

Balint Groups: a doctor-student mutual investment company

DISCUSSION

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ABSTRACT

Balint Groups were traditionally established as reflective groups by psychoanalyst Michael and Enid Balint for general practitioners to reflect on the doctor-patient relationship. Balint described components of this relationship between doctor and patient including the collusion of anonymity, the doctor as a drug and the mutual investment company.

This paper discusses two case examples from the perspective of a junior doctor facilitating medical student Balint groups and from the junior doctor participating in a peer group. Comparisons between the doctor and student emotional expression, empathic ability and apparent preconceived ideas of the “doctor role” are discussed, with reflection on potential origins and contributing factors to such internalised views and responses.

The author explores potential professional benefits of medical student Balint groups facilitated by junior doctors in influencing empathic response and internalised personas, as discussed through the eyes of Balint’s components of the interpersonal doctor-patient relationship.

INTRODUCTION

The eponymously named Balint Group provides a model for reflective practice, traditionally comprising 8–12 general practitioners (GPs) and one psychoanalyst facilitator. (1,2) Balint advocated for the exploration of the doctor–patient relationship within these groups, with awareness of the effect the patient has on the doctor and the doctor’s ability to establish deeper meaning within the patient presentation. Since their origin in the 1950s, groups have adapted and are now commonplace in UK psychiatry and GP training programmes with facilitators of various professional backgrounds.

While training as a psychiatrist, I facilitated medical student groups and participated in regular peer groups. This led me to reflect on preconceived ideas of the doctor and patient roles as well as comparison of doctor versus student empathy and emotional expression. I continue by discussing whether Balint groups might help maintain physician empathy and reduce a sense of isolation many describe within their professional work. Further, I propose a potential mutual benefit for both parties when junior doctors facilitate student groups, through the doctor–student relationship.

BALINT GROUP CASES

During the student groups, a student presented a case involving a 55-year-old gentleman with terminal bowel cancer. The student first encountered the patient in discussion with her consultant colleague, whom she described as rigid, abrupt, and controlled in manner. After meeting the patient, she described feeling deeply sad for him yet disappointed with herself as she felt so emotionally overwhelmed. She also felt surprise that the patient appeared so “normal”. In the group, students shared their pain at meeting patients with similar issues to those of themselves or family members. Profoundly, they described conflicted inner feelings: shock at the consultant’s apparent nonchalance when discussing the case, and disappointment with their comparative personal “emotional weakness”. There was a feeling of unity as students shared their internal struggles in gathering their identities in this new world of clinical medicine.

I was interested when comparing this case with a peer Balint group. A fellow trainee presented a case of a professional lady in her early twenties who had been studying law at university, had a supportive family and during an acute manic episode had destroyed personal relationships, dropped out of university and presented as angry, rude and derogatory to others. Following much silence, the group spoke of practical management plans for the patient. Increasingly, the patient angered the group with her apparent incompetence. Alongside themes of frustration arose a sense of unspoken fear. The presenter felt her own mortality within this patient, commenting the patient was “like us”. However, we skirted around the topic

of our own vulnerability completely. The vulnerability was in the patient, and she angered us with her inability to solve it.

Facilitating the students, I was struck and saddened most by the intense shame the students felt from being so emotionally moved by patients. One participant asked if it was weakness to show sadness in front of patients. It was as if the students were learning how to be stoical medics, torn between their natural human responses and desire to mimic their seniors. I also felt ashamed that, with the students’ case, I would have behaved more like the consultant than the students.

DISCUSSION

In both cases, the presenter was surprised at identifying with the patient, and discussion of the patient and doctor archetypes arose. One notable difference I observed between the doctor and student groups, was the raw sadness shared between the students and the anger and practical solutions thrown out by the junior doctors.

There were recurring themes amongst the students of death and sadness when identifying with the “normal”, every-day person. Students struggled to disentangle the stark contrast between the doctor’s structured patient–interactions, and their own emotional responses. Professional development, identity and role confusion are common themes in medical student groups. (3) Feelings relating to treating patients who may never get back to full health and witnessing injustice are also common. (4)

In my doctor groups, presenters often brought a sense of frustration and anger, usually born of helplessness. Published literature involving doctors in Balint groups highlight common themes, including trainee emotional experience, trust and responsibility, (5) and difficult feelings of inadequacy and insufficiency. (6)

In both cases I described, the doctor’s role was objective, immune, and apparently lacked emotional expression and empathy. This persona conflicted with the students’ natural emotional responses to the patients but was nonetheless held as an ideal: to exhibit raw emotion was a weakness, while remaining un-phased by adversity was stoical. This was mirrored in the groups’ emotional expression where students shared sadness and pain while the doctors showed anger at perceived incompetence, once the lack of emotion was worked through.

