CONTENTS: BALINT CORE VALUES: COHESION AND FLEXIBILITY

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PROCEEDINGS

"Balint core values: cohesion and flexibility"

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“Balint core values:

cohesion and flexibility”

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INTRODUCTION to the proceedings

By Christian Linclau and Monique Aubart

The SBB (Belgium Balint Society) is honoured to publish the Proceedings of the 22nd International Congress taking place in Brussels in 2022.
In this book, you will find the presentations of the Brussels Congress, but even more. Indeed, the Ascona prices are presented in their integrity, and we added some articles that were sent to the scientific committee but couldn't be added to the program of the congress.
We want to thank the members of the scientific committee for the amount of work they realized to select the presentations, workshops and posters. A great thank goes also to the presenters who were flexible enough to submit their contributions twice, the first time for 2021 were we couldn't organize this event due to the pandemic situation. A very warm thank goes also to our organizing committee for organizing and re-organizing without losing their motivation.

By Florence Decorte

In this book, we have collected in-depth articles that offer food for thought and references to support caregivers in understanding and experiencing this subject of infinite dimensions: the care relationship.
We juggle with texts that articulate and respond to each other with cohesion and flexibility as the theme requires. After having shared on a global scale a virus that has affected us all, in every way, here is, as a remedy, an open window on international experiences of Balint practices.

Three young caregivers, talented Ascona 2022 winners, open the reflection with great fineness: close to their patients, they offer the freshness and depth of the first significant experiences. They also give hope for the continuity of the Balint movement.
Who doesn't feel the current urgency of an even more frank commitment to all that is human, communicative, comprehensive in the relationship between caregivers and patients? And how contemporary Balint's response is! And yet, adjusting Balint work to the 21st century is challenging and not smooth sailing, as several authors share. How to be flexible and rigorous, how to transmit?
Between cohesion and flexibility, the members of the groups, the generations, the facilitators, trainers, pedagogues, move away, rub shoulders, and come together.

We leave you to discover these points of view and lines of research, with the hope that this review will allow you to extend, after the congress, the reflections started in Brussels.

INTRODUCTION TALKS of IBF and SBB presidents on Wed. 31st August.

HERE WE ARE FINALY!

This congress initially planned in 2021 has been postponed to 2022 because of the pandemic.
Maybe this assembly is not as completed as it should be because of health problems due to COVID 19 or due to something else or because of the fear of war not far from our borders or maybe for economic reasons!
Indeed, these years have changed our present and are affecting the future, for the IBF but not only, they have also an impact on caregivers all over the world and on people, generally speaking.
I think the title of this congress is more relevant than ever: core values and cohesion!

Are the core values of our movement the same as those of Michael Balint seventy years ago? Have they been transformed? And if so in which way?

Nowadays, the International Balint Federation (IBF) is composed of 28 Societies all over the world! Cultures, historical backgrounds, languages, healthcare systems are such a patchwork! How can we maintain cohesion in our federation? To what point is flexibility acceptable considering our differences? Flexibility is also an ability to adapt ourselves to uncertainty and changes.

In 2017, in Oxford, our 20th congress was about "Diversity" ("Balint theory and practice: exploring diversity"). In the next, in 2019, in Porto, we were asking ourselves how we could "See medicine through other eyes". Innovations on the way to lead a Balint group were proposed. In 2020 we also have become more familiar with new tools like videoconference due to the pandemic crisis with COVID.
I'm sure we will find some paths and creativity by sharing our thoughts during these days together.
Already a great thanks to the Belgium society which has kept the challenge.

As the president of the Belgian Balint Society, I'd like to welcome you to this 22nd International Balint Congress at last.

The carbon atom which is represented in the Brussels monument "the ATOMIUM" is an important element of life! This metallic construction and the European Flag with its stars, are two of the symbols of our beautiful capital where the 22nd congress is taking place. This is what you can see on the congress logo created by Dr. Luc Decleire!

An atom is composed with one core symbol of cohesion and multiple electrons symbol of flexibility. It seemed obvious to the Belgium Balint Society that it could therefore represent our concerns: the balance between core values, cohesion and flexibility.

This congress is an incredible opportunity for renewal. Living in uncertainty can be a source of freedom and creativity. Living with uncertainty cannot be taught by books. Balint said, leave room for your stupidity. This is the place of liberty and imagination!

Doing a Balint education is learning by yourself, not in loneliness but in the privacy of a group, in a kind of seclusion but surrounded by peers, it is learning things who will never be taught anywhere else.
What will never be taught in caregiving is how to stay present to someone who can't be healed, to stay present when we can't help.
We learned what to do in an emergency but not to avoid doing something when it is not necessary. And how to have the wisdom to distinguish the difference, although sometimes it is just a nuance. But when we have done our best, joy is our reward.

No one can teach us how to live with the strength of desire and the power of life.
Nobody can instruct the way to open our eyes and heart to our peers, to look at ourselves and see that the other is singular and distinct. …Except maybe in groups … And of course in Balint groups.

That is why this incredible conference with people coming from all over the world is a wonderful opportunity to learn.
I really hope it's going to be a joyful meeting for all of us.

The organizing committee decided to begin with the Ascona prices because their testimonials are always so invigorating for our generation. It is also a way to know them and to welcome them warmly.

CONGRESS PLAY of Wednesday 31st

Staging elements

Two highchairs, type bar chairs, with high round table, a screen near a dozen of coloured chairs of various shapes coloured chairs in semi-circle

Senior physician alone

Dr D: -*Adelaide? Are you done with your consultations? Can you join me for the debrief? I am in the 2nd office.*

The cell phone rings. Dr D responds, gets up and walks away as junior doctor Adelaide enters.
They pass each other and greet each other through eye contact.
Senior doctor Dr D continues the telephone conversation trying to cut it short.

Dr D: -*Yes, Mister Gerard, yes…*

*** Adelaide enters the room. She settles quietly in front of Dr D.***

Dr D: -*Just to be sure, are you asking me if you should wear slippers when you are sleeping? What do you think about it yourself? Yes, I agree, it may be better during the day but not very comfortable during the night, right? Allright, I need to go, see you soon Mister Gerard. Have a nice day!*
-It was this patient, Mr Gerard, an old lad who lives alone since his mom's decease, he lived with her his whole life, you know I am affected by that type of person and willing to help them. It's not easy, a lot of effort to keep in touch with them, sometimes they call me for very small inquiries and various diseases are forgotten.
-Anyway, how was your day of work?

A: -*It went by fine on the whole… I saw the Delahaye, they wanted to be seen by you though, they were extremely annoyed that there was only me…. And oh, something funny happened this morning, you remember Mr K?*

Dr D (**hesitant and looking in computer**): -*Mr K?*

A: -*Yes, the patient that Alex had not accepted to see yesterday because he made a remark about him being late. You know Alex's short temper.*
Dr D: - *Ah yes, I do remember!*

A: -*Well, this patient said something really strange, he told me « I came to see Dr D one week ago, but I think I consulted too early, so I am coming back today. » It was quite unexpected… and it made me remember that book that you had talked to me about some time ago…. This one « The Doctor, His Patient and The Illness »*

Adelaide gets up and goes to one of the coloured chairs and remains standing

Dr D: -*You are reading Balint, this edition from a very old edition too…. Where did you find that?*

A: -*I got it online from some thrift shop kind-of website.*

Dr D: -*That is so interesting, you know I take part in Balint groups, right? Last week we were just talking about how Balint is not inspiring the young generation anymore… even if the simple word is always a very good Key word for the test and the exams.*
-What did you think about the book?

A: -*I find it fascinating, there are some parts that I don't really understand…. but it opened my eyes on many things… I was wondering sometimes what is the sense of these visits where patients come for « nothing much », a flu, a simple cough, a runny nose… why do patients still come for these « small illnesses » that they probably have every other year? And what about all these patients who come only for a renewal of drugs? That is exactly what they say as soon as they enter the office « it is just for the renewal » They seem to not expect much more from us than reprinting the prescription, signing it and giving it to them, turning us into ticket machine… I sometimes feel like a fraud, just giving them what they are asking for on the surface, and not reaching deeper for meaning in these encounters.*

Dr D: - *Maybe it is quite difficult to feel or in fraud or to take a chance in going deeper alone*

D gets up and goes from one chair to another full of hesitations.

A: - *And this is where Balint's thoughts are really inspiring, it is about delving deeper, understanding oneself and the patient on another level. It is about sublimating the consultation. Understanding that the space of a medical encounter consists of the meeting of two very different universes, with their own languages, codes, biases, visions of health and illness. It is about how they meet and how they can cross without clashing with each other, how to resonate together.*

Dr D: - *Everything you say, is very moving… You know. There is something you should do*
A: - *What is it?*

Dr D: - *not stay alone with only theory and lectures but go and participate in a Balint Group there are many ways to go in and be welcomed by going to the 22nd International Balint Congress, you are going to love it!*

Ascona winners

This is a prize granted by the Psychosomatic and Social Medicine Foundation for medical students from all countries.

€ 5,000 is available for the authors of the three best essays. The articles are in English.

The essay must describe an assistant-patient relationship, a personal experience from the student's medical studies, a description of how he lived this relationship, the way he responded to it and finally a critical reflection on the evolution of his state of consciousness and the way to improve it.

1. Madloba, dear Mikheil. (Thank you, dear Mikheil.)

Jill Kar

5th year Medical Student at New Vision University School of Medicine, Tbilisi, Georgia.

That Thursday morning at the hospital, I wasn't my usual self. Awfully perturbed by new updates about yet another friend getting a job and another one getting married, I felt like my life was at a standstill. I was a restless third year medical student, constantly counting and recounting the years before I could start earning my own bread. Musing upon my distant dreams, profound passion and puny patience, I sat in the gloomy conference room, amidst the soft buzz of students whispering, waiting for our patient interview assignment; Completely oblivious to how far I was about to be pushed from my comfort zone in the next few hours.

We were called to assemble in the inpatient department for the briefing. The symphony of the beeping heart monitors, ringing intercoms and rasping coughs intensified as we entered. The bright tinsels over the monotonous blue walls did cheer me up a little as Christmas was around. I stood in my white coat, subtly excited, feeling responsible already.

We were then informed about our respective patient wards and were paired up with our partner students for the assignment. Tamar, a Georgian student, was mine that Thursday. I knew what that meant; Being a foreign medical student from India, here in a small East European Country like Georgia, I faced a massive language barrier, as most of the population here spoke Georgian or 'Kartveli'. In case a patient didn't speak English, the English-speaking students were paired up with Georgian students who could talk and translate during the interview, thus bridging the communication gap. I had been lucky with the previous two Thursdays of my Internal Medicine rotation, where I was assigned English-speaking patients. But this one was going to be utterly challenging and I wondered how could I possibly participate in this interview? I presumed my sole duty was to just take notes and to watch and ponder over the words of Kartveli that I didn't know, and to make sense of the few, that I did know. "I've got to do this anyway so let's get this over with" that's what I told myself as I followed the nurse escorting us to the Gastroenterology ward, where our patient was located. As she exchanged pleasantries with her colleagues on the way, I checked if I looked decent for the interview; I was visibly anxious about how this awaited to

unfold, but Tamar on the other hand was as calm as a kid on Valium! We were supposed to interview the patient in room 415. Outside the door, I fixed my hair one more time, and with permission, we both walked into the unknown.

The room was aglow with the blinds pulled open, inviting in every ounce of bright daylight. At the corner was an old, thin and pale-looking gentleman, sitting up on the hospital bed, welcoming us with a warm smile. He had a few wispy strands of white hair, and his grey eyes lit up as his droopy cheeks tried to hold up a smile. He looked perplexed to see me, his eyebrows subtly approached north, and deep furrows marked his forehead as he looked at my brown Indian skin and dark eyes. I could feel him questioning my presence! His bedside wheel table caught my attention next as it was loaded with belongings, suggesting that he had been there for a while. I looked at him again, only to realize that his eyes were still bored into my foreign face.

