on the photographic archive of primary care (I have an interest in photography). The subject had a logic to it given that English is not widely spoken in Japan, and I hoped to use visual material by way of a peg to hang some ideas upon.

I tried to pose the question of why it might be useful for us to look at this archive. After all, one might take the view that family medicine/general practice is not inherently very photogenic. In the wider culture, the 'spectacle' of medicine more often gets located in operating theatres, resuscitation rooms; perhaps jars with grim specimens in pathology museums. Two or three people talking together in a nondescript room? Not so much.

Nevertheless: the pictures are there – how could we make use of them, I wondered. I drew on the ‘longue durée’ as a phrase: the view of history that concentrates on slowly evolving structures. I put to the audience of doctors that self-evidently we were part of a long lineage; that doctors from earlier eras may well have shared many of the satisfactions of practice as well as the challenges, the agonies.[1] There is a risk that new doctors coming into the profession may feel part of only a recent temporal landscape – the last few years of NHS turbulence dominate the frame. Lasch (1979) describes an idea of ‘the evaporation of history', a certain ebbing away of any identification with historical continuity in the culture. In Japan and elsewhere, giving this talk, I've invited people to survey a longer vista of time.

Fast forward to this year. I gave the same presentation to local GP trainees – doctors right at the end of the postgraduate training, five years post medical school.

[1] While my first audience was Japanese, for the sake of brevity one thing I have to forgo here is a transcultural narrative within these ideas.

At its latest 2023 iteration, a different theme seemed to dominate the discussion afterwards. If the pictures I showed hinted at a set of 'frames' for thinking about practice, then an important one related to ‘liveness’: the photograph as a residue of a live face-to-face encounter. How could we think about the live encounter? Leaving aside for a moment practicalities like physical examination, could medicine be (largely) practiced remotely? What was the added factor X in the face-to-face consultation? There was a view in the room that the post-pandemic reconfiguration in GP work, with less of an emphasis on seeing patients in person, was perhaps a useful residue.

It's hard to avoid the Covid pandemic at this juncture. There is no question that the reconfiguration of primary care work in March 2020 was huge. Around that time, it was commented that a process of reform that might otherwise have taken four years happened in about five days. The majority of GP surgeries adopted a triage-first model, with the emphasis on conducting as much of the business of medicine as possible without having to meet face-to-face. The reasons were obvious. Nobody reading this essay will have been untouched by the gigantic upheaval of the pandemic. One could argue that over three years later we remain in a pandemic, and that there is a public health case for sticking with this new modus operandi. Clearly, I'm not here to unpack these arguments from a public health point of view. But I make the observation that while most of public life has returned to something closer to ‘normality,' the pendulum swing that took place in medicine has not been reset. A default setting for telephone and video consultation as part of everyday life has become accepted and indeed embedded within normal medical practice. It is as though a tacit revolution has taken place.

Considering our work (pre-Covid) one might take the view that the basic building block of medical work was to sit in a room for an increment of time, talking to a patient, on occasion examining their body, and coming up with some kind of agreement or plan. This has changed.

And I want to say, has no one else noticed? Is anyone else shocked by these developments? Is this not a tectonic shift?

A search of the BMJ archive on this subject since Covid yields one single item: a letter written by London GPs with a brief though impassioned defence of face-to-face consulting as the gold standard. This in turn got precisely one positive response – not exactly a cacophony of voices. There will be countless arguments to bring to bear on this subject: the value, or otherwise, of this change from a systems point of view, from a position that acknowledges the scant resources in the NHS, the need to maximise efficiency. These bring in useful perspectives, and indeed many of those I share. I'm a partner in a busy inner-city practice and we have to make it run. Those arguments are for a discourse elsewhere.

It will be no surprise then that I'm for maintaining a practice based around face-to-face clinical work, a position I imagine is shared by most who are reading this piece. I may be wrong. I may also be pushing at an open door, and the purpose of writing this piece is not really to put forward a manifesto for it. But it does make me ask two questions. What is it about the live encounter that contributes so much? What is the factor X? The other question is, why might it be that our profession has settled so readily for this different way of seeing patients?

