IS THERE A PLACE FOR BALINT IN VOCATIONAL TRAINING?

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In earlier issues, others have described various techniques of group work with trainees such as topic discussions, role play, problem case analysis and more esoteric activities such as 'buzz groups' and 'brain-storming'. It may well be asked what, if anything, the Balint recipe could add to this extensive menu.

One must start by stating that there can be no such thing as a Balint group in vocational training. The normal criteria for a Balint group are that:

1. it should consist of GP principals having full responsibility for their patients.

2. it should have a fixed membership, usually of 8-10 members, committed to a minimum of two years' regular attendance (30 - 36 sessions/year).

3. members are volunteers who have clarified their understanding of, and motivation for, the work involved in a 'mutual selection interview' with the leaders.

In a trainee group we have instead:

1. members whose responsibility for patients is delegated and limited, and may relate to hospital as well as GP patients.

2. a fluctuating membership of mainly one-year trainees, often with 'carousel' entrance through the year, and not necessarily constituting a group of ideal size.

3. conscripts who should not be either excused or excluded from participation even if they seem disinclined or ill-suited to the work.

Ought we then to abandon the idea of Balint work for trainees because we cannot offer them the total experience? Those who appreciate its value would be unwilling to deny them at least a taste of it. Many may profit from, and be satisfied with, this diluted dose of the Balint philosophy. For some it will undoubtedly be an effective immunisation against the real thing. For others it can open a whole new chapter of the pharmacopoeia, to be studied and practised later on.

Despite the constraints, there are in fact some advantages in a group composed of trainees, whose other joint activities on the scheme engender a degree of intimacy and group identity which would take months to develop in a traditional Balint group.

What does the group do?

As in any Balint group, the purpose is the study of the doctor-patient

relationship in general practice by means of case discussion. The method is the presentation of members' current cases, from memory, without recourse to notes. The fact that this gives a subjective version is fundamental, since it is the manner of the doctor's recollection and presentation, with all its frailties, uncertainties and hesitations, which contributes important clues to the understanding of the unconscious processes at work.

By contrast, the objectivity of a videotaped consultation makes this an appropriate tool for the study of its verbal and behavioural aspects. These two techniques are complementary, not conflicting.

The doctor describes the patient, the history, and one or more consultations, including his perception of the patient's feelings and his own. In the group discussion the emphasis remains chiefly on the interaction between doctor and patient, rather than on the minutiae of physical signs, investigations and drug therapy.

This discussion must not escape into endless interrogation of the doctor, but should lead the group towards speculation and imaginative thought around the material which has been presented. This technique of 'free association' in the group setting is the Balint inheritance from its psychoanalytic parentage, but it is neither necessary nor desirable for the group members to concern themselves with analytic concepts or jargon.

Just as a group studying a clinical topic draws on the collective knowledge of the group as its primary resource, so this group can draw on the experience and understanding of human behaviour which exists in differing degree among its members - experience derived from their professional and their personal lives.

By examining cases in this way they become increasingly aware of the patterns of behaviour which underlie the problems patients present and the difficulties doctors have in handling them. As members become familiar with looking at cases in the group they can make better use of this same kind of creative imagination in the surgery setting when trying to understand what a patient is presenting to them and their own response.

Any case is suitable for discussion but cases are usually brought because the doctor feels puzzled, angry or frustrated by his inability to understand or make progress, or because the relationship is uncomfortable or threatening. These may be termed 'problem cases' but it is not a 'problem-solving exercise'. By exploring what is going on between doctor and patient to find what lies behind the difficulties being experienced, we are trying to understand the real problems of the patient, rather than producing solutions to the problems the patient is creating for the doctor.

In a group, a female trainee described a middle-aged woman patient whose frequent attendances were becoming intolerable. She presented multiple somatic anxieties and had had numerous, predictably inconclusive, hospital referrals.

Some time previously her alcoholic husband had apparently been found dead in a garage after she had turned him out of the house. This story was common gossip in the practice, though the patient had told the doctor a somewhat different version.

The doctor's first question was whether she should challenge the patient with 'the truth' about her husband's death. Her frustrating failure to cure the patient's symptoms seemed to have resulted in dislike and a desire to punish her. She even wanted to know whether, if you were a principal, you could remove a patient like this from your list.

The group, free from the constraint of actually having to deal with the patient in person, could take a more sympathetic view. They wondered what sort of intolerable life she may have led with her alcoholic husband. She already seemed to be punishing herself for her responsibility for his death, by her symptoms and fears, and by alienating her doctor, and presumably other people in her life too.

As the group's perception of this unhappy woman broadened, so the doctor's future relationship with her began to seem more bearable. Already she appeared more of a victim than a villain, and the doctor found herself almost looking forward to their next encounter.