Tamar & I said, "*Gamarjoba*" ('hello' in Kartveli), introduced ourselves and explained why we were there. My Kartveli was just as broken as his English. He looked at me and asked "where *shen* (you) from?" to which I replied, "India". He smiled and said "*Kargi... Kargi...*" (Good...Good...) gently taking his gaze off me.

We pulled the stools close to his bed and I sat ready to write. I was naïve to the possibility of even slightly connecting with him as I believed my job was to just listen to Tamar as she would talk and translate. I could also ask any questions I had, but they too had to reach him through her.

"How are you doing today?" Tamar asked in Kartveli. He responded, and I stared at him, hoping to catch a word or a phrase that I knew to decode his response. I couldn't catch the words though, but I read his face and body language; Seemed more comprehensible that way. It was like communicating beyond words, with just sight and observation of emotion. The slight grin on his face made me guess that he was doing fine, but then the grin changed into an expression of some discomfort as he pointed towards the middle of his chest, moving his wrist up and down as if something was coming up. I guessed that he must be having pain from acid reflux, but I silently waited for Tamar to dictate his response to me, which in fact was that he felt okay but had a little chest pain from acidity. I felt a tranquil cheer as I wrote it down, because even without the ease of words, I had somehow decoded his response nearly accurately. The concepts of 'non-verbal communication' that I had learnt in my first year of medical school, that seemed so trivial then, were paying me a visit now!

We continued the interview this way learning more and more about him. His name was Mr. Mikheil[1], and he was 73 years old. He was a retired mechanical engineer, was married to his high school love and had two children. He pointed out that his son and

[1] Names and personal details have been changed to protect privacy

daughter had gone to work that morning and his wife had gone home to fetch some fresh clothes. From the way he spoke, it seemed to me as if he didn't want us to think of him as a lonely old man in a hospital, perhaps people had judged him in the past. A part of me felt sorry to have led him to feel like we would judge him too, but I left that unsaid, pretending I didn't notice. By now, I had started to feel more comfortable as Mr. Mikheil, even though, was talking to Tamar, was also acknowledging my presence by looking at me every now and then, so that I won't feel ignored. He was a considerate man. I reciprocated by nodding like a plume to assure him my undivided attention, I wanted him to think that I acknowledged his expression, even without comprehension.

Mr. Mikheil was admitted to the hospital with the complaint of burning chest pain, abdominal distention and jaundice over 3 weeks ago. On ultrasound, they had found a mass in his gall bladder, but he was told that it was inoperable due to his heart condition. He underwent an endoscopic biliary stenting procedure but that didn't help with his symptoms. He had constant pain and often so severe that he'd have to curl up in bed for hours. Sometimes the pain would be of a burning character, making it unbearable. He wasn't so fond of taking medications but at this point of his illness, he had to take them just to get through the day. Enduring this agonizing pain, that only intensified each moment, Mr. Mikheil was in dire straits.

With downcast eyes and a gradually sinking voice, he continued and what I heard next could explain his demeanor. He told us that recently, the doctors had advised a PET Scan which came positive for a gall bladder carcinoma with metastases to his liver, lungs, neck and abdominal lymph nodes. The only words I could catch while he spoke were 'PET Scan' and '*kaansre*' (cancer). "Well, that can't be good" I thought to myself, and when Tamar translated it, it was even worse than my initial apprehension. Subdued, as I wrote his diagnosis, I still remember the hesitation I had when Tamar dictated me the list of multiple sites of metastases; after each site she'd dictate, I'd look up at her hoping 'that's all...'

Mr. Mikheil was terminal. Doctors had advised that only symptomatic treatment could be given to comfort him at this point. He was scheduled to be transferred to the palliative care home once his symptoms stabilized. I could never have guessed he had cancer by looking at him. The smile that he had greeted us with was flashing before my eyes. Now that he had mentioned it, I could notice how skinny he was by the prominence of his clavicles and the protruding bone of his wrist. I felt sorry for him, and while I was on the brink of feeling any misery, a gush of thoughts began to storm my head reminding me that I shouldn't be too emotional about a patient. Doctors shouldn't get easily attached like that, it's an unfair world, people suffer, you can't feel for all of them, can you? My sinking heart and my rational mind had reached an ethical conundrum. Where do I draw the line? Could I quantify my empathy for Mr. Mikheil? How much was too much? Will this stand in the way of being a good doctor? I was at my wits' end trying to justify my feelings, but it occurred to me that being in

this unfair world, sure I couldn't attach myself to every suffering human, but could I not just make that one person at the other end of my stethoscope feel cared for, with my compassion and kindness? I had mixed feelings. I continued to read Mr. Mikheil, but this time with a cautious form of empathy, ensuring comfort, his and mine.

Mr. Mikheil had asked the doctors how much time he had left to live, to which he had received no proper answer. He had only been told that once everything would be stable, they would check if they could change his stent to help with the pain. There were no promises made, just the message that death was near. At this point, if he could just wake up in the morning, he felt hopeful, it was like living one day at a time. Not weeks, not months, but days determined his fate.
As he spoke of death, I could hear him choke up a little, he looked up at the ceiling trying to blink tears back while I wrote with a heavy heart. I couldn't just sit back and watch him break down, what kind of a human being would I be? But then, would it be unprofessional if I got up and tried to comfort him? Afterall I was just a medical student, trying to learn and understand the convolutions of Medicine each day. Would it matter if I tried? I wasn't bound by any direct responsibilities in Mr. Mikheil's care, but could I just help him through the grief? I couldn't address the array of questions I had at that moment, but it occurred to me that I'm a human first. This shouldn't be so hard; this shouldn't be awkward, I'm human.

I cared about Mr. Mikheil, I got up and handed him a tissue. As much as he tried, he couldn't hold the tears in, and I felt a lump in my throat as I realized how small my problems were in this world where everyone has been fighting a myriad of personal battles with bravado. Mr. Mikheil had known his death with an acute certainty and was only in the pursuit of acquiring the strength to accept it. I stood by the bedside wondering if it would be appropriate for me to place my hand on his shoulder as he sobbed. I wanted to let him know that we empathized with him. Tamar came close and spoke to him in Kartveli expressing our support while I touched his shoulder in hopes of providing a tinge of comfort...in hopes of learning all of him. We had a moment of complete silence. Mr. Mikheil picked himself up and smiled as we made the gesture, trying to hide the embarrassment of breaking down, "*Gaikhaare...*" ("I wish you happiness") he said softly.

In that moment, I realized how naive I had been to the possibility of connecting with Mr. Mikheil beyond the barriers of language, culture and ethnicity, and here I was, defying my own expectations. I had wondered how I would empathize with him without the comfort of spoken words today, but words seemed to meekly surrender to the power of humane gestures. I believe that a physician's empathizing words in conjunction with gestures make up the true humanistic side of medicine. None of my previous patient interviews taught me this, maybe because I thought words alone could have the impact that was needed in a doctor-patient communication. I stood corrected. Tamar and I communicated with Mr. Mikheil, embodying the two qualities of a good

physician separately; she was the verbal guide who could listen and speak all the words right and I could give credence to those words non-verbally.

We returned to our seats and gave Mr. Mikheil a moment to get himself together. As I sat down, our eyes met for a second and I blinked at him with a smile of optimism. He nodded back, hoping against hope, as he wiped his nose dry. He didn't believe me, but I sensed that he really wanted to.

He gently asked us to continue and from what I heard next I realized that there was more to Mr. Mikheil than just this illness. On being asked about his past medical history, he told us that he was diagnosed with gall stones six years ago, which was only medically managed at the time due to his history of a coronary artery bypass graft surgery four years prior to that. It made him a high-risk candidate for gall stone removal surgery and thus the doctors had decided not to operate. Since then, he had been taking medications intermittently for his symptoms. He was never relieved as he felt unwell constantly. He mentioned having been to multiple doctors for his problems and nothing had seemed to make him feel better over the years. Some doctors even said, "it's all in your head" and he had to walk out of appointments in despair. This had fueled him to become a more aware patient. He stayed informed about his disease, maintained a diary of his symptoms, medications and the diet that he was taking to keep a complete track of how those things affected him. Sadly, it was the diary that no physician had found the time to even take a glance at yet. He seemed like the perfect patient to me! I was taken aback by the discipline Mr. Mikheil had portrayed regarding his healthcare, how ironic that within a disciplined exterior with such dogged determination lay a complete disarray of cancer cells, devastating him bit by bit.

The years of unsatisfactory medical appointments had turned him into a '*willful endurer*', a person who endures the pain, tries to find answers on their own and only seeks help when it's intolerable. He had somehow taught himself to live with discomfort. Mr. Mikheil felt that it was a blunder he had made, and he blamed himself for his diagnosis because the doctors at this hospital had told him that he should have come sooner. He looked down, heaved a sigh and said, "Eight months ago, one doctor did ask me to consult an oncologist..." He repented not taking him seriously because he didn't believe in his advice then. He had decided that he wanted to get checked up in Gastroenterology medicine only, because cancer seemed far too extreme, and he wasn't sure if everything else was eliminated before he had to come to terms with such a diagnosis.

An air of melancholy filled the room as Mr. Mikheil sat with drooped shoulders regretting his decision, succumbing to self-reproach. I knew it wasn't part of the history, but I was curious about what could have made Mr. Mikheil ignore that one doctor. I told Tamar to ask him the same and she got curious too. To our question, Mr. Mikheil smiled and said, "he was a good guy dear, but he never looked at me, I thought if he didn't even look at me properly, what would he know about me having cancer?"

I didn't have to write this piece of information in the history, but I was moved. I had a patient in front me who could have been in a better place, had he received just a genuine eye-to-eye contact of compassion with his doctor. All it would have taken was an empathizing look! For doctors in the outpatient department, busy and occupied as always, a look of genuine empathy and a few reassuring words in a 5-minute patient encounter might seem evanescent, but for the patients, it resonates with them the entire day. This doctor whom Mr. Mikheil chose not to listen to, had spoken the words right, given him good advice but had still failed. I was surprised to learn what a massive impact 'empathy' and 'nonverbal communication' could have on patient compliance!

Mr. Mikheil looked frail, the guilt was crushing him and with his eyes doleful, he sat in silence. Tamar told him that he shouldn't blame himself for this and it was unfortunate that it happened, but it wasn't his fault. She then started turning the pages in her notebook to recall what to ask next and suddenly, Mr. Mikheil looked up and asked something. As soon as she heard him, she turned her head towards me like a reflex, with her eyes wide open. I sat there staring blankly, unable to comprehend what had just happened, but then she translated it and her reaction could be explained. "Is there a chance you would know how much time I have left to live? An estimate? A guess maybe?" was Mr. Mikheil's question that had sent Tamar's anxiety to the moon.

"So, what should we tell him?" she whispered as Mr. Mikheil waited for us to answer. We were unsure of how to respond because we didn't have the knowledge or the authority to advise him, and it broke our hearts to see Mr. Mikheil make a forlorn attempt to have a desperate shot at hope. We felt his pain commeasurably as he did so, but in all honesty, we told him that we didn't know, and that we were just students who were still learning.

