Balint Work in England: Lessons for American Family Medicine

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The work of Michael and Enid Balint in developing case discussion seminars for general practitioners in England has important implications for the teaching of family medicine in the United States. Focusing on the physician-patient relationship, their seminars evolved from an emphasis on a psychiatric history taken by the physician to a more pragmatic concern with the process of the everyday brief consultation.

The leaders of traditional Balint groups guide group members toward open discussion of case material by modeling listening, curiosity, and tolerance for group members. Seminar goals include increasing general practitioners' sensitivity to their patients' emotional problems and expanding the practitioners' repertoire of interventions in the medical interview. With modifications, Balint-type seminars have been incorporated into some general practice and family medicine training settings both in England and in the United States. The unique features of Balint seminars within the context of medical education are their nondidactic, participatory nature, their goals of an emotional change within the physician, and their focus on the physician-patient relationship.

General practice medicine in England has been greatly influenced by psychoanalytic thought and practice, particularly by the work of Michael and Enid Balint. Beginning in 1950, they led groups of general practitioners at the Tavistock Clinic and later at other medical centers and hospitals in London. Focusing on the physician-patient relationship, these seminars stemmed from Michael Balint's dual interests in medicine and psychiatry, which began at the start of his career in Budapest,[1] and from Enid Balint's seminars with social workers at the Tavistock Clinic in the late 1940s.[2] The Balints trained other Tavistock psychoanalysts to lead Balint groups, and the training scheme expanded. To date, 594 general practitioners have participated in the Tavistock groups. Thus, psychoanalysis as a discipline with its emphasis on unconscious processes has had a powerful influence on British general practice medicine.

In contrast, family medicine in America has been influenced by behavioral scientists from a wider range of therapeutic disciplines often working in collaboration with physicians[3]: psychiatry,[4] medical sociology,[5] medical anthropology,[6] family therapy,[7] communications, psychology, social work, and group therapy. The contributions from psychoanalytically oriented clinicians in the United States, although significant,[8,9] have dominated the field far less than in England. A second generation of family physicians, better trained and more sophisticated in psychological issues, is emerging in both countries. They are offering original contributions to the field of behavioral science in family medicine[10–12] and are doing much of the teaching in this field.

Balint seminars are a feature of some family practice residencies in the United States[13] and of some vocational training schemes in England.[14–16] Continuing medical education is beginning to value the countertransference perspective of using as important data the physician's own thoughts and feelings about his or her patients.[17,18] This paper will focus on the current process, leadership, and content in British Balint work, with the goal of providing useful information for American family medicine educators.

EVOLUTION OF BALINT'S IDEAS

In 1957 Balint's seminal work, *The Doctor, His Patient, and the Illness*[19] emerged out of his first general practi-

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tioner seminars. The core ideas enunciated in this book remain a key part of the theoretical understanding for continued Balint work today. In the early groups, Balint encouraged general practitioners to conduct lengthy interviews with selected patients, with the purpose of obtaining a full psychiatric history. As one early participant commented, "The outcome of this was that a very small minority of family doctors were able to treat a very small minority of their own patients. Many of us automatically assumed that we had to imitate the psychoanalysts whom we knew as leaders."[20] Near the end of his life, however, Balint wrote, "In spite of all our efforts so far to create a technique suited particularly to the setting of medical practice, the 'long interview' has remained a sort of foreign body in the general practitioner's normal routine."[2]

A shift in Balint group discussions to the everyday, brief consultation resulted in the publication in 1973 of *Six Minutes for the Patient.*[21] The focus was on the immediate understanding that can occur between general practitioner and patient in even the briefest of interactions: "getting onto the patient's wavelength; tuning in to the patient—every single patient, not just the favored few."[20] Discussions in the groups shifted from a presentation of the patient's childhood history to the current, fluid state of the physician-patient relationship and an analysis of recent office visits: "We started talking more about processes and less about states."[22]

