Medical students struggle in their search for a professional identity and their need to appreciate the role of emotions in illness. Being with students in a Balint group is a creative experience and their idealism and sensitivity are inspiring. Encouraging them to find the connection between their emotions and those of the patient is challenging and the real objective of such groups, but not always easy to achieve. Students in Balint groups may feel uncomfortable talking about their feelings for patients in front of peers and the group leaders. To help develop the students’ trust in the group, Balint leaders need to be aware of the types of emotional experiences that are likely to emerge, and the ways in which students relate to each other and the group leaders; their approach to students may require certain modifications.

SOME COMMON EMOTIONAL EXPERIENCES DISCUSSED IN STUDENT BALINT GROUPS.

Balint groups give students an opportunity to explore many themes relating to their emotional experiences. Often in the early sessions students briefly discuss several clinical cases with much time spent on describing incidents they have witnessed and been worried by; as they become more confident about talking in the group, we encourage them to
discuss individual patients with whom they have been directly involved. In the early groups students often talk about their anxiety that they have no real role and that they are exploiting the patients to learn to become doctors, but later, as they begin to explore their communications with patients more positively, they begin to see their value for these patients. Suckling identified a number of common themes in her study of 3 consecutive student Balint groups.

1. *The student’s role:* Students often speak of incidents where they feel in the way, such as when a seriously ill patient is being assessed by a doctor, they feel they have no role, but on other occasions, when students are given a specific task to do, they feel a useful member of the team.

2. *Issues to do with confidentiality:* Students are concerned about the need for privacy when talking to patients, especially when patients confide thoughts about self harm in them.

3. *Issues to do with consent:* There are often discussions about patients giving informed consent: for example being invited to learn to do a rectal examination on an anaesthetised unconscious patient, who has not actually consented to this.

4. *Dealing with the very ill patient:* Students describe concerns about how to approach a seriously ill patient and how to answer their questions, which can be difficult if one does not know how much the patient knows, or what to say if their condition is serious.
5. **Dealing with death and dying**: Students are aware of the risk of being too detached from the patient’s and their own emotions in the effort to remain ‘professional’ and sometimes see this in the doctors’ behaviour.

6. **Acknowledging feelings of revulsion towards patients**: such as with those with disfigurement or poor personal hygiene or because of prejudices expressed by the patient.

7. **Difficulties in history taking**: Many difficulties with history taking come up: such as it not being possible to find a patient willing to be seen by a student, or because students are asked to see patients in pairs which makes it difficult to speak to them about sensitive issues. There is often a conflict between trying to listen to the patient’s own story and taking a full systematic medical history with the standard questions.

8. **Recognising and handling professional boundaries**: Students worry as to whether to behave like a professional and risk being impersonal, or like a friend when it was easy to be over familiar? They want to be friendly without becoming the patient’s friend. With their cancer patient pathways patient there are issues about how close they can be to the patient and how to end the six allocated meetings.

9. **Issues to do with the Student – Patient Relationship**: Students speak of the privilege of being able to enter the patients’ lives and share some of their experiences and are surprised at how some patients are able to trust them even though they are not yet doctors, often feeling that they
give nothing to the patient and are a nuisance, but an appreciative patient helps them to feel valued.

10. Observations on doctors’ attitudes and communication:

Students are often impressed by the doctors’ respect for patients, but also they feel uncomfortable with the power that the doctors hold when they taught, and with their good and bad communication with staff, relatives and patients (Suckling 2005).

Clearly these themes are more basic issues than those brought up by qualified doctors in Balint groups. Students want to develop a professional identity, which will allow them to remain empathic towards their patients whilst preserving their boundaries. Group leaders should be aware of these things and prepared to shape their approach to students accordingly.

STUDENT EXPECTATIONS AND PATTERNS OF RELATING IN BALINT GROUPS.

1. Helping students to understand the purpose of the group and bond with the leaders.

We meet each student before they join the group to discuss the purpose and expectations of the group, explaining that we want students to try to speak spontaneously about their patients, rather than to come with a well rehearsed case history and encourage them to try to focus on relationships they make with patients. This preliminary interview helps make a bond between the student and the leaders.
2. Dealing with students’ fear of showing emotions in front of peers and teachers.