He smiled...he must have thought how silly this was. Tamar and I looked at each other, sharing a feeling of worry but then it occurred to me that if we can't answer his questions, maybe we could just help him find them. Tamar seemed convinced as I told her this and we made Mr. Mikheil an offer. We asked him if he had any more unanswered questions and wrote them down as he spoke. Our idea was to ask the nurse in charge to help Mr. Mikheil find answers after the interview. His second question was, "What does it mean to be stable? Am I not stable?" As the doctors had told him that they were waiting for him to get 'stable', to finally consider changing his stent, he was unsure if he could properly understand what that meant. We assured him that we would find his answers soon, to which he let out a faint chuckle saying, "soon please! it doesn't look like I have much time!" hiding misery with humor as a defense mechanism.

He then remembered a couple more; He was curious to know why he got cancer and what he could have done differently all his life to not be in this place right now. He also asked if his children and grandchildren could have a risk of developing cancer because of him. We guessed his children might be at risk from the general knowledge

we had about cancer, but we didn't want to misinform him about anything. "I hope I'm not troubling you so much with my questions" said Mr. Mikheil with a stoical smile. Before we could respond, he began explaining why he couldn't ask the doctors directly. Although he owed us no justification as he was entitled to ask questions and it was his right to know about his disease and prognosis, we didn't want to interrupt him mid-speech. We listened to him as he pointed out that his doctors here were always in a hurry, so he felt like he'd bother them by asking too many questions. I could understand his hesitation because I had also been a patient once and had a similar encounter with a doctor back in India. As much as I could speak in the interviewer's chair here, I could be equally demure in the patient's chair there.

"I'm 73 dear, when doctors see me, they only look at my chart to check if I fit the definition of 'urgent', they don't see me to chat or listen. It's hard to be taken seriously when you're 73!" said Mr. Mikheil, bursting with laughter when we offered to request the nurse to ask his doctors to come see him more often. We understood his sentiment beyond the humor, but it was sad that we couldn't do much to help. We promised Mr. Mikheil that we would always take him seriously no matter what, to which he chuckled and said, "I'm sure you two would become very good doctors dear!" That, right there, meant a lot to us.

I wondered how Mr. Mikheil had been at the hospital for over 3 weeks now, with so many questions waiting to be answered! It was surprising to see how modern medicine underestimates the patient's desire for information and participation in their care. Also, the fact that no physician had checked his diary yet, exposed the doctor patient relationship as being more authoritarian than being a partnership here.

We continued to connect with Mr. Mikheil and hoped to have made him feel as comfortable as he'd made us. While Tamar and I were taking a quick glance at my notes, he picked up a few papers from his bedside table and handed them to me. I had never seen anything like that before. Those were in fact his PET Scan results and I flipped the pages in awe thinking "woah, so this is what a PET scan report looks like!" He requested us to try if we could help him meet the cancer specialist who had come along with his physician a couple of days ago to explain his findings, as his name was in the report. This specialist had told him something about the type and stage of the tumor and had mentioned that his cancer was a 'terminal case' but Mr. Mikheil didn't understand or remember any of that information. He only wanted to know about things like how much pain he would have, how tenuous would he become, and whether he could miraculously recover one day? He had no quantifying answers to these. This was an extraordinary lesson for me because I realized that even though doctors may feel like they provided the accurate information about an illness to their patients, the patients will only define their disease in terms of personal suffering! They don't care if their tumor was a Stage IV or a T3N1M1, they only care about how they will experience it. Learning what matters to our patients and delivering the information in

a format that they can make sense out of, is crucial... That was something I couldn't have learnt in a classroom.

We listened patiently as Mr. Mikheil continued to narrate about the specialist, perhaps a tacit justification for wishing to see him again. The specialist had told him that the five-year survival rate for his metastatic carcinoma was only 10%. I could understand what he had in mind while giving Mr. Mikheil the statistic of survival; implicit within that was the unspoken estimate of death. What he ignored was that Mr. Mikheil did understand that the odds were not in his favor, but he only wanted an answer tailored to his situation. He knew he couldn't be promised an estimate, but his ability to make dinner plans had been shattered and he desperately needed someone to tell him that he could make it another day, another week or another month. I wondered if a generalized statistic could ever be useful while answering a patient in such medical dilemmas. The answers should fulfill a patient's individual expectations instead of classifying them into a statistic that they have to infer on their own. Through his eyes, I could visualize the loopholes in communication that he had fallen prey to.

We promised Mr. Mikheil to request the nurse and see if a meeting could be arranged and continued the interview by asking about his family. His eyes lit up! He giggled and said, "My wife is my soulmate, and she thinks that she can treat anything with her love and cooking! My children are my pride and are experts in reading the doctors' sloppy handwritings, and my grandkids, oh they are my life..." His wife had seen him through every stage of his illness and had filled him with the love, warmth and courage to endure the pain. She made him tonics and drinks that she believed could beat cancer, and as silly as he thought she was being, he did drink them all with gusto. His children had spent hours researching about the best doctors in the state to help him and they had left no stone unturned throughout his care. His grandchildren visited him at the hospital on weekends and fell asleep on his chest as he told them stories. These were the moments he lived for. As he spoke, he reached towards the bedside table looking through things, I got up and tried to help him find what he was looking for; It was in fact a handmade 'get well soon Grandpa' card from his grandson, with a doodle of Mr. Mikheil as a stickman, leaving the hospital. He was elated to show us his prized treasure. Every bit of ink on that card screamed only two things, hope and strength. I was pleased to see Mr. Mikheil looking at his doodle, smiling like a happy little toddler!

Living with a terminal illness had transformed not only his life but also his family's life altogether. He cherished each moment he spent with them, and I could see that amidst these difficult times, his family provided him with a cathartic escape. He was able to experience each day as a special one and he ceaselessly strived to give them all the love he had. Perhaps the expectation of his death that was destined acutely, added more value to his present life, as if to subsist as a mortal being is only what manifests meaning to all of man's merriment and misery in this world.

Mr. Mikheil's view of the world wasn't constrained by his reality of living one day at a time, his optimism and his humor in the face of death was inspiring. He hoped to see the dawns and dusks, the meadows and moors and the beauties and bounties of life, everything together with his family by his side, as he went through the last lap of his journey. He expressed that he sometimes prayed he'd die soon so he wouldn't have to wear away his children's hard-earned savings but then he'd see his grandchildren and pray to revert the previous wish. He laughed, and we laughed with him. Hearing about his family made me miss mine, back home in India. After this interview, I was supposed to go home to an empty apartment, make lunch and videocall my parents to fill the silence of the rooms. I wished I could be with them too, to share moments of love and support. It's beautiful how a family can embody the essence of love, support, care and understanding, making life worth living, from cradle to crematorium. The healing power of companionship and human to human connection is sometimes underestimated in medicine.

"*Me am tskhovrebis madlieri var*" ("I am thankful for this life") said Mr. Mikheil as he ungripped the blanket. I didn't understand but as Tamar translated it to me, I knew I would never forget how he sounded. It touched me how despite of all the pain and suffering, he had a reason to love and be grateful for this life. Mr. Mikheil's gratitude was ethereal, and I had no right to complain. I could recall being annoyed this morning after seeing a bunch of friends doing well in life. I felt restless, grinding through medical school while the world around me was busy achieving. Talking to Mr. Mikheil made me realize that if anything is important in life, it is this very moment. In this moment, we can either be thankful for what we have and be glad or frown for what we can't have and be sad, it's a matter of personal choice. I had been wishing to graduate as soon as possible so I could start my internship and earn money like my other friends, oblivious to the fact that being a medical student and going through this journey at this moment is the best thing that could happen to me. If I were a doctor right now, I would have been limited by the constraints of time and responsibility and I could never have known Mr. Mikheil the way I do now. I felt blessed to have met him, because unknowingly he had reconnected me with my lost self, he had somehow added more meaning to my dreams of becoming a good doctor.

In the following moments, we found ourselves with our jaws dropped to the floor. Mr. Mikheil had given us his diary to note down his medication and social history; There were tables, lists, graphs and what not, all organized beautifully. We saw what all his physicians missed; a reflection of Mr. Mikheil's discipline, who was indeed the perfect patient. On being asked about his family history, he pointed out that none had cancer, and that's why his diagnosis had come to him as a surprise. We moved to the 'Review of systems' and ended shortly after a few more monotonous questions. I looked in my notebook, all the data had to be organized and we had to create a proper medical history document and submit it by the next day. We were going to be evaluated based on our submission. I had written Mr. Mikheil's questions and requests

in a separate box that would remind me to talk to the nurse. We thanked Mr. Mikheil for being patient with us as he had to wait every time for Tamar to translate and dictate his responses to me. He had been so kind and cooperative throughout.

It had been ninety-three minutes since I was anxious to enter room 415, and now, I was reluctant to leave. Mr. Mikheil and I had connected in the silences of our bizarre tête-à-têtes that were devoid of words but brimmed with compassion. Mr. Mikheil was not just another assignment for me anymore, not an interview I had to 'get over with', he was a patient, a person, a human, worthy of respect. The way physicians shouldn't categorize a patient into a diagnosis, symptom or a statistic, a medical student too shouldn't categorize a patient into an assignment, task or a project. I was guilty of doing the same unknowingly but from that moment on, I knew it was the last time I did it. In those ninety-three minutes, Mr. Mikheil had made me a better doctor, sparked inspiration in me to be courageous in life and taught me lessons that I could never have learnt in a lecture hall. He taught me that life is not a matter of holding good cards, but of playing a poor hand well [(1).] He taught me that medicine is an interplay of Expertise, Ethics and Empathy and as we are only chasing the 'Expertise' in medical sciences, the 'Ethics' and 'Empathy' are just as valuable. No number of hours spent on Lecturio or Amboss could have taught me the humanism of medicine. "Medicine is learned by the bedside and not in the classroom. Let not your conceptions of disease come from the words heard in the lecture room or read from the book. See and then reason and compare and control. But see first." [(2)] This quote by Sir William Osler was suddenly making a lot of sense to me. As the interview ended, I promised myself that I would learn the theories in lectures, and I would learn the humanism by the bedside; and only by the integration of the two will I be a humane healer.

Amid all these silent revelations, it was time to leave. We thanked Mr. Mikheil for taking the time to talk to us and he wished us both the best of luck. I said "*nakhvamdis*!" ("bye!" in Kartveli) to which he said "*nakhvamdis bye bye*!" We chuckled and waved at each other like little kids. We left the room giggling but made a straight face as soon as we saw a nurse looking at us. With subtle embarrassment, we walked past her heading to the nurse in charge at the counter to give her the list of questions Mr. Mikheil had asked. She wrote them down and promised to run them by the doctors. Tamar and I felt content and went back to the gloomy lecture room to take our bags and head home, and as I entered the lecture room again, I felt like I was back from a surreal adventure to the same old monotony of life, but this time it wasn't as monotonous. I was glad about being a medical student that day, thinking about how studying medicine had made me a better human being. My two previous patient interviews were over when I had walked out the door but this one kept resonating with me on my way home, it felt like I was missing Mr. Mikheil already.

The day went by like a breeze and I thought of Mr. Mikheil a couple times, studied a bit, and prepared the patient history by organizing all the information with Tamar over the phone. I finally mailed it to our professor and in that moment, after hitting 'send',

I didn't hope for a good score as much as I hoped for Mr. Mikheil to get better. I hoped for his wellbeing, not with a misguided faith in a miraculous recovery but with a pragmatic prayer to mitigate his pain.

Listening to Mr. Mikheil had made me reflect upon the eroding doctor-patient relationship. The lessons I had learnt were crucial for my career to eradicate the hostilities of today's doctor-patient encounters. My understanding of medicine and healing have taken a quantum leap ever since, and to this day, I think of ways to make it better. I believe there is always scope for improvement, and the following ideas may be beneficial to bring about a paradigm shift in the state of modern-day doctor-patient communication.