GOALS OF BALINT GROUPS

The goals of Balint seminar training have traditionally been set forth in psychoanalytic rather than educational terms, and thus have not been amenable to behaviorally stated objectives or to systematic evaluation. For example, a major goal set forth by Balint himself was "a limited, though considerable change in the doctor's personality," an outcome extremely difficult to observe and evaluate. He hoped that the physicians in his seminars would undergo this "loosening up" in personality, and thus become more sensitive to a wider range of emotional problems in their patients, to understand these problems more fully, and then to use this understanding for therapeutic effect.[23]

Recently, an attempt has been made by British Balint group leader Dr. Oliver Samuel[24] to set forth more specific Balint work objectives, setting aside "change in the doctor" to "change in the way the doctor takes care of his patients." Samuel suggests three broad aims for Balint training: "to encourage doctors to value their interpersonal skills and learn to understand their limits; to improve the doctors' perception and understanding of their patients' communication; and to allow doctors to become aware of their 'blind-spots' in their interaction with their patients." This shift to alterations in physicians' behavior with their patients makes it possible to evaluate results of Balint work more systematically through direct practice observation in the training setting and through leader observation of behavior change in the group itself.

Specific objectives of Balint group training, then, would be more in the area of attitude and skills than of knowledge as such, and should include the following in-practice and in-group developments: In a group, physicians will be able to (1) present cases to the group with a focus on feelings and interpersonal interactions rather than on medical details, (2) use their own awareness of and insight into feelings to shed light on difficult physician-patient interactions, (3) respond to presentation of other group members with increasingly empathic and helpful questions and comments, (4) exhibit a decreasing deference to group leaders as the "experts" with the "answers," and (5) attend group regularly and participate enthusiastically. In practice, physicians will be able to (1) handle more comfortably patients who had previously been intolerable or frustrating to care for, (2) develop a variety of personal styles with patients rather than maintaining the same structured medical interview for all, (3) step back more easily from patient-exerted pressures and examine their meanings, (4) critically analyze the process of a consultation afterward with an emphasis on their own response to the patient's behavior, and (5) exhibit a nonjudgmental curiosity about patient behaviors that they previously may have labeled irrational.

THE PROCESS OF BALINT GROUPS

The Tavistock seminars consist of eight to 12 general practitioners who meet once a week with a psychoanalyst group leader for two hours; they stay together for a minimum of two years. One general practitioner presents either a new or follow-up case, which is then discussed by the group. The group begins with the unvaried question, "Who's got a case?" asked by the leader. In early seminars Balint occasionally admitted physicians who were not doing ongoing clinical work, but then concluded, "The pressure of actual and constant therapeutic responsibility is an essential factor for our sort of training."[23] Balint himself insisted on the focus on the physician-patient interaction, although many Balint groups have recently broadened the focus to include encounters with other health care professionals and even interaction problems among partners in practice. The discussion itself is free-floating and open; one participant has commented, "The most important ingredient is a relaxed and playful . . . atmosphere, one that is marked by openness and absence of preconceived ideas, allowing enough room for unexpected insights to surface."[25]

Within this atmosphere certain dynamics occur that may be commented on by the leader. One frequent occurrence is described by an experienced leader: "Sometimes it is possible to notice how the doctor is identified with his patient and starts to impersonate him in the seminar, and gets the other members to respond to him as if he were the patient. . . . For example, a doctor says 'no' to all the suggestions and remarks made to him by his colleagues in the seminar,"[26] thus unconsciously helping

seminar members to feel his own dilemma with the patient. Other dynamics noticed by leaders have been derived from the insights of psychoanalyst Wilfred Bion[27] in his work with small groups: (1) the tendency for the presenting physician to pair with the group leader and secure his attention for himself, (2) the tendency for group members to depend on the leader for the magic answer to the dilemma presented in the case, and (3) the tendency of group members to flee at times from difficult aspects of a case by shifting attention to other matters.