Both are complicated to answer. In the spirit of a Balint discussion, I make a start, as though a shot in the dark. Balint himself would likely have had much to say in this discussion, one which will wander in and out of the space of the group. And as with much in medicine, and the wider domain of caregiving, or therapeutic work, you scratch the surface with questions like these and their complexity is laid bare. One binary to start with, which one can think about in relation to medical practice, is that it incorporates elements that are *transactional*, and others that are *relational*. To frame it in a different way, the dilemma of the doctor is whether they are principally to *do something* and or to *be something*. This starts to lay bare the odd

hybrid nature of General Practice: it foregrounds medicine as a relational practice, and the biomedical recedes.

A first foray: what do the photographs give us on this? Perhaps in seeking out this archive, I wanted to get closer to the fine grain experiential side of being a doctor, being a patient. What does it actually feel like, to be ill, to be a patient? While we can see it, it doesn't take us right inside. In truth, the pictures themselves only take us so far. For a start, the photographic record is biased. Photographs privilege certain aspects of medical care at the expense of others: we do see encounters, we see affect, relationship; different qualities of attention, of listening. We see some of the transactional 'business' of medicine. What they don't say very much about is the *method* of medicine, about cure, or diagnosis. (One might say these don't necessarily figure prominently in the primary care space either.) We don't see 'good' or 'poor' practice. The photographic record skews things in other ways, too. The space of the consultation is a private one and taking a camera and photographer into the space, to come away with pictures that can enter the public domain, is fraught with ethical complexity. The view is only ever partial, fragments from a vastly bigger unrecorded body of practice.

Where else to turn in unpacking this binary between the transactional and the relational in medicine? Framing it in this way creates a point of contact between the practice of medicine and psychotherapy. And a nodal point in that terrain is, of course, one we have touched on – the tradition and practice of Balint groups. No doubt a similar live-versus-remote debate goes on with regard to group work. I confess I feel less strongly on this issue of live practice in relation to groups. Let's be pragmatic: like most engaged with Balint work, my own group went online during the pandemic; it worked well enough, and the sessions were a blessing and a solace during that difficult time. And one cannot ignore other practicalities: if remote/online groups are the only way that colleagues in far-flung places can meet,

then the case for that is unassailable. So in expressing that opinion there is a voice which is unavoidable – the pragmatist.

Back to the first question again, about the nature and value of 'liveness'.

There's one psychoanalytic body of work I want to try and use: the Kleinian mother-baby dynamic. It has been suggested that healthcare encounters can be thought about through the lens of Klein's (1970) mother-baby dyad. It's an idea that, once explained, has stuck with me. The link is how illness and distress engender primitive behaviours around fear and a kind of regressing in age: regressing on the part of the patient, and at times the health professional as well. So, by this logic, the person who is ill, vulnerable, may present as though a baby. Their illness evokes and revisits early primitive behaviours: fear, terror, splitting, idealisation. The doctor as devil, the doctor as angel. This baby's world is binary: food/no food, happiness/catastrophe, breast/no breast. So: very split, with good objects, damaged objects. The skilled mother has a sense of how intuitively to facilitate the shift from this primitive position (the 'paranoid-schizoid') to one that is more digested and resolved (the depressive position). If there's a theory of mind here, then it is the sense that the baby feels 'held in mind': a reparative quality conveyed by the skilled mother to the baby. But there has to be something lived and experienced in the live moment for this to take place – disturbance and a back-and-forth in both parties, things communicated both subtle and at the same time powerful.

There's a risk of eliding these two settings too easily (mother/infant, doctor/patient) and oversimplifying. But if there's a kernel of truth here, it's this comparison: what does the baby want, what does the patient want? What has happened when the doctor feels that a correct and helpful moment of communication has taken place in the consultation? It may be that the patient wants to feel they are held in someone else's mind, that their words and communications don't just disappear into the ether, they land on fertile ground, they're held onto, and thought about, digested. If the doctor can do that holding, and then convey it

to the patient, it is very therapeutic, powerful. This Kleinian baby felt very familiar to me in the consulting room. We can take it into the group as well. I wonder if something of the same shift (paranoid-schizoid to depressive) comes up in our sessions. Where is the 'held-in-mind' located there? In a group, the leader has a different role to the rest and may embody this most strongly. But that quality also gets passed around the participants and perhaps at times sits collectively in the group as a whole (I take this idea back into the GP practice, the doctor group, the wider staff group, even the building itself as a version of 'brick mother').