(i) We should be trained early on to address to a patient's fears, faith and fortitude, attend to their emotions, ailments and expectations and listen to their own ideas of their illness to make the communication truly 'patient-centered'. The concepts we learn in our current curricula are theoretical and they seem obvious in terms of how a normal human being should approach a conversation, but the doctor-patient communication needs a deeper understanding and that can only be possible if student-patient interaction is encouraged more. Also, the holistic evaluation of how well a student has communicated with a patient should be based on the patient's satisfaction, and not only on the accuracy of the patient's history taken. No one asked Mr. Mikheil for feedback before I got my scores for the assignment. I believe my competence as a doctor is governed by both- my skill of history taking and how well a rapport I establish with the patient while doing so.

(ii) Mr. Mikheil's vulnerabilities and emotions weren't addressed to like they should have been in his past encounters and we all, as a community owe him an apology as his story has highlighted the modern-day limitations of the doctor-patient communication that needs urgent resuscitation! Just like CPR, we can call it DPRR (Doctor-Patient Relationship Resuscitation) concept. We can practice the 30:2 rule here as well; 30 seconds of speaking but 2 minutes of listening to the patient. Use 30 simple words to explain instead of 2 complicated medical terms. In a 30-minute consultation, learn at least 2 things that matter deeply to the patient. Ask 30 questions and order 2 tests, not vice versa. At the end of the consultation, spare 30 seconds to test patient recall twice. The humanistic side of medicine should be under scrutiny to eradicate the inhumanity and impersonality of patient encounters these days, and the DPRR can help ensure this.

(iii) Innovative apps and websites can be made for medical students which provide simulated virtual patient interaction that can help students choose the right response to the patient's concerns in the form of an interesting game. This form of training can be engaging and helpful in the current digital age, pertaining to the limitations of physical contact in the unfortunate times of a global pandemic. Apps like 'InSimu'

have been doing well, helping students practice their diagnostic accuracy, so a similar app for practicing communication skills would be beneficial.

(iv) There are many techniques of communication that we learn in medical school, but the power of gentle humor is underestimated in establishing rapport with the patient. For this relationship to be a partnership, healthy humor can help develop a form of amity. For example, once I had taken my mother to an orthopedic doctor as she had fractured her ankle, the doctor looked at her X-ray and advised her to go for conservative treatment assuring that the fracture will heal, and no surgery was necessary. My mother was afraid and asked the doctor if he was a hundred percent sure that the conservative treatment will work, to which he said "Dear, I will leave my orthopedics practice and become a circus clown if this treatment doesn't work for you, I promise!" We laughed and it was in that moment that he had won our faith. Training students in this aspect can be helpful in communication.

(v) The importance of non-verbal communication should be addressed to adequately during our training at medical school. Words alone can't have the longevity expression can, and our postures and gestures are just as important. It wasn't Mr. Mikheil's fault that he felt unheard and unnoticed by that one doctor he decided to ignore. The words were in place, but they lacked every bit of compassion in the way they were expressed. This subtle art of expression by coordinating the verbal with the non-verbal aspect can be taught via special practical training and personality coaching techniques.

(vi) Interactive workshops, guest lectures, seminars, webinars and TED Talks for students on this topic should be frequently arranged to keep us engaged. In addition to the basic curriculum, we should be trained to look past bias while meeting patients and to avoid the habit of developing preconceived notions. The doctor-patient relationship doesn't begin only when a doctor and patient engage in a conversation, it rather begins from the moment we have seen the patient enter. In the interview with Mr. Mikheil, I had entered the room with a notion that I couldn't connect with him anyway because of the language barrier, thus I was reluctant to try, but during the interview I could see past that bias. Training in this aspect will not only help us treat our patients better but will also improve our outlook and perspective towards other people.

(vii) The dilemma of empathy vs. emotion must be taught cautiously during our training. The focus of our learning leans more towards emotional detachment, but empathy plays a pivotal role in communication. The Hippocratic Oath rightly says, "I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug." [(3)] Compassion, empathy and kindness can modify a patient's fears into faith, put together with words, they can influence the medicine and heal even more than the

medicine. Modern day medicine has somehow made the term ‘EMPATHY’ look ‘EMPTY’ by confusing it with ‘EMOTION’, which is the actual culprit in impairing our judgements. Simulated patient cases with such dilemmas must be given to students for practice to help better differentiate the two.

(viii) Interactive training (in the form of plays, presentations etc.) about the delivery of medical information to a patient in a more personalized manner should be encouraged. Instead of providing information to patients objectively, we should be trained to provide information tailored to personal relevance, without the use of medical jargon. Also, patient blaming has become a common practice and training to understand the difference between warning a patient against habits that jeopardize their health and blaming them for the same, under the tutelage of experienced physicians is important. Professors do not have the time to train every student in these prospects but having an annual evaluation of the doctor-patient communication skills in medical schools may favor both students and future patients, and it should start from the first year itself. Student-patient interviews can be video graphed for evaluation with the patient’s permission, or professors can evaluate our skills in the form of an OSCE where they play the patient, ensuring more comprehensive training.

(ix) Students should be encouraged to carry out patient surveys at university affiliated hospitals to submit one mandatory research on doctor-patient communication outcomes, during their study period. Talking to patients about their feedback and experience post-interview prevents the contamination of research by the Hawthorne effect on doctors during an interview. This would also help to make students aware at an early stage, increase their participation in research and mold their behavior in future.

(x) The care teams that are employed for patients by hospitals for home care must include a medical student as well, who can carry out a weekly visit, interview them and learn about communication on the practical front. For patients, better communication with the care team would mean a better understanding of how to take care of themselves and thus reducing their visits to the hospital.

(xi) Nursing students should also be provided with similar training in communication. I believe that giving nurses a higher responsibility in their career can assist in communication between doctors and patients effectively as they spend more time with patients. They can inform the doctors about the individual fears and expectations of patients during their encounters, that doctors can personally address later. Doctors may find it odd to receive help from nurses in communication as they are at a higher position in the healthcare hierarchy, but this might be a good change and may benefit the patients.

(xii) Verily, doctors are busy and everyday practice has detached them from looking at a patient beyond the illness. Patients have become just another puzzle for them to

fathom. With the time constraints and the huge patient influx, doctors get overwhelmed and are in a hurry, and an overwhelmed doctor will overwhelm the patient. The way the system treats a physician, a physician will treat his patients, without even knowing it. I believe for achieving the ideal patient satisfaction, compliance, recall and adherence to treatment, doctors also need to be cared for. Amidst all this we must not forget that we're human, not diagnostic machines! The caustic reality has deviated from the theories of 'patient-centered approach' to an 'illness- centered approach', as a result of which we tend to categorize patients into a 'case', 'disease' or a 'symptom' instead of looking at them as a person. As students we must be trained to not let our patients pay the price for our adversities, keeping our emotions under control and making sure that when we are with the patient, they are the only thing we think about. Doctors need just as much attention from the authorities as a patient needs from them, and a lot needs to improve down this road.

It was late and I dosed off reflecting upon the encounter with Mr. Mikheil. I woke up to a freezing Friday morning relieved that it was the last day of my Internal Medicine rotation but during my rotation hours, I couldn't help but think about Mr. Mikheil. I decided to go check on him and ask if he received the answers to his questions. I was curious to know whether Tamar and I had contributed to his care even a small bit. In a hurry and worry, I had completely forgotten about Kartveli! How was I going to speak to him? I had just rushed with no plan in mind! I went and greeted Mr. Mikheil. He was tucked in his bed and his wife was sitting on the stool beside him reading the newspaper. His son was standing by the window talking to someone on the phone. I greeted them both and Mr. Mikheil started talking to them, I could sense that he was introducing me. They both welcomed me with a smile and my enthusiasm came to a standstill as I couldn't utter a word next, while my mind was buzzing with the things I wanted to say. I asked his son whether he knew English, but he shook his head no.

I heaved a sigh and took my phone out to open a translation app, I wasn't a fan of the accuracy, but I had no other option. I typed and showed the translated text to Mr. Mikheil, and the way he looked at the screen, I understood he needed his glasses, so his son offered to read it for him. After talking to him, his son typed his response in Kartveli which got translated to English for me. I established the communication this way and learned that his doctor had come to meet him last night and had answered all his questions. His cancer specialist was scheduled to meet him on Saturday, so he was optimistic about that, the nurse had given him pain medication this morning, and he was feeling alright. He thanked me for my help and gave me his blessings. I was happy to know that Mr. Mikheil was doing well, and he finally had a satisfactory interaction with his doctor. I wished them all a splendid day and went home.
I didn't think of Mr. Mikheil that day or the following days until Tuesday. I had been out shopping in the evening and on my way home, I decided to go to the hospital as it was nearby, to meet Mr. Mikheil and ask how the meeting with his cancer specialist went. I reached his room but found the bed empty. The belongings were gone. The

blinds were shut, and the ward boy was changing the sheets. I was happy as my first thought was "phew! Maybe Mr. Mikheil's symptoms had stabilized, and he was transferred to the palliative care home. Good for him!" I proceeded to the nurses' room to ask about when Mr. Mikheil was transferred. I stood numb with my hopes shattered to pieces as they told me that Mr. Mikheil had passed away the night before. His health had progressively deteriorated since Saturday evening, and he was on Oxygen therapy but eventually had to be put on a ventilator for two days. Monday night, he died from a cardiac arrest. All I could think about in those moments was my meeting with him last Friday, as if I was reliving it, but this time only noticing Mr. Mikheil. He was just smiling with unassailable optimism; I could never have seen it coming. With a heavy heart I walked back to room 415 and had a grim moment of silence. I took one last glance at the empty room that once saw a loving family fill a dying man with hope, warmth and endearment; The room that saw Mr. Mikheil face his illness with grace, grit and vigor; frail with a terminal disease but never weakened by it.

I'll never forget the lessons I learnt from Mr. Mikheil, and I thanked him one last time saying "*madloba!*" (thankyou), with hopes that he'd hear me from his heavenly abode.

On the way home, with tears in my eyes, I prayed for him and his family, wishing them peace, pleasure and prosperity, wherever they went.

(Names and personal details have been changed to protect privacy)

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2. Life, death and the in-between

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Growing up, I came to realize that Murphy's law is an inseparable part of my life. This adage, stating that "Anything that can go wrong will go wrong", has never missed a chance to strike. More accurately, I often felt that whenever I was afraid of something or preferred to avoid it, I always ended up being attracted to it somehow.

It was in the middle of my 4th year of medical school, three or four weeks into the 14-week internal medicine clerkship. It was our first clinical rotation, and I was excited and eager to learn. For three and a half years, all I saw was the inside of the lecture hall, but never the inside of a hospital. We dedicated so much time in the classroom to discussing clinical cases of different patients, without ever meeting one in person.

There was a sharp transition from the pre-clinical to the clinical years. Pre-clinical studies are a safe zone. You are just one of tens of thousands of university students, you wear regular clothes and at least externally, there is nothing that really sets you apart. Thus, no one has any special expectations of you, except, of course, not failing all your exams.

Clinical years take you out of this safe zone. The moment my six fellow students and I first proudly wore our white coats and stethoscopes, we could feel that people looked at us differently as we were walking along the hospital corridors. They frequently asked us how to get to a certain department, and patients' relatives would call us to see what was wrong with their loved ones, asking us to give them some pain killers or change the IV bag. All of a sudden people expect you to help them, and you don't really know how. I could feel their slight disappointment when I said I was just a student and that I would call someone else to help. The white coats and stethoscopes might have made us feel important, but the truth was we knew very little.