THE ROLE OF THE LEADER

How much these, and other, unconscious forces are commented on by the leader varies widely, but the general rule is for the leader to make comments related to the overall group process only when the group's work is being impeded by it. One Balint group participant notes that the Balints themselves avoided group interpretations, "apart from such general observations as 'Dr. Y.'s case seems to have made us all rather depressed.' "[28] Some feel, however, that this approach unnecessarily limits the work that is possible within a Balint group.[29]

Balint also set firm limits on the revelation of personal material by individual group members, a difficult and controversial task. One of his group members notes: "Because it has been generally agreed that a Balint group should not become a therapeutic group, but should remain a training geared to professional development, the concept that there is a professional ego suitable for training and a personal ego to be left alone has emerged, but we all know that there is really only one ego."[30] Both the strength and the difficulty of Balint work is that it occupies the middle ground between therapy and training, and "in practice the distinction between these categories can wear very thin."[28] One British general practitioner describes a Balint-type seminar that meets weekly with three rotating themes: patient care, personal life issues, and relationships with professional colleagues.[31]

The role of the leader in Balint groups has become increasingly important as general practitioners and non-psychoanalyst behavioral scientists take over leadership roles in training settings. Fortunately, many of the skills that make a good Balint group leader are closely analogous to the skills of the consultation in general practice.[14] The following summary of leadership roles incorporates ideas from several different sources. Each leadership task is accompanied by examples from Balint seminars.

The leader as listener: "An essential point of the leader's technique is to listen attentively and to restrict his questions during the first reporting phase of the discussion to a minimum."[26] The leader models an attentive silence and noninterruption after his initial question, "Who's got a case?" Often the first people to speak after the initial presentation is a seminar member, not the leader, who instead listens.

The leader as model for "being there" rather than "doing something": The principle of "masterly inactivity"[15] entails avoidance of the "expert" role by the leader, who also should resist the temptation to "treat" the presented patient. A Balint group leader may say, "Just by listening to this patient and tolerating him, you are doing something terribly important." The leader, by being there, helps the group to avoid the temptation to come to premature closure with a "plan of action" for each patient presented.

The leader as model of common sense: Psychoanalyst Robert Gosling[26] wrote of the Balint group leader: "His most valuable contributions have more to do with common sense and ordinary awareness of the human lot than with any special medical knowledge. So . . . disease-centered is the picture painted by contemporary medicine that the leader may often be forced to voice humanity's heartfelt cry on behalf of the individual patient and his suffering." As medical education becomes broader, all group members participate in this function more often.

The leader as encourager of speculation: In the playful atmosphere of the group, the leader encourages open curiosity, speculation, and even predictions, with such questions as: "What is going on here?" "What is the patient doing to Dr. X?" "There are any number of possibilities." "Let's look at this case from a slightly different angle." "You've told us a lot about the patient; what about the doctor?" "It will be very interesting to see what happens."

The leader as model for tolerating uncertainty: The current president of the Balint Society recently stated, "It is my personal belief that there may be two sorts of general practitioner: those who from time to time experience self-doubt; and those who don't, but ought to."[32] The Balint group leader indicates, "We don't know what is going to happen." Enid Balint[22] is currently studying "surprises" in general practice, and recently wrote, "The ability to be surprised seems to be an absolute necessity for any worker in any scientific field." One Balint leader has stated that a major function of the leader is "to lessen the doctor's anxieties and need to be always in control of the situation and the need to be always therapeutically potent, and so liberate his compassion towards the patient."[28]

The leader as limit-setter: The Balint group leader must take responsibility for the process of the group. He must preserve confidentiality, help the group start on time, focus on the task, and avoid distractions; consult the group about visitors and new members; prevent self-disclosure that he senses a member may later regret; monitor the criticism by the group of the presenting physician; and even summarize important points about a case. He must also comment on a group process that is interfering with the group's work. In trainee groups, some direct teaching may be appropriate.

As the members of a seminar mature and gain mutual trust, the leader should let the group members do the work and learn from each other. It is therefore important for leaders not to allow the group to see them as the only ones to give insightful, sensitive contributions, the only

ones to listen attentively, and so on. The leaders need to avoid being seduced into a "special" position in which the group becomes dependent on them for the very qualities they wish to develop in themselves. Gosling[26] summarizes the leader's task:

> The leader introduces into the experience of a seminar the picture of a person, himself. . . . He brings into the . . . seminar someone who has a certain attitude of enquiry and forbearance towards his fellows. What he does in the seminar will carry more weight than the cleverness of what he says. . . . By his recognition of the need for time for trial and error, for re-evaluation and for new hopes to grow out of disillusionment, he sets the stage for the doctor's own development, and he provides a model that can be used by the doctor in his attendance upon a patient similarly caught up in a process of growth and change.