Balint, on describing the Apostolic Mission, stated “in the first place that every doctor has a vague, but almost unshakably firm, idea of how a patient ought to behave when ill”. (7) So too, might there be a presumption of the doctor’s behavior.

When do we create such views of the doctor/patient personas and why did the students aspire to such structured, non-empathic responses?

The doctor's professional role, throughout time, has carried with it certain stereotypic personas: trusted, (8) a guide, (9) high ranking in society, (10) professionally unaffected by stress, (9) confident, (11) rescuing, (10,12) and heroic. (12,13)

From ancient Egyptian times, the doctor was "the healer", with paternalistic practice dominating throughout centuries until Szasz and Hollender advocated for mutual doctor-patient participation in the 1950s. (10) Perhaps, we harbour, at a core societal level, a deeply internalised perception of what the doctor role entails and strive to achieve this whilst avoiding shame at failing, much like the students in my group.

Patients might also view doctors with preconceived ideas, resulting in the doctor persona being impressed upon us from the expectations of the other. In the doctor case mentioned above, one participant shared a line thrown at them once by a patient, "You're not ill! You don't know!" The doctor had been filled with anger and confusion: to this patient, he, a doctor, could not have any illness. In that moment of patient assumption, he described feeling robotic and inhuman, not mortal: his emotions and identity were taken from him. And so, the "immortal doctor" persona was established in that moment of engagement with someone holding the patient role.

This persona of immunity might co-occur with decreased empathy expression. A decline in student empathy has been observed as the training years progress, regardless of gender or specialty. (14) This decline was most significant in the 3rd year of training, which is when most students commence their clinical training. A decline in empathy has been linked to physician burnout and psychological defense mechanisms. (15) Training is a time where many doctors focus on learning to avoid feelings of failure and shame. (16) Trainees can learn to rationalise fears and soldier on. (11) Horrifically, this external persona, does not match what is being felt inside. (16)

Our own beliefs that we must cope have a part to play. So too, does the system. Doctors' clinical years have been described as "a breeding ground for feelings of insecurity and self-doubt". (11) Increasing technological systems, as well as specific incidents like the unexpected death of a patient, systemic issues such as staffing shortages, and course structure, including volume of knowledge required and workplace rotations have been linked with reduced clinician empathy. (15,17) The impact of the institutional or organisational faculty on trainees is important to recognise. (18) If a busy faculty fails to address its own motivation, ambivalence and feelings of being overwhelmed by workload, this is likely to be, at least partly, projected onto the trainees who, in turn, identify with it and act it out. (18) The result is that trainee behaviour towards patients mirrors the physical and emotional unavailability of the faculty. Therefore, if the faculty can resolve their own systemic issues, such as feeling overwhelmed and busy, they are less likely to delegate unhelpful parts of themselves to trainees. (18)

A combination of system pressures, internalised societal views of what it is to be a doctor, personal defence mechanisms and unresponsive faculty responses might coalesce to create this breeding ground for burnout, rather than compassionate medics.

"Empathy can be lost, but it can also be gained" (15)

Balint proposed several components of the Doctor-Patient relationship: the Drug Doctor, the Collusion of Anonymity and the Mutual Investment Company. (7) The doctor-patient relationship is fundamentally different from the student-doctor relationship. However, the wordings of Balint's doctor-patient relationship components led me to consider this analogy within Balint groups and in particular, within doctor-student relationships.