Tuesday morning, 07:30 AM, all seven of us were preparing to collect morning blood samples. The department had a phlebotomist, but our tutor assigned each of us a patient to draw blood from, so we could practice and improve our blood drawing skills. We learned how to draw blood only a short while before, and at that point there was a better chance that I would cause pain and leave a large bruise on the patients' arms than actually collect a worthy sample. I felt insecure. I wasn't comfortable practicing

something on others when I didn't feel confident enough performing it, but our tutor thought it was the best way to improve.

"Keren, please go and draw blood from Ms. Leah Cohen[2]", he said. "She's a psychiatric patient". We developed a habit to take a quick peek in the patients' medical records before drawing blood, in order to get some basic information concerning their age and general condition. This helped us decide which needle to choose before approaching the patient.

Reading the first sentence in Ms. Cohen's admission note, I found out that she was 80 years old, a Holocaust survivor. *Oh, no*, I thought to myself. I preferred to be assigned a rather young patient for starters, thus increasing my chances of succeeding, thinking that a successful blood draw would help build my confidence. However, that, obviously, didn't happen.

On top of that, the "psychiatric patient" part made me feel even more inconvenient. I didn't really understand its meaning at that time. We hardly had any exposure to psychiatry during the preclinical studies, so I don't think I knew more about it than a random person on the street. As a result, I must admit that when I thought of the term "psychiatric patient", I imagined an odd or even quite intimidating person, mumbling or screaming some incomprehensible words.

To sum it up, I hoped to get a relatively young and cooperative patient, and what I got in reality was an elderly patient with a mental illness. Murphy's law at its finest.

Taking all those things into account, all I wanted at first was to ask for a different patient. I almost did, but then I remembered that I only read the first sentence in the admission note, so I decided to continue to the second. It said, "Ms. Cohen attempted suicide by taking 30 tablets of Diazepam". This I didn't expect. When I gave it some thought, I realized that whenever I heard of suicide in the news, it was usually a young man or woman, sometimes a middle-aged person, but never an elderly person. I thought of Ms. Cohen and my heart ached with pity for her, thinking of the different reasons that could lead an 80-year-old woman to attempting to take her own life. I couldn't imagine what pain and hopelessness she must have felt. After a few moments of thought, I left the room, prepared all the necessary phlebotomy supplies, took a deep breath and made my way to Ms. Cohen's hospital bed.

It was wintertime, and as it unfortunately happens in many internal medicine departments during this time of year, the department was in full capacity. It was full of patients who suffered from pneumonia or severe Influenza, and there wasn't a vacant bed for Ms. Cohen in any of the rooms. She was placed in the corridor, right in front of the nurses' station so she could be easily observed, behind a white room divider that wasn't really effective in keeping her privacy. A man was sitting next to

[2] The name has been changed to maintain confidentiality

her. I was told he was a guard assigned to watch her, which is a hospital policy in cases of suicide attempts, designed to prevent patients from trying to hurt themselves again. However, the guard didn't seem to care too much about Ms. Cohen's suicidal intentions, as he was staring at his phone and wasn't even looking in her direction.

Standing there, I was unsure as to how to start a conversation with her. Every opening line that I could think of seemed inappropriate or even foolish. I assumed one must be provided with special training and acquire certain skills for the management of suicidality, and probably some experience would also be useful, and I had none of those things. I had absolutely no idea what to do.

I was also worried about timing. I knew I was expected to complete this task fairly quickly, in order to have enough time left to draw blood from another patient or two before the 08:00 AM morning meeting. However, I couldn't just introduce myself, draw blood while completely ignoring everything that happened to Ms. Cohen, and then leave. I felt it was almost inhuman, a feeling that grew even stronger when I noticed she was there all alone, without any relatives beside her. *Maybe she needs someone to talk to? Someone to share her feelings with after the overwhelming experience she has gone through?* I thought to myself. *But then again, maybe she doesn't want some stranger to start asking her questions? Maybe she just wants to be left alone?*

I took another deep breath and approached her bed.

Ms. Cohen lay quietly, looking frail and tired. She was very thin, with bright brittle hair and a large hematoma around her right eye. As I came near, she looked at me with her sad, sleepy, brown eyes.

"Hello, Leah", I said. "I'm Keren, a medical student, and I came to draw blood from you today. How are you feeling?" I asked and set by her bedside.

"Listen, my dear", she said slowly and clearly. "I am not depressed, and I'm completely clear-headed. I just wish to die". Her straightforwardness caught me by surprise, and I wasn't sure how to respond. I felt so sorry for that woman, and all I had in mind was that I had to do everything in my power to make her change her mind, to give her a reason to keep on living. It might have been quite naïve of me to think that a 26-year-old student will have any influence on the suicidal ideation of an 80-year-old Holocaust survivor she had never met before; However, I was determined.

"There must be some things in your life that bring you happiness, some things worth living for", I said and looked into her sad eyes. "Is there anything that you enjoy doing?"

"Well, I love my job very much", she replied.

"That's a good thing", I smiled, feeling there might be a glimmer of hope. "What do you do?"

"I work as a gymnastics instructor in a nursing home. I enjoy exercising with the residents", she answered, and it occurred to me that it's quite unusual to still be working at 80 years old, let alone as a fitness instructor.

"Wow, that's impressive. That sounds very nice", I said with mixed emotions. I was glad to have found something that makes her happy; and sad to see her lying in bed like this, so weak and fragile, the complete opposite of what she was probably like when teaching fitness classes, so much so that I could hardly imagine her doing that at all.

"It is", she said, smiling sadly, "but it's not enough. I'm tired of this life, and I want it to end".

Ms. Cohen's words broke my heart. I took a moment to think. I didn't know anything about her marital or family status – *Is she married? Does she have any children or grandchildren?* Family can often be a source of comfort and strength, particularly in hard times or times of crisis, and can give one's life a meaning. However, I was hesitant to ask her anything about her family, especially due to the fact that there were no family members around her. *Perhaps she has a poor relationship with them? Or maybe she doesn't have any family at all?* I didn't want to bring up anything that could be a sore spot for her, so I decided not to mention it. Nevertheless, I had to keep trying to identify positive things in her life, something to hold on to.

"I'm so sorry to hear you say that, and I wish you didn't feel that way", I finally said. "I know life can be hard, but there must be some good things in it, too. Please tell me more about your hobbies and interests. What do you enjoy doing in your leisure time?", I asked Ms. Cohen.

"I like reading, I enjoy classical music and I love to paint. I used to paint professionally when I was younger", she gazed at me with a dreamy look in her eyes.

From there on, the conversation was flowing quite well. We talked about our shared love for books and art, and I listened as she spoke about her favorite writers and composers. She told me more about her paintings, describing some of them in detail, and for a moment I thought I might eventually be able to persuade her to reconsider her decision.

I held her hand and said "It seems you have so many passions, Leah, things that make you happy. Please try to stay strong, please don't give up", I pleaded with her.

"I don't want to be strong anymore", she said, making me realize that maybe she didn't want to be convinced, at least not at that moment. She told me briefly about her early

childhood during World War II, living with her family in the forests of Poland after they had joined a group of partisans. "You see, my life has been too hard, and I've had enough", she concluded. "And now, my dear, could you please bring me a glass of water?"

Her request somehow reminded me of the blood sample I had to take, and I realized I wasn't at all aware of the time. A quick look at my watch showed it was already eight o'clock, and I haven't even drawn blood yet, but I couldn't refuse her request. I headed to the kitchen, right by the exit, and filled a disposable plastic cup in cold water. She thanked me and had some slow sips.

"Leah, I'd like to draw blood from you now, if that's OK. I promise to do my best so it won't hurt", I tried to sound as confident as I could.

"Yes, of course", she said and stretched her right arm forward. I failed at my first attempt, but the second one was successful, and by reading her facial expressions I was quite sure I didn't cause her much pain. This was a relief, as the last thing I wanted was to cause that woman more pain than she already felt.

"Leah, I need to go now", I said, although I didn't really want to leave her there on her own, with just the indifferent guard by her side. "Think of our conversation, and please don't give in".

"What is your name?", she asked and took my hand.

"It’s Keren", I replied.

"Keren, you are a sweetheart. I will always remember you", she said slowly, looking straight into my eyes, and I felt it was a sort of a farewell, not sure if it was meant just for me or for the whole world.

It was 08:10 AM. I headed towards the meeting room, but my heart was still by Ms. Cohen's bed. Her last sentence filled my heart with sorrow. I had a strong feeling that she was saying goodbye for good, and there was no one there to hold her hand but me, a complete stranger. I couldn't help thinking that this might be the last time I'd see her.

As I was about to enter the meeting room, I met my friend outside the door. She noticed I was missing and went outside to look for me.

"Is everything alright?", she asked, and I burst into tears. I told her briefly everything that had happened, and she gave me a consoling hug.

"Let's go inside, so they won't get angry at you for being late", she said. "Tell me the whole story in detail as soon as the meeting ends, I really want to hear it".

We went inside and I tried my best to go unnoticed, which was practically impossible as the room was small and crowded. As I made my way to an empty seat at the far end of the room, I could feel some of the doctors' dissatisfaction by the way they were glowering at me. Although nobody made any comments about my lateness, I certainly felt embarrassed. I suppose most people feel embarrassed when being late for a meeting, especially if they are given a look of reproof from their supervisor, and even more so when they try to make a good impression, like I did. From the moment the clerkship began, I performed all the tasks to the best of my ability and tried to meet expectations, and I was afraid that all my efforts and hard work might go down the drain. It's a well-known thing that tardiness is considered an act of disrespect, rudeness even. I was quite positive that when I entered the room at 08:15 AM, the members of the medical staff simply assumed that I went to buy a cup of coffee, made a personal call, or just didn't care. But the truth was that I cared a lot. I cared about an elderly patient in distress, lying alone in a hospital bed, wishing her life were over.

The next day, I went to visit Ms. Cohen. I panicked for a moment when I didn't see her bed in the corridor, thinking of the worst-case scenario, but a quick check in the computer reassured me that she was transferred to one of the rooms. I breathed a sigh of relief. I approached room no. 2 and immediately noticed her. She sat on the edge of the bed closest to the door, looking better than the day before. She was still weak but appeared slightly more vigorous.

"Hello, Leah", I smiled at her, "how are you today?"

"I'm fine, thank you", she replied.

"You look good today, I'm so glad to see that you begin to regain strength! I was so worried after our conversation yesterday", I said.

"I'm sorry, but have we met before?", she asked and looked at me, confused.

This I certainly didn't expect. *Has she really forgotten everything that happened yesterday? Does she have no memory of our conversation at all?* Her words kept ringing in my head. She had promised she would always remember me, but eventually, she didn't. I realized that she was probably still under the influence of the many Benzodiazepines she had taken, but nevertheless, I couldn't help feeling truly disappointed.

Even though I wasn't at all experienced with situations like these and wasn't exactly sure how to handle them, I thought I had managed to touch her heart. I felt our conversation was meaningful, and I hoped that my words made a difference, even a small one. She, however, had no recollection of what seemed to me as such a meaningful interaction.

It is an indisputable fact that each person experiences things differently, and perception differs between people since each of us has a different set of attitudes, beliefs and values, individual personality traits and a different cultural background. Nonetheless, does it make sense that a shared experience, especially an unconventional one, will have such a fundamentally different effect on each of the people involved? Can an experience be so impactful for one person, and completely insignificant for the other?

It occurred to me that as part of a healthcare team, you spend most of your time helping people who suffer from an illness, lying in a bed in the unnatural environment of the hospital ward, probably in pain, possibly anxious, confused or scared. During their stay, you take a medical history, perform a physical examination, take different tests, diagnose their medical condition and provide treatment, give explanations and answer questions, listen to their concerns and try to give them a comfortable feeling. Thus, it's only natural to think that you can make an impact on your patients. *However, what if it's not always the case? Perhaps we don't always have such a strong influence on others as we might tend to think?*
Immersed in my thoughts, I almost forgot to answer Ms. Cohen's question.