The mother and baby duo is the reminder (one of many) that the space of the consultation has two active subjectivities at play, two actors affecting each other reciprocally. Let's not idealise this process: the two-way conduit that happens in consulting allows doctor and patient to not only take benefit, but also to enact and interrogate suffering. This live space is one of strong colours, both light and dark. Psychiatrist David Bell (2001) brings into focus this dynamic in the clinician's inner world:

> We all enter the field of mental health for complex reasons, but probably coming to us all is a wish to repair our own Damaged inner objects. In order to be able to work effectively, we need to be able to tolerate the patients' attacks on these reparative wishes, our most vulnerable point. We need to be able to stand failure so that the patient can improve for himself, rather than experience the need for progress as a demand from those caring for him. […] more than anything else staff morale is the vital therapeutic ingredient; morale that needs to be robust and not dependent on any individual patient getting better. (Bell, 2001)

These commentators evoke a space in the consultation that is charged, and dynamic, full of reciprocal processes and intersubjectivity. At its most vivid, this happens in physical proximity, lived and experienced from moment to moment.

I turn for a moment to the other question: why might it be that our profession has settled so readily for this different way of seeing patients? I put this question to psychologically minded colleagues and the answer invariably comes back: surely it's a defence. Psychiatrist Tom Main (1989) is useful to recruit here. In an address to the Balint Society, he uses Balint's 'pedagogic breakthrough' (group work) to point up with compassion the ways in which doctors limit what they take on: 'Like all of us the conscientious doctor shies away from lifting more than he can carry, and if he is in danger of feeling more than he can cope with he takes avoiding measures'. For Main, recruiting defences so as to work with patients is inevitable; the key is to do this with some understanding, to avoid those defences that are 'thoughtless, rigid and automatic'. This concentration on defences is easy to relate to in clinical work. Main's paper describes phenomena close to my day-to-day life at work. Indeed, as one starts to think around this, defences appear pervasive. Starting work again after a break, there is a case in point. Casting my eye down the list, certain names resonate and start to fill my consciousness. A certain 'pre-defence' starts to take its place. (A defence against what? Collectively the sense is of The World about to re-enter the room, with its perennial problems). To start the surgery is to take a deep breath, with a hardening resolve, and re-enter the fray. In truth, many of the defences involved are very concrete, embedded: in the scheduling of our time, the architecture, the means available for our patients to communicate with us. Usually, they are experienced by patients as barriers to getting in touch. Reception colleagues act to restrict access to us, to maintain barriers, to ensure the rationing of our time. We can only survive on this basis.

The literature on social defences is extensive. Menzies' (1960) celebrated study looked at how defences became embedded in professional practices so as to

cope with the anxiety that comes with care of patients. Defence mechanisms among the nurse group that she studied fell into certain categories: behaviours to prevent intimacy between patients and staff, others to diminish the individuality of both. Overall, these entailed a stepping away from responsibility; stepping away as well from the anxiety involved in care work. Main's point is key here: it behoves us to use defences in ways that are self-aware and insightful. Thus – if there is something avoidant in the way that GP care is offered principally as a remote contact, then at least have some self-knowledge of that. But he holds firm to a view of clinicians that is compassionate in spite of these manoeuvres; of clinicians doing their best in less-than-ideal conditions.

A change of tack: what is the value and the nature of the live encounter for me? I return to the scene of seeing younger training colleagues at the lecture, conveying to me that they had no problem with this current 'even-handed' approach to the consultation. No-one wants to appear a luddite, or a stick-in-the-mud. As a trainer, I accept we are duty bound to coach our trainees substantially for the world we inhabit now, for the years ahead. For these doctors in their late 20s, and it must be said for patients too, new tech is ubiquitous and inevitable, and modes of care consistent with modern service industries are not going away anytime soon. Nevertheless – the longue durée. What will endure? Or perhaps: what must we teach such that it will endure? So the last data I turn to around 'liveness' is my own. The group would say: well then, bring a case. In fact, I sidestep that; my thoughts turn to fragments, sense impressions that try and get close to what's happening on my side of the desk.