Clearly the leadership of Balint groups is a task requiring much skill and personal maturity. One helpful forum for developing such skill is the leaders' workshop. At these meetings, verbatim transcripts of Balint seminars, both with experienced general practitioners and with trainees, are examined in depth and critiqued by experienced leaders, with a special focus on the leader's role and techniques.

BALINT GROUP DISCUSSIONS

The case issues raised in Balint work tend to be those in which the physician experiences some sort of inner conflict or uncomfortable feeling about the patient. The author participated recently in a Balint group of experienced general practitioners at the Tavistock Clinic and in a Balint group of general practitioner trainees at two vocational training schemes in London, hearing 58 case presentations. The emotional dilemmas that were presented most often included the physician feeling baffled or confused by the patient; controlled or forced by the patient or family into doing something he or she feels is inappropriate; responsible and guilty, angry, or frustrated; painfully identified with the patient; depressed and burdened by an inability to help; and caught among conflicting needs and wishes of family members. Other recurrent dilemmas were the physician feeling in conflict about his or her relationships with colleagues; feeling conflict about ethical issues; fearful of being blamed, hurt, or humiliated by patients; and feeling inspired or touched by certain patients. The situations that most evoked these powerful feelings included death and dying, family problems, psychosomatic issues, noncompliance, chemical abuse, domestic violence, chronic illness, culturally distinct families, fear of AIDS, psychosis, pregnancy and childbirth, and the need to deliver bad news. This range of concerns fits closely with the author's experience in similar discussion groups of American family physicians.

EVALUATION

Attempts to evaluate Balint work as an educational method have been plagued by a vagueness in goals and objectives. The Balints and their Tavistock colleagues did develop a detailed rating system and reported on its results in the book, *A Study of Doctors*.[23] They first examined the dropout rate in the seminars, which decreased significantly after the introduction of a pregroup mutual-selection interview in 1956: 43 percent of the 1950 to 1956 participants stayed in seminars for more than one year; 73 percent of the 1956 to 1964 participants remained for over one year. (In this interview a Balint group leader and a physician discuss expectations for the seminar and mutually decide on the physician's suitability for this type of training.)

Seminar leaders then answered three questions about all members of their seminars (including early leavers): (1) Did the physician's behavior change during the seminar? (2) What were the mechanisms of minimal or no-change reactions? (3) Has the physician gained anything from his experience in the seminar? Evidence of changes in the physician's manner of presenting cases, participation in the discussion, and reported handling of cases were all included in the categories thus obtained. In all, 223 participants were evaluated, 72 before 1956 and 171 after 1956. Twenty-eight percent of those who stayed more than one year in the first category were judged to have made some changes in seminar behavior and to have gained from the experience; 61 percent of those who stayed over one year in the second category were judged to have made changes and to have gained from the experience. Many participants were rated by more than one leader; high interrater reliability was noted. Recent Balint groups have not been evaluated according to the more specific behavioral objectives beginning to be developed for them. This task is necessary for establishing the efficacy of Balint work as a teaching method.

BALINT GROUPS IN THE TRAINING SITUATION

With slight modifications in the original goals, leaders, and structure, Balint principles have proved to be widely applicable in a variety of settings. The Balint Society was founded in London in 1969 by a group of Balint-trained general practitioners to carry on the Balints' work. Shortly thereafter, work was begun by the Royal College of General Practitioners on vocational training, which became mandatory for general practitioners in 1982.[33] Some Balint seminars that are led by Balint-trained general practitioners take place as part of weekly day-release courses for trainees.[14] During annual weekends at Oxford that are sponsored by the Balint Society, general practitioners participate in "fishbowl" Balint groups to get a taste of the process and to discuss leadership issues. In addition,

the Institute for Psychosexual Medicine in London has at any given time 200 physician trainees in Balint-type seminars.[34]

The setting provides the constraints in Balint groups for trainees. Balint group leader and general practitioner Marie Campkin[35] notes of the British training scene:

> There are several obvious ways in which a trainee group cannot meet the criteria for traditional Balint training: the timescale is short, usually only a year; the group is seldom optimum size and often members are joining and leaving . . . throughout the year; as trainees they do not carry full responsibility for their patients; and perhaps most crucially, the group members are not selected, nor indeed are they even volunteers, but conscripts, some of whom could be ill suited, and some disinclined, for the work involved.