"Actually, we did", I said carefully. "I'm Keren, a medical student. I came to draw blood from you yesterday and you told me about yourself and your job, and we talked about the paintings and the books… Remember?"

"I'm sorry, my dear, but I'm afraid not", she replied. "You seem very nice, come and sit next to me", she said, and I took a chair and sat by her side, trying not to show my emotions.

"Do you want an apple?", she asked, and pointed at a bowl of fruit on her bedside cabinet. "There are clementines, too".

"No, thank you", I politely refused. "So how are you feeling today?"

"Better, I think", she answered. "A few staff members of the nursing home where I work called me today and inquired about my well-being. That was very nice of them".

"Absolutely, it's really heartwarming", I agreed. "It's always nice to feel that people care about you", I smiled at her.

"You're right", she said with a half-smile.

Once again, I pondered whether to ask Ms. Cohen about her family, or enquire if someone came to visit, but eventually I gave it up. She seemed in a better mood, and I didn't want to hurt her. We spoke for a little while longer, and at some point she lay back in her bed.

"Are you tired?", I asked.

"A little", she admitted.

"So, I'll let you get some rest", I said and got up.

"Thank you, my dear", she said, looking straight into my eyes. "You are very kind, Keren. It was nice talking to you".

"The pleasure was all mine", I said with a smile, "I enjoyed our conversation as well. I'll come again tomorrow, alright?"

"I'd love that", she returned a smile, and it was the first time I saw her genuinely smiling.

I waved her goodbye and left the room. None of us mentioned the suicidal thoughts nor the suicide attempt. She was the one who brought up the subject last time, and I wasn't convinced that bringing it up myself would be a good idea, and frankly, I began to think that maybe there was no use in doing so. We had a pleasant conversation which seemed to cheer her up, so I thought I'd better not discuss it with her again this time.

Thursday was a busy day. We had a few lectures, and a training session to improve our clinical skills. Each student was assigned a patient for the purpose of taking a comprehensive history and performing a thorough physical examination. Then, we had to document all the information and findings and present our notes.

In the early afternoon there was a short break in the schedule, so I took advantage of it to go and see Ms. Cohen. I was heading to room no. 2, but when I got to the door, I saw a man standing beside her bed. He looked in his fifties, his black hair started turning gray and his face was expressionless. *Maybe it's her son?* I thought to myself. Ms. Cohen noticed my presence and looked at me with her soft eyes.

"Hi, Leah! How are you?", I asked, still standing at the door.

"I'm fine, thank you", she replied.

"I came to see you as I promised, but I see that you have a visitor, so I'll come back later", I said, smiling.

"Hmm… Do I know you?", she asked, and her words hit me like a punch in the gut.

I couldn't believe this was happening again. I felt my mind and my heart were at conflict. Rationally, I was almost positive that the fact it happened for the second time proved that this short-term memory loss could be attributed to the amnesic effects of Benzodiazepines. Emotionally, however, I was frustrated and even slightly offended.

"I'm Keren, a medical student", I replied, trying to hide my feelings. "I came to visit you yesterday, to see how you were, but you were a bit tired so perhaps you've forgotten. I don't want to interrupt, so I can come by another time, if you like".

"OK", she said and smiled at me, while the man stood still and said nothing.

Later that day, I sat at the computer again. I figured that even though I had already had two encounters with Ms. Cohen, I didn't know much about her, so I decided to review her medical records in more depth. Reading the notes, I discovered she was generally healthy and had no underlying medical conditions, neither organic nor functional. She had no underlying cognitive impairments of any kind, but the Diazepam overdose caused acute cognitive deficits, and its effects on her memory functions were particularly evident. Her body was struggling to handle the high quantities of Diazepam she had consumed, so her neurocognitive recovery was relatively slow.

I noticed a "social worker" section in the medical record, and found a summary of her conversation with Ms. Cohen, which was held on the very same morning. It included a great deal of information concerning Ms. Cohen's social circumstances, that certainly shed light on her story.

She had gone through the Holocaust as a young child in Poland, as she had told me herself. She was divorced and lived by herself in a small apartment owned by a state-held housing company, which provides subsidized housing, primarily for the lower socioeconomic sector of the population. She had a son who was dealing with functional and/or mental difficulties of some sort and reading between the lines it appeared that he was unmarried and had no children. But that wasn't all. I was appalled to find out that she had had another son, to whom she had been very close, who had committed suicide 30 years earlier. Following his death, she made her first suicide attempt. On top of all that, she had a lengthy legal dispute with her neighbors, which was a source of great frustration to her, and a short while prior to her hospitalization the court had given a decision that she couldn't come to terms with. This was the straw that broke the camel's back, and ultimately brought her to try to end her life once more.

In her note, the social worker described Ms. Cohen as a lonely and despaired woman, with no significant sources of support. She concluded that according to Ms. Cohen's request, she would arrange for her to be transferred to an assisted living facility, where Ms. Cohen was hoping to get more emotional support.

I took a few minutes to reflect on everything I've just read. Looking back, I realized I was so focused on finding reasons why Ms. Cohen shouldn't give up on life, that I haven't even asked her what made her feel that way in the first place, why she wished to take her own life. She had gone through so much anguish and grief – first she suffered the agony of the Holocaust as a child, then went through a divorce, and finally

lost her beloved son in tragic circumstances. And if that wasn't enough, it seemed she had to cope with all these life crises, as she herself described them in her conversation with the social worker, without sufficient support. I didn't know what the nature of her relationship with her living son was, but considering the difficulties he had been dealing with, it wasn't unlikely that she was the one who supported him, while he was unable to fulfill her emotional needs.

I was thinking about the times in my life when I had to deal with crises. Even though it wasn't easy, I have always had supportive people around me – my parents, my partner, my friends – who were there for me, who listened to me and encouraged me. *But who was there for Ms. Cohen when she cried? Who held her hand when she buried her son? Who was there by her side when she tried to take her own life after he was gone?*

It was already late afternoon. The sun had already set and a sound of a thunder could be heard from a distance. I was the only student left. Seeing the whole picture, all I wanted was to sit by Ms. Cohen's bed and hold her hand. I passed by her room a few more times, but the man was still there and I didn't want to disturb them, so eventually, I decided to go back home.

Friday and Saturday in Israel are weekend days, and since the clerkship didn't involve weekends, the next time I arrived at the hospital was Sunday morning. After blood drawing and a morning meeting we had another lecture, and although I tried my best to listen, I kept thinking about Ms. Cohen.

I got to her room as soon as I could, but she wasn't there. I was told she had been discharged earlier that morning and returned to her small apartment. For some reason that I didn't quite understand, she apparently regretted the idea of moving to the assisted living facility. *But who is going to take care of her now? Who is going to make sure she doesn't do it again?* I looked at her empty bed, thinking I didn't even get the chance to say goodbye. *She didn't even know who you were, so what difference does it make?* I thought to myself. Well, to me it did make a difference.

My encounters with Ms. Cohen provided me with important insights into the human soul as well as into the emotional and psychological aspects of the patient's medical condition, and our ability as a medical team to discern them.

To begin with, Ms. Cohen's story has made me think of the way doctors or future doctors perceive mental illness.

Only in retrospect have I realized that Ms. Cohen wasn't at all a "psychiatric patient". She wasn't diagnosed with any mental health conditions, wasn't prescribed any psychotropic medications and wasn't known to the psychiatric services. A suicidal

attempt doesn't always indicate a mental disorder and shouldn't automatically be labeled as such.

In addition, my interaction with Ms. Cohen has helped me change my views on the patients who do have mental health problems. I've learned to look beyond mental illness labels and really see the person in front of me – to focus on the person, not their illness. However, I believe some things could have been done differently to make it easier for me to learn this important lesson.

First, a better choice of words could have been made. Language shapes our perception of reality, and to me, the term "psychiatric patient" was intimidating and daunting. Many mental health organizations around the world call to change the terminology used to describe mental illness. Instead of using the terms "mentally ill" or "psychiatric patient", they offer new terms such as "a person living with a mental illness", "a person with mental health issues" or even "a user of mental health services". These new terms show more respect and increase the tolerance towards these patients, and by using them we could reduce the stigma associated with mental illness, particularly among physicians and medical students, and avoid perpetuating stereotypes.

Secondly, I believe it is essential to teach medical students about the major and common mental disorders before their first interactions with patients, and even during the preclinical years. Mental disorders such as depressive disorders, anxiety disorders and substance abuse disorders are highly prevalent, and students spending a few weeks in internal medicine departments are also likely to meet at least one patient with schizophrenia or an eating disorder. Early improved education and exposure may lead to a decline in stigmatizing beliefs and negative attitudes towards patients with mental health issues. Knowledge is power and understanding those diseases better will help us build more positive student-patient relationships and improve our student-patient communication.

Another thing I've learned is the importance of a strong support system. Caring relationships are important for an individual's wellbeing and have a positive influence on physical and mental health. The lack of such relationships in one's life is associated with depression, anxiety and an increased risk of suicide.

Ms. Cohen was all alone during most of her stay in the hospital, and had no one to lean on, no one to even bring her a glass of cold water. I replayed my first conversation with her in my head. I was focused on her job and many interests and tried so hard to make her see them as great sources of comfort, but she said it wasn't enough. After reading the story of her difficult and complicated life, I could understand why she had told me that. *Can music replace human connection? Can art replace a meaningful relationship with a loved one?* For some people the answer might be yes, but for her it was clearly not the right answer.

Ms. Cohen's story has also opened the door to a discussion about the Holocaust and its long-term psychiatric and psychological effects on survivors and their families. After becoming familiar with Ms. Cohen's life circumstances, it occurred to me that the Holocaust might have been the root cause of her life crises. It reminded me of the tragic and traumatic events that some of my own family members experienced during the Holocaust, and the impact they had on their mental health.

My mother's aunt was sent to Auschwitz, where her mother, sister and nephew perished. She was led to the gas chambers along with other Jewish prisoners, naked as on the day she was born, knowing her end was near. They stood there, preparing for death, but nothing happened. After a short while they were miraculously taken out, as apparently, there weren't enough prisoners inside, so it wasn't "worthwhile" to spend gas when the chamber wasn't completely full. She survived. She returned to her homeland, got married and gave birth to two children, but a few years later she attempted suicide, twice.

My grandmother on my father's side spent time in the ghetto and then in different concentration camps. Her husband was shot to death in a nearby forest, and her six-year-old son was murdered some time afterwards. Later, she was also sent to Auschwitz and eventually managed to survive. She immigrated to Israel, remarried and had my father, but suffered depressive episodes, one of which led her to admit herself into a mental health hospital.

Ms. Cohen was only a little girl when the war broke out, but she neither told me nor the social worker what she had actually been through during these years. *Maybe she was torn from her family? Perhaps they were shot in front of her eyes? Or maybe she had suffered other horrific experiences that she couldn't recover from? What if it disrupted her ability to maintain a healthy relationship or to mother her children, which ultimately affected their own mental health? And perhaps her childhood trauma and everything that followed resulted in such substantial emotional distress that could no longer be tolerated, and there was nothing we could do about it?*

All of the above made me realize that people have the right to life, but they also have the right to die. It may seem counterintuitive to our fundamental duty as physicians to preserve and protect life, and might raise ethical and moral issues, and yet, one has autonomy over one's own life. There's no doubt that the medical staff must offer the best patient care and do everything in their power to provide support and maintain hope, but the final decision is in the patient's hands. It can be a patient with aggressive cancer who refuses chemotherapy, for instance, or a patient signing a DNR order. We need to discuss patients' preferences and choices with them, make sure they understand all their meanings and consequences, and if they do, we have no choice but to respect their decision.