The importance of continuity

The strength of the Balint method, and the sine qua non of its use in vocational training is the continuity which allows the group to follow up cases over a period and examine the developments in the light of speculations, suggestions and predictions made early on. This also provides support for doctors dealing with difficult cases where there is understandable anxiety about getting out of their depth.

Just as a single consultation should be seen in the context of the continuing doctor-patient relationship, so a single group session is only part of an ongoing process in which the group and its members change and develop. Like most consultations, group meetings contain some muddle and leave many loose ends, but just as this allows the patient to work on his problems between consultations, so the group members can chew over their own unfinished business, and understanding may progress between sessions.

For these reasons, this kind of group can not be run as an occasional alternative to other forms of group work like role play or topic discussion, but needs a regular, preferably weekly, slot in the programme to achieve its aims. This does not preclude, but will in fact enhance, the effective participation of the same group in other kinds of group activity on the course.

Follow-up reports were of importance in this case of another patient who was causing her doctor great anxiety. She was the devoted deputy matron of an old people's home which the doctor

often visited. This lady never complained for herself, but one day was found to be seriously ill in left ventricular failure. She categorically refused hospital admission or referral, and though she improved with treatment the doctor feared a possibly fatal recurrence.

At first the group were preoccupied with the pathology, suggesting ways of persuading or coercing the patient to accept investigation, and reassuring the doctor. They then began to speculate about the patient's fear - what might have happened to make hospital more threatening than death? Or could she not bear to leave her world of caring for others, to be looked after herself? Perhaps without her job life would not be worth living anyway?

Some time later she confided to the doctor that as a child in Ireland she had found her beloved older brother of 17 dying after a haemorrhage from pulmonary tuberculosis. The doctor's awareness that some such experience might exist had created the climate for a story to emerge, without intrusive questioning, which she had told no-one in forty years. This did not solve the problem of her refusal of treatment, but made it more comprehensible and tolerable.

A further development was reported when, following the illness and death, from lung cancer, of another brother, the patient became anorexic with gross weight loss and oedema, though still looking after her old ladies. She refused help but demonstrated that she was drinking water "to stop the doctor from worrying about her".

The group wondered whether this brother's death from lung disease had re-activated feelings of grief, fear and perhaps guilt related to the earlier death. The doctor did not want to pry into this area of the patient's life, nor to bully or threaten her, but remained supportive and accepting. Sometime later she heard that the patient had talked to her priest, and subsequently begun eating normally again.

An important lesson from this case was the way in which the doctor must sometimes accept the role of 'being there' rather than 'doing something', when that is how the patient wants it to be.

The role of the leader

To some extent this same principal of masterly inactivity may seem to apply to the group leader, but this too must be in the context of awareness of what is going on. A Balint group leader should normally have had experience both as a group member and in co-leadership with a trained leader before running a group himself, but in trainee groups a course organiser or trainer with less experience may have to manage as best he can.

He may be fortunate in having as co-leader another trainer, counsellor or psychologist with an interest and experience in similar groups.

The leaders' function is the usual one of facilitating discussion and enabling everyone to contribute while keeping the group at work on the task in hand. They should not be seduced into teaching the group, since, contrary to the group's fantasies, they do not have all the answers, and in any case it is the members who must do the work. If something important is being missed they should try to lead them towards it rather than providing it directly.

The course organiser/leader sometimes faces a dilemma when an important question of factual information crops up and he finds his teaching and leadership roles are in conflict. He must avoid allowing the group's principal task to be subverted, sometimes deliberately, into an irrelevant digression. It should be possible to note the problem to deal with elsewhere on the course, or if it seems essential, to supply the information briefly and return at once to the case.

The most important function of the leadership is to keep the work focussed on 'the doctor, his patient, and the illness', and their interrelationship. The illness is considered insofar as it relates to this particular patient, so we avoid getting side-tracked into the clinicopathology of the disease itself. The patient is considered in terms of all his relationships - with his job, his family and specially with his doctor, since this relationship often sheds light on all the others.

The doctor is considered in terms of his relationship with the patient and his illness, and occasionally in his other professional relationships - with the trainer, partners, sometimes hospital doctors - where this is relevant to the case under discussion. But his personal relationships are not the group's concern - otherwise they may become a therapy group sorting out each other's problems instead of a working group studying their professional tasks.

It is the particular responsibility of the leadership to get this aspect right - so that discomfort or distress in the doctor are not ignored, neither are they made the primary object of the group's attention, but are worked through in the context of the needs and problems of the patient rather than of the doctor. In this way the doctor can learn things about himself or his way of working which may be painful or surprising, but he can take them away to absorb in privacy.

Leaders of groups doing Balint work can study the problems of leadership in the group leaders' workshop. Here a group meeting will have been recorded and transcribed, and the transcripts circulated to members, who will examine in detail the way in which the leaders performed with their group. This can be a salutary and revealing experience for the leaders concerned.

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