I'm in clinic. Time and again, when starting work in an irritable, skittish, distracted state of mind, it dissipates and I become focused simply by starting to see patients. The work becomes integrating, calming. The role I take on has its effect on the particular cognitive state needed. Along with, of course, the patients themselves. In ways that are hard to understand, these encounters repair me, and

I'm fit for purpose again. There's a more specific and heightened version of this. If the talk is of defended states, this is something more like a sudden letting go of a defended self. It is something somatically experienced, a powerful example of patients having an overt effect on me, as well as some notion of the reciprocity involved. This is during clinic, when a serious matter, part of the history that has a self-evident gravity, as though able to break free from the subjectivity of the patient, comes into the consultation. It may be a symptom, or a physical sign, or indeed something about a mental state that is immediately striking and of concern. This is a moment when everything turns on its head, and what may have been a scattered state in me – boredom, or irritation, or being at a loss – suddenly becomes integrated and focused, and the room becomes a place of exchange, alertness, and great meaning. It is as though epistemologically the air clears, the tension goes out of the situation, and with it there comes a clarity of bodily experience, that is prior to, or separate from, anything mentalised.[2] The power of this instantaneous process is striking and consoling. It is indelibly a thing of the live encounter alone. It is a hard thing to describe, or indeed to understand, and it were as though I am content to stay in a state of 'non-knowledge' about it. (Or perhaps not entirely. David Bell's [2001] description of the clinicians 'reparative wishes' may shine some light here – a sense that that reparative quest is indeed two-way. The urge to be reparative to the other, consistent with one's vocation, is echoed in some way in this process of self-repair I'm trying to describe.)

These phenomena link with another subjective element that, for me, is essential to stay in touch with in clinical work: the sense of privilege in doing it. This sudden 'embodied clarity' that I describe above leaves a residue of feeling

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[2] I have wondered about a link with Enid Balint's idea of the 'Flash' moment in a patient encounter, though the mapping is not exact, when reading of how she meant that term. Likewise, a useful phrase used in discussion by a tutor, Zoe Playdon: the *compassionate realisation of possibility beyond oneself.*

grateful, of feeling privileged to be in a position to do it. *The Fortunate Man*, indeed (Berger, 1967).

This might seem idealising and sentimental. GP work can be hard, draining, thankless. But the word feels to me accurate, sound. Not a fantasy or some kind of virtue signalling. A GP friend abroad says how burnt out he feels, and one point I want to convey, one of many, is the critical necessity to keep alive this sense of privilege in the doing of it. Again, in ways I do not fully understand, this also feels important in Balint work. A good, alert, discursive session in the group gives back that quite primitive feeling that we are fortunate to do this work – to be given this work. It is echoed and magnified: feelings of fraternity, recognition, comradeship are additional powerful elements in the group setting. Even if there is less necessity for the group discussion to be face-to-face, nevertheless, such a successful exchange seems closely bound in with managing to find, articulate, and use the power, the vivid colours of the live doctor-patient encounter. When this quality is made clear again, in our sessions, as though a window rubbed clean, I am reminded that it is a state in which there is no place for narcissistic pleasure, for the ego-trip.

Where can we get to with all this, for now? In the spirit of a group session, my two questions have been thought about – and passed round, a few flags placed in the sand, even if they elude 'open and shut' answers. The discussion probably needed some material on touch and examination – things corporeal, complex subjects deserving of their own discursive space. And I can still hear the pragmatic, rationalising voice within me, trying to accommodate all the caveats around this. Thus:

Remote consulting is here to stay.

Let's not be precious: much of the work is simple. Much of the work IS transactional.

These modes of working clearly suit some doctors, and very often they suit patients.

And so on.

In trying to tie off the two questions posed, I return a last time to the trainees in the seminar room. The issue of how to use the historical archive was answered with one further observation: that our profession is one in crisis. A crisis of morale, of motivation; chronic problems with recruitment and retention. An emerging workforce less willing to embody vocation as a professional raison d'être. At the end of the session, feeling something of a lone voice, I looked out at the group and thought there was more at stake than the quality of their clinical work going forward: that it was the very future of these young colleagues, their wellbeing, their ability to sustain their work, that was on the line. I put to them bluntly: consider the longue durée. Leave aside appraisal, revalidation, the timescale of MRCGP; the 'launch phase' of your career. How will you stay engaged and interested, and emotionally available, in this work for 20, 25, 30 years?

This was probably the motive to write this essay. It's not an academic piece; neither, as I've said, is it a manifesto. I have no qualms about saying these things publicly, but it won't be printed on a poster to take to the barricades. The pragmatist again: the work goes on, we keep going. We do the best we can, in as thoughtful a way as possible. For my trainees, I think of modelling in different ways a style of practice that has sustained me for this time, that has deepened my own engagement. But the piece is also a cri de coeur. As I stood facing my young audience at the seminar in January, I accepted that these colleagues would come through and effectively take the profession forward, but there was an elegiac feeling as well. I fear for what may be lost amid the current melee of our time, and the underlying powerful forces of change.

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