Ms. Cohen wished for her death, and I made every effort to persuade her to choose life. However, sometimes choosing life can also take a toll. *Who was going to help her deal with the pain she had been feeling? Who was going to support her through her struggles in life?*

Following my encounters with Ms. Cohen, I've recognized the critical importance of seeing the patient as a whole person. That is, not only meeting his medical needs, but also his emotional ones. Not to look at the patient as a composite of symptoms or a medical problem to be solved, but to adopt the holistic approach encompassing his/her values, beliefs, psychosocial issues and individualized needs.

Unfortunately, doing so often conflicts with the physicians' many duties and responsibilities. They have a responsibility to treat and monitor 30 and sometimes even 40 or 50 inpatients, many of whom have numerous underlying chronic diseases and complex medical histories. Physicians working in internal medicine departments often suffer from high levels of stress, resulting from heavy workloads and extended working hours in a stressful and demanding environment, and barely have time to breathe. They don't always have the time to address the patients' psychological and emotional needs as they would have probably wanted to, and not always do they have the patience or energy to do so. This tends to negatively affect certain segments of the population more than others, such as elderly patients, disabled patients or patients lacking support systems.

Therefore, I believe that medical students can contribute to this cause. They have the privilege of not carrying the burden of full responsibility themselves, thus being able to dedicate more time to the patients. Apart from fulfilling their academic obligations and improving their clinical skills, they can participate in patient care by fulfilling some of the emotional needs of the patients – listening to their concerns, keeping them company and alleviating their loneliness. Not only will this benefit the patients, but it will also benefit the students, increase their sense of purpose in the clerkship and help them develop empathy and effective communication skills.

The presence of medical students in hospital departments could also be leveraged to identify suicidality or perhaps even victims of domestic violence who come to seek medical attention. Students can be taught what warning signs to look for, how to recognize those conditions and how to approach them correctly. I've personally heard stories about a few of my classmates who managed to diagnose patients' diseases themselves when the physicians had failed to do so, just because they had enough time to speak with the patients and take comprehensive history.

Thus, under the right guidance, students can add value to patient care and even save a patient's life.

Finally, I've learned that we can make a difference in small but meaningful ways. Many people become physicians because they wish to make an impact, but it doesn't necessarily have to be a long term one. A short-term impact isn't less valuable. Making the patients feel better, showing empathy and making their stay even slightly more comfortable and pleasant – sometimes that's all it takes. And even if eventually they don't remember who you are, at least you know you did the best you could.

My interaction with Ms. Cohen taught me about the complexity of the human soul, about compassion and prejudice, about life and death, and about the power of a human connection.

Well, maybe Murphy's law isn’t so bad after all.

3. An unexpected journey

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At the orientation session on the very first day of our very first clinical year, the Head of School, whom I would later discover is also an oncologist, asked at the very end, "Right, now who's Thomas Swinburn?" Having been one of the last to arrive, I found myself in the front row and slowly raised my hand, bemused and sheepish in equal parts. On that day, in front of the whole cohort, I found out that I would begin my clinical placements with oncology. Little did I know then that this unexpected allocation would expose me to patients who would fundamentally challenge my perception of clinical medicine in this formative stage of my journey towards becoming a doctor. In this essay, I will share the story of my relationship with one of these patients, a Māori man named Ereuti[3].

I first met Ereuti on consultant ward round as I was coming to the end of my first whirlwind week. Until then, I had been largely preoccupied with trying to be helpful to the team and simply keeping up without getting in the way. The medical team bowled into 14B[4], I probably closed the curtain, and it was in that whitewashed room with sunlight streaming in that I first saw Ereuti. He was a gaunt, pale man with sunken eyes sitting silently in a chair in a hospital gown, sprouting various lines leading to various whirring devices. Listening to Ereuti that day, I wondered whether he just wanted to feel a bit of normalcy; he asked us whether the nasogastric tube and catheters could be removed so that he could go home, and what would happen if he did. The consultant oncologist was sympathetic but didn't mince his words: Ereuti could go home but, without the constant infusion of intravenous nutrition, he would be making the choice to go home to die. Ereuti looked into his hands and said nothing.

I found myself in a state of contemplation to the point of despondence as I tried to make sense of the enormity of the decision – the ultimatum – with which our team had just left him. I thought of Ereuti sitting alone in that whitewashed room, literally having to grapple with matters of life and death. Not one of my life experiences gave me even a starting point for imagining what this must have been like. As we continued the ward round, I scanned the faces of my senior colleagues, seeking a knowing look to reassure me that I was not alone in my unease in feeling that was a hard conversation. I did not find that reassurance. It was certainly not because I harboured the impression that this was because the doctors were unattuned or uncaring. Instead,

[3] name and details changed to maintain anonymity
[4] name and details changed to maintain anonymity

I came to wonder whether my attempts at understanding what I perceived as an *extraordinary* situation were met with indifference for the very reason that this was in fact a rather *ordinary* interaction. For us, was 'popping in' to see Ereuti for five minutes to deliver this news a routine call between attending to the patients in 14A and 14C? Was this just all in a day's work?

Later that day, my registrar suggested that I take a history from Ereuti. It feels embarrassing to admit that my initial, visceral reaction was one of apprehension, for earlier in the week I had taken a history from a similar patient, and I had not managed to establish the connection for which I had hoped, making for an uneasy if otherwise polite interaction. Memories of this past experience surfaced at my registrar's mere suggestion. As I walked towards Ereuti's room, I could feel myself carrying my biases down the corridor and conjuring worst case scenarios. I wasn't sure how to manage these thoughts and emotions, so I simply allowed myself to name them as being on my conscience.

As I sat down with Ereuti and we began to connect, it quickly became apparent that our interaction would unfold neither how it had with the other patient earlier in the week nor how I had imagined it this time round. I felt caught between relief and a sense of guilt that I felt relief. That fleeting moment served a powerful reminder that as doctors, despite what we, and perhaps society, might imagine and even expect of ourselves, we are not immune to the human condition. Assumptions and stereotypes shape our interactions and relationships before we have even set eyes on the patient. The totality of our previous experiences, the way we innately identify self from other, and even more simply our basic human needs like hunger and sleep, can subconsciously interfere with our commitments to professional ideals. I don't believe we can totally transcend our human nature as subjective beings, but a good starting point may be the ability to be honest with ourselves about our real emotional reactions.

As our conversation took shape, alongside all the usual questions, I decided to try something a bit different. In medical school, we are taught to ask patients about ideas, concerns and expectations, and in the past, I had seen these as perfunctory, tokenistic questions needed to obtain distinction in end-of-year clinical exams. However, intuition spurred me to ask Ereuti what mattered most to him now. After just a few seconds to catch his breath he replied, "Money and career don't matter now. What matters is regaining health and being able to live naturally again. Being able to eat without this tube in my throat and to move my bowels naturally. Relationships. Not superficial relationships but deep relationships. Relationships where I can be myself. Relationships like the one we're building, you and me."

In the past, actors with whom we had practiced might have responded to such a question with something like "getting rid of this knee pain" or "returning to work as soon as possible", and reassurance with neat, prepared formulas was easily rendered. But here, sitting one-on-one with Ereuti, I wasn't prepared for an answer that felt as though it drilled down to the very essence of what it means to be human, even as I feared that some of Ereuti's wishes might prove impossible to fulfil. Here, I didn't

have any charismatic stock phrases up my sleeve. Here, I couldn't tide the silence with a polite, empathetic smile before signposting into the past medical history. Instead, I remember being both mesmerised and strangely uplifted by his answer. I was struck by his clear sense of priorities, and I was moved by his yearning for dignity and the unwavering resoluteness and certainty I detected in his voice. I sensed that he had had time to meditate deeply on the answer. It almost felt as though he had been waiting to have the opportunity to express his heart's deepest desires.

Over the next few days, I found that I couldn't help but ask myself the very question I had asked Ereuti. Whilst I tried to reason that his perspective on the most important things to him had undoubtedly been influenced by his terminal diagnosis, it was both confronting and refreshing to undertake my own introspection. Whilst Ereuti wished simply for a healthy body and meaningful relationships, the value I placed in academic and career pursuits, often at the expense of spending time with family and friends, seemed shallow and short-sighted in comparison. We've all heard the age-old adage that one learns from one's patients. I didn't just learn clinical medicine from Ereuti. Instead, I couldn't help but be challenged to stop and evaluate my values, the journey I've chosen to travel, and what matters most to me, both now and when the time comes to look back on a life lived. As doctors we have a significant potential to serve, and we have an even greater privilege to be privy to the innermost lives and thoughts of our patients. The doctor-patient relationship is one of reciprocal learning, as is the student-patient relationship. Whilst we give what we can, the insight and wisdom we gain, and perhaps take for granted, is humbling.

When I reflect on our initial conversation, I realize it was the first time I had actually *seen* Ereuti, and the first time I had allowed him to see me. On the ward round, the gaunt man with sunken eyes had been the object of my removed, medical gaze – more than it perhaps feels comfortable admitting to myself. That is not to say that I was devoid of emotion at the time – far from it. However, I did let what I perceived and therefore assimilated as a clinical, professional exterior – a 'thick skin' perhaps – to belie my true feelings and compassionate instincts. It was not until I sat with Ereuti one-on-one, sunlight still streaming into that whitewashed room, that I felt we truly saw each other as people – Ereuti and Thomas. I gave myself permission to be seen beyond my position as the student doctor with a shiny stethoscope and ironed shirt. This opened a relational space in which I could glimpse Ereuti's life beyond his position as the patient in a hospital gown. He was a brother. A son who would be outlived by his mother. A tribal researcher. A father to a son my own age.

In the past, I held a perception that upholding the integrity of the student-patient relationship required maintaining a certain distance. I thought sharing of any personal information on my part would be inappropriate and risk compromising that relationship. I've now come to realize that, despite the professional context, the student-patient relationship is just that – a *relationship* – and relationships are most healthy when both parties feel comfortable revealing their true selves, communicating openly, and, at times, being vulnerable. Of course, legal and ethical standards necessarily exist to define the boundaries and maintain safety, but these need not and

should not impede establishing the connection that is so fundamental to the art of medicine. By becoming too tied up in the showmanship of the formalities and formulas, we diminish our ability to relate as people. The Māori concept of whakawhanaungatanga is often defined as the process of establishing relationships or relating well to others, but its literal translation is more akin to 'the act of making family'. Fundamental to this process is taking time to engage in kōrero (conversation) in order to identify the shared connections that bind people. The student-patient relationship is no exception to this ancient wisdom.

Over the next few weeks, I came to enjoy popping in to see Ereuti, sometimes for no other reason than to say hello. I felt the warmth of his smile as he recognised my increasingly familiar face, and I hope he felt mine. I made a conscious effort to spend just a little bit longer with Ereuti than I might with other patients, whether that was spent sharing some medical knowledge, attending to his comfort, or talking about our shared aspirations: for the bowl of grapefruit sitting on the windowsill to ripen, for Ereuti to return to his tūrangawaewae (place of belonging), for health equity in Aotearoa New Zealand. At times, I did harbour doubts about whether I was acting appropriately. Whilst I felt our interactions were always professional, I worried that perhaps the extra time I spent with Ereuti compared with other patients might be considered unjust. If as a doctor I continued this practice of spending more time with some patients than others, would this equate to inequitable practice? I was able to reconcile this uneasiness when a mentor shared with me that inequity of input is often required to achieve equity of outcomes – put simply, some patients will need more time than others. Sometimes, what looks like privileging one person at the expense of another may actually be an act of equitable practice – a just effort to level the playing field.