INTRAPERSON DRUG DOCTOR

"The Drug Doctor", describes the idea that the patient-doctor relationship itself acts as the most valuable aspect of consultations and treatment. Balint groups are recognised as tools for reduction of both stress and burnout in clinicians. (19-21) Of course Balint groups are not personal therapy and it is right to maintain focus of the relationship between the patient and the doctor (the interpersonal). However, these cases highlight that once the students and doctors acknowledged their human (patient-like) vulnerabilities, empathy with the patients and a deeper understanding of the interpersonal relationship ensued. Here, I observed the doctors and students, within the professional boundaries of the Balint group, acknowledging the doctor-patient relationship within themselves (the intrapersonal). Balint groups might, through exploration of the intrapersonal doctor-patient relationship, have a therapeutic benefit to participants. Participating in Balint groups can actively contribute to development of one's professional identity. (22) Trainees report groups left them feeling "more at home with own emotional responses, (22) improving their confidence to exhibit spontaneous emotion and vulnerability in clinical encounters, which can benefit patients, (23) while maintaining optimal self-care. Groups can relieve confusion and frustration, (24) by helping trainees separate themselves from the dynamics occurring within consultations. (25) The result can be modification of attitudes and behaviours with improved student awareness of the impact their personality has on the doctor-patient relationship. (3,24) In the cases I facilitated, I observed students acknowledging their own intrapersonal doctor-patient relationships, following which they could better access a therapeutic stance for their patients. Balance in acknowledging our own vulnerability and patients' needs is required and this is where facilitation of groups is key. (23) Students have found that an empathic role model helps reduce, if present, their detached personas. (17) This is where I feel junior doctors, in their transitional position between student and consultant, might play a part. I wonder if junior doctors who model an empathic stance whilst facilitating student

groups might hold a pivotal role within the doctor-student relationship. If we extend Balint's Drug Doctor to the doctor-student relationship, one might even view junior doctor facilitators as the drug themselves within the interpersonal doctor-student relationship: as long as the doctor models empathy, encourages sharing of emotions and supports students in exploring the doctor-patient relationship.

DOCTOR-STUDENT COLLUSION OF ANONYMITY

Collusion of anonymity exists when "the patient is passed from one specialist to another with nobody taking responsibility for the whole person". (26) It can carry benefits: less burden of responsibility and allows different specialties to learn from each other. However, it can leave patients confused in their care and medical leadership.

As students and doctors, recruitment is a national process: we are ranked, then sieved through interviews in a centralised location. Like our patients travelling from one speciality to another, we travel on the conveyor belt of training, moving from rotation to rotation as "another nameless junior doctor". Similar to Balint's patients, within the Collusion of Anonymity, feeling confused with their care and leadership, medical students struggle with the level of uncertainty they carry as they transition into clinical work. (27) Such uncertainty may be related to factors such as patient management or workload expectations and has been linked with anxiety and stress. (27) This, in turn, could lead to burnout and reduced mental health if not addressed. Balint groups, by their very process of not aiming to find solutions, might aid students in practising the process of holding uncertainty as doctors. Furthermore, recognising one is not alone in uncertainty can be healing in itself. Trainees found groups left them with feelings of increased solidarity and they felt more confident and satisfied in their work. (22,28) Student Balint groups facilitated by junior doctors might help reduce this isolating anonymity by providing continuity for students through one facilitating clinician, and by providing a space where clinicians may share experiences, not only amongst themselves, but also between generations of training colleagues.

DOCTOR-STUDENT MUTUAL INVESTMENT COMPANY

Balint described the doctor-patient relationship as a mutual investment. The doctor is involved in "educating" patients. (7) The investment is long-term and both parties provide, borrow, and lend skills and knowledge. The strength of the investment allows trust and confidence to build and risks to be taken. (29) Just as both parties provide, so too do they benefit: doctors might gain employment and patient improvement whilst the patient might gain care.

The idea of a mutual investment, where two parties build a trusting relationship and can learn from one another, with mutual gain, feels apposite to such doctor-student groups. Facilitating student groups,

not only was I able to impart support and aid discussions, but I learnt from the students. I was reminded of a more empathic stance I had not achieved through co-participation with peers.

As a participant in trainee Balint groups, I have frequently completed the task set before me, attending groups out of duty. As facilitator for students, I felt humbled and privileged to be part of their group discussions: a space where I felt more freely again. I could observe professional-patient relationships with a fresh eye, reminding me of what it was like during those first encounters with patients (and how much I had somehow changed even in my relatively short years of being a doctor). I feel it brought me back to a more human stance, which left me rejuvenated. I was able to carry this forward into my relationships with my own patients, hopefully aiding in improving their care.

Junior doctors hold a pivotal position in the development from student to consultant. Without facilitating student Balint groups, I wonder if I would have recognised my transition towards acting like the consultant in the student case described. A shift in culture may well be required to support students and trainees in cultivating professional identities whilst maintaining expression of innate emotional responses. I advocate for more medical student Balint groups, where junior doctors nurture that relationship, lead by example and professionals learn from each other, creating containing spaces for our own mutual investment to flourish.

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