American trainees do, of course, carry full responsibility for outpatients over a three-year period and could theoretically participate in a Balint seminar over that entire period. In both American and British training settings, interruptions in the group meetings are common, as hospital-based trainees are called to emergencies.

The issue of motivation is a crucial one. Given the mutual-selection interview, general practitioners attending the Tavistock seminars are usually extremely committed. In training programs where Balint seminars are mandatory, however, there is a wide range of interest among trainees. It is well known that some trainees "vote with their feet," as any medical training program offers competing priorities. Yet part of the leadership challenge is in interesting the young physician in the physician-patient relationship. Even trainees who attend, but who do not actively participate in Balint groups, can be seen to internalize a bit of the philosophy or curiosity.

There are even certain advantages to the trainee situation. Campkin notes that groups of trainees are often already cohesive and functioning groups as a result of their other joint activities. Trainees who are not yet set in their pattern of interaction with patients can often benefit quickly from the recognition and fostering of their own individual styles and resources. During an anxiety-ridden time in their fledgling careers, trainees may be more than willing to talk about their feelings; indeed, the need to talk about more personal issues may be predominant. Some training programs offer separate, optional personal growth or support groups.

The leader's role in a trainee group, while essentially similar to that in groups of experienced physicians, needs some modifications. Departure from the psychoanalyst's neutral position of not giving "pats on the back"[26] is clearly indicated, for trainees need encouragement and positive reinforcement. Because trainees are often more vulnerable than experienced physicians, the leader's "deflection of destructive criticism"[14] is an even more crucial function. The group leader of trainees may need to take more of a teaching role, encouraging experimentation and, at times, stating opinions, summarizing, directing the discussion, or even making the occasional recommendation, despite Balint's view that "it is better to allow the doctor to make his mistakes . . . than to try to prevent him from making them."[19] Leaders need to be sophisticated in dealing with resistance from unwilling seminar participants. An attitude of flexibility must be present to focus on brief hospital interactions and relationships with consultants or nurses as well as the more traditional clinical cases. The leader must help to foster a group feeling and identity even when the membership of the group changes frequently.

Balint Society member Paul Sackin[14] found in visiting a wide variety of case discussions in vocational training programs that "the successful discussions depended on skilled leadership." Skilled leaders may be family physicians or general practitioners, Balint-trained and non–Balint-trained, or clinician-teachers from a variety of behavioral science and psychoanalytic disciplines. Most optimal at this time may be a collaboration between the two.

COMMENT

The psychoanalytic approach to behavioral science in medicine, as epitomized by the work of Michael and Enid Balint, has a number of features that are applicable to the training of family physicians in America today. Balint work has by no means a monopoly on understanding the physician-patient relationship, but it is a successful method of achieving that understanding, and it incorporates an approach that can be internalized by the physician and used long after the formal training has ended—an essential criterion for any continuing education endeavor.

Balint work in the United States has much to learn from the rich history of general practitioner groups in England. One Balint-trained physician notes that general practitioners who have participated in Balint groups will have "discovered that people are more interesting than diseases. Their lives are more interesting and so are their feelings. The doctor has also become a little more interested in his own feelings, especially those aroused by the patient. If a patient makes him feel angry, instead of shouting . . . he is a little more likely to say to himself, 'What's going on here? What am I getting upset about?' He may even be able to share his conclusions with the patient so that they can both understand it."[36]

These thought processes, fostered by the Balint group leader and internalized by group members, can both assist the patient and create a new source of practice satisfaction for the physician. The Balint approach, modified to fit a variety of settings and with the newly created behavioral objectives, is quite in keeping with the rich eclecticism of current American behavioral science teaching, which focuses on patients' needs for physicians who grasp the importance of the relationship and who have the skills to nourish it.[37,38]

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