Ereuti continued to receive inpatient treatment after my placement in oncology had ended. You can imagine my surprise when a few weeks later, I pulled back the curtain after talking to another patient on another ward, only to find Ereuti in the neighbouring bed, sitting up and dressed in his own clothes with a big smile on his face, waiting to be discharged. He was reintroducing soft foods into his diet and his bowels were moving once again. He proudly showed me a photo of one of his mokopuna (grandchildren) whom he was off to see shortly. In return, all I could offer was my sincerest wishes for his future. As we parted for what I thought would be the last time, Ereuti joked that I could find him catching 'kingi' off the wharf in Kawhia. As the months passed, I found myself smiling, perhaps naïvely, at the thought he was out there fulfilling the wishes he had shared with me in our very first conversation.

That was until I passed the palliative care doctor unexpectedly in the corridor one evening. "Ereuti's back. You might want to visit him, because this will probably be his last time in hospital." I realise now that the gravity of those words hadn't quite sunk in as I made for Ereuti's room, a spring in my step as if I were going to meet an old friend. Pulling open not a curtain but a door this time, it was in that whitewashed room with shadows creeping in that I last saw Ereuti. I had been naïve. Ereuti had returned, but he was gaunt with sunken eyes once more. It was difficult to maintain

composure as a wave of shock then indignance then finally profound sadness washed over me. “It’s good to see you again. I’m at peace with dying… It’s good to see you again,” Ereuti managed between laboured breaths. Whilst a part of me longed to sit with him again, to hear any final existential musings the ‘master’ might have for his ‘apprentice’, the space we once knew and shared had changed. I sensed that he just wanted some time alone. Ereuti had embarked on the final chapter of his unexpected journey. Holding back tears, I said goodbye and we exchanged warm smiles for the final time.

Despite being almost a year since we first met, memories of my time with Ereuti frequently punctuate my thoughts. He was and will always be part of my journey, the stories I tell, and the memories I hold dear. As I reflect on our relationship, I realise that he continues to help me to make meaning of the world, both within and outside the hospital. I feel privileged to have learnt so early in my career that the practice of medicine lies as much in sharing our common humanity as it does in prescribing and intervening. Sitting alongside penicillin and morphine, asking and listening are among the most essential tools in our medicine cabinets. Sometimes, a simple smile is top-shelf medicine. Whilst I have no doubt that the plethora of lines and devices contributed to Ereuti walking out of hospital, at least for a time, so too did the simple gestures of kindness of the medical, nursing, and support staff.

My time with Ereuti ultimately showed me that it is perhaps not our technical skills but rather our ability to be present with a person in their vulnerability and distress that is one of the greatest gifts we can offer. After all, as humans we are hardwired to connect and to care. My experience is that medical school often focuses on teaching the former – the ‘hard skills’ – and these undoubtedly have their rightful time and place. Yet this must not come at the expense of nurturing the latter – the ‘soft skills’ – within each of our natures, for it is these abilities that ultimately distinguish technicians from clinicians. Fortunately, these essential attributes are neither novel nor esoteric conceptions, but rather are basic skills we all possess and develop throughout our daily lives.

Therefore, medical training need not take a didactic approach and treat these skills as an *external* ‘body of knowledge’ to acquire, as may be appropriate for other subjects. Instead, students should be supported to tap into their own *innate* desire to connect with, take an interest in, learn from, share with, and care for their patients. This may allow students to hone what are, after all, fundamentally human instincts as they navigate professional settings, particularly the doctor-patient relationship. Importantly, students should feel empowered to develop their own unique perspective on, and approach to, the student-patient relationship, which will naturally vary between patient to patient, and may shift and evolve throughout one’s life. Of course, some universal understanding of this dynamic is desirable and indeed essential, but our collective strength as a profession lies in the diversity of our life experiences and the resulting diversity of outlooks each of us brings to this special relationship.

I have come to appreciate that one of the joys of medical school is that it provides a rich experiential milieu in which to learn both the science and the art of medicine. The clinical years in particular are analogous to a 'medical sandpit' in which we enjoy relative freedom to seek out experiences that teach us about the nature of medicine, about others, and about ourselves. It is often unscheduled, unexpected encounters that can lead to the greatest personal and professional growth; I can certainly attest that my relationship with Ereuti taught me far more than any formal teaching could. These moments can also be the most confronting and the most challenging. During the clinical years, it is thus essential that students feel well supported by both formal and informal avenues to interpret and learn from these formative experiences in order to make the most of this unique period of apprenticeship in medical training. Empowering students to draw on their human skills, supporting them to make sense of and grow from pivotal experiences, and facilitating the development of their unique approaches to the student-patient relationship, along with the confidence to adapt those approaches to the needs of different patients, may be key features of effective medical training. These are the things that may ultimately enhance students' state of awareness and ability to be fully present, allowing them to become the doctors they wish to be, and to reach their full potential as health*care* professionals.

When I set out on the very first day of our very first clinical year, I thought medicine was about diagnosing and treating disease. Through walking alongside Ereuti on his journey, however fleetingly, I am privileged to know now that it is about much more. As I embark on my own unexpected journey, whilst there are many technical skills to learn, Ereuti showed me that sometimes it is the human qualities we all possess that are the most powerful medicine.

Chapter 1

1.1 Balint core values: cohesion and flexibility: from small groups to the IBF

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Abstract

Is there still cohesion between Balint work in the fifties and what we are doing today? Going to a Balint group takes time, does it really help caregivers? Are Balint groups still worth it? Medicine has changed, there is more scientific evidence and technology has advanced, the family doctors have given the way to general practitioner, isn't it better to go to an academic course to increase her knowledge?

And wat about such a "big group" like the IBF? How can we continue effective cooperation? We have minimal criteria, is it enough? Do we share the same core values? What are they?

Is the IBF unity a myth? What's the place of gossip in our field? The pandemic and the increasing number of members could lead us to a crisis. How can we go through it without meeting "in person"?

I'm the 2nd child of a family of 4 girls where the oldest had Down's syndrome and also had a tetralogy of Fallot; actually, she was blue! My professional choice was obvious: I will repair the trip that life had done to my family, I will be a doctor and cure people! Soon after the beginning of my career, I realized that this was often an impossible task. I was faced with suffering, death, my own fears and above all my helplessness. Then, fortunately, I discovered the Balint groups…

It is also his personal history and the external realities which conditioned the intellectual approach of Michaël Balint, born Mihaly Bergsman: son of a general practitioner with whom one can suppose that the relations were difficult, of Jewish origin, he changed his name, religion and country in a period when psychoanalysis upsets patterns on one hand and when Nazism forced him into exile on the other hand.

When with his 3rd wife, Enid, he created his first group, it was a period of crisis. The scars of war were strongly present in society and in the body and soul of all the people. Doctors, who were almost only men, had to face the trauma caused. The idea of Michaël Balint was that family doctors probably had specific skills and were able to help many of their patients. The training was more about a know-how than theoretical knowledge. That is why it wasn't a master class but a mutual "training cum research".

Is there still cohesion between Balint work in the fifties and what we are doing today? Going to a Balint group takes time, does it really help caregivers? Are Balint groups still worth it? Medicine has changed, there is more scientific evidence and technology has advanced, the family doctors have given the way to general practitioner, isn't it better to go to an academic course to increase her knowledge?

The majority of doctors are now women. Perhaps partially because of that, private life seems to be as important as the professional one. The doctor is no longer on a stage and patients can find many things on the internet. At the same time, we have seen with the COVID pandemic, how human relationships continue to be so important. Then why are there so many burnouts in professional health care? No more "medical vocation"? For me, one of the reasons is the lack of purpose in our life. Money and performance (even in science) are not enough to fill one human life.

Couldn't people become "good doctors" without going to a Balint group? Not to mention doctors working without any sensitivity, only "technically" because of extreme specialization or because of economic reasons, those are "medical providers" as Philip Herzog told us in our last leadership conference, it's a pity!

Caregivers are like everyone: simplest is easiest, guidelines based on evidence are probably less scary than questioning ourselves with a why? What about me? What about the others? Taking part of a Balint group, pooling our existential anxieties soothes them and it's one of the goals. Our differences feed this work, embracing these differences is not easy as, for me, it was not to be the sister of such a stigmatized person¡

"*…the professional identity crisis of so many practitioners who want to participate in a Balint group could be a part of their motivation or could emerge while participating in such a group*" write Hélène Openheim Gluckman(1). Understanding what we are doing as medical doctors, why we are involved in this career, what's the place of human relationship in our work as in our life, that of fantasies (ours, those of patients), how to keep the difficult balance between our professional ideal, the role society (generally speaking) wants us to fulfil and the necessity to have a personal existence, is more acute than ever.

A Balint group is a place where you can explore these questions. You are not alone in this quest. The members of the group are trying to apprehend what is going on with our patient and to improve the link if possible, to understand the sufferance and the request of that person. As much as possible, "**the case of one become the case of all**"(2). What is offered in a Balint group is the opportunity to work on our own behaviour as a caregiver through the unconscious of the group (the transference and countertransference, using metaphors). The group helps us to admit and endure negative transference without taking it for ourselves. It's, therefore, easier to accept sadness and disillusion and consequently find the "good enough" distance. It allows us to be more aware of our "apostolic function" and to gain more flexibility in our connection with a specific individual but also with our place in society. This could give more meaning to our being and make us more aware and stronger. Perhaps thereby we could become a better doctor because allowing us to better support the patient and sometimes to understand where the root of the problem could be, taking into account as physical as psychic problems and their interconnection. This is valuable!

Once in the Balint group I have been leading with my co-leader for years, tension and aggressiveness emerged at the beginning of the COVID crisis. The reason was the different thoughts and approaches of this period of time. We were afraid that the group could fall out and separate. On the contrary, in the following session, one of our participants started with, I quote "It took a long time for me to think about what happened last time. I had to be out of the group for a moment to realize that we have dissimilar realities. It doesn't mean I have to lose my identity but just admit that the way each of us looks at life comes from his own window with his own landscape". This example shows the relevance of afterthought! Usually, it takes time to understand what's going on with us, the group is the witness of the evolution of each other that's why regular attendance is so important.

A dangerous myth could be considering people involved in Balint groups "above the fray", more kind, more able to face adversity, avoiding anger and jealousy, only "good people"! Being blind to these aspects could lead to a predicament! "*According to Balint, you can't acquire psychotherapeutic know-how without the acknowledgement of tough and unpleasant discoveries of your own limits and those of the others as well. That makes a group crisis as inevitable as necessary for the participants and the leaders 'evolution. (..) The lack of crisis is worrying. It could testify to defensive elements that Balint names "defensive mutual admiration*" (1).

We have to be ready "*to take the risk to be transformed by the other*"(3) and sometimes to be shaken in our "certainties", even if it doesn't seem very fun. That's where I see **flexibility** but if we aren't able to sit together and speak about our cracks, then flexibility could lead to reach a breaking point.

It could be a too demanding task unless we mention that the **cohesion** of the group and its brotherhood, create a warm atmosphere of both tears and joy. As the member of our group said, it's also important to keep cohesion in oneself: no radical

transformation but "*a minimal but considerable change*" (4). Of course, we can find these values in other humanistic disciplines such as philosophy and spirituality, generally speaking. The task here is an improved interaction with a patient. The specificity of a Balint group is that it is a group of peers supervised by a couple of facilitators who serve as an identifying model from which the participants will have to differentiate themselves in order to have their own originality. There is no threat to you if you dare to tell your weakness, your stupidity, your mistakes. Confidentiality and confidence in the group are undoubtedly required and are on the shoulders of the leaders. These values are important. The training and supervision of these leaders is therefore essential.

And what about such a "big group" like the IBF? How can we continue effective cooperation? We have minimal criteria, is it enough? Do we share the