By introducing some structures it makes it easier for this to happen. So as with other types of Balint group, after a student’s presentation, we invite the others to ask the presenter for factual details about the patient, and then invite them to put themselves in the presenter’s shoes by discussing what they would have done, while the presenter is silent, in this way getting the members of the group to try to identify and reflect on emotions arising in the discussion. At the end of their participation in the groups, we give students the task of writing a reflective essay about one patient they presented and how the ensuing group discussion influenced their thinking. This helps them evaluate their emotional experience.

The size of the group affects group interactions: we find 8 to 10 students an optimum number. If there are too many students, it may be difficult for the shyer members to be confident about presenting cases and if there are too few students, there may not be enough clinical material for presentation each week. Also ideally there should be between 8 and 12 weekly groups for a satisfactory group process to develop.

3. Helping students’ to tolerate their uncertainty about emotions.

A lot depends on how well members of the group bond with each other and how much the leaders are prepared to be active and supportive and make interventions endorsing and valueing the students’ contributions; sometimes it
helps if the leaders are prepared to share their own emotional experiences of clinical situations spoken about by the student.

4. Students’ focusing on observed incidents, rather than on their relationships with patients.

   It helps to remind students that they should try and focus on a patient they have got to know, rather than only to describe situations involving others’ behaviour towards patients. This is difficult when the majority of their encounters with patients are fleeting. At UCL in the first clinical year students follow up a cancer patient over 6 months and we encourage them to talk about this relationship. When a full patient encounter is described, we encourage students to follow up the patient they have presented and in each group we ask if any student has a follow up.

5. Students’ discussion of personal problems in the group.

   We discourage students from bringing personal problems to our group and if a student shows signs of significant emotional difficulty we try to speak to them outside the group and may suggest they get further help. Occasionally a student has shared a more private experience with the group, such as witnessing a recent death in their family, which enhanced the group’s understanding of a particular clinical case, and helped the group to feel closer and more trusting.

6. Group leadership:

   When leaders are medically qualified, or have had significant medical experience like nursing, they are more likely to appreciate the students’
clinical experiences. It is better if they have also been in a Balint group. Clearly with the shortage of available qualified Balint leaders and medical psychotherapists, trainee psychiatrists can be very helpful as group leaders, if they have also been in a Balint group and can be regularly supervised, as in the Bristol model. Students because of their closeness in years to a trainee may find it easier to relate to him or her, than they would to an older person, who they may fear being more judgemental. Likewise, a younger trainee may more easily identify with a student than an older leader. However students can make a strong attachment to an older more experienced leader, who may represent a more parental figure and a trainee leader may be too passive and silent. Coleadership in which one leader is a GP and the other a psychiatrist will have the advantage of bringing ideas about the body and mind together.

CONCLUSION

In a recent group a student called Irena told us about how getting to know a friendly middle aged man with leukemia, whom she had visited on the ward a number of times. One day she returned to the ward to find his bed was empty and was told by the registrar in a rather detached way that this man had died in the night of a massive oesophageal haemorrhage. She spoke of her shock at learning this: it was the first time a patient she knew had died. The other students while sympathising with her started arguing about the value of talking about their feelings; then one of the leaders spoke of his own experience of his father’s death from a similar haemorrhage. At this point
Irena began to cry and the other leader commented on this and she said how sad she felt about her patient’s death.

My memory of being a clinical medical student was of feeling too disconnected from what I saw and felt, particularly when too little was said about the patients’, doctors’, or student’s emotions. It wasn’t until I had a General Practice placement where I saw doctors, with whom I could identify, discussing their patients’ and their own feelings and asking me about mine, that I began to see the role of emotions in illness. The majority of students who come to our groups are more connected with their patients and better motivated than I was, but they still need help to see the value of these first emotional experiences with their patients. Leading a Balint group is rewarding because it gives you the chance to help students see the relevance of their emotions to the relationships they are trying to build with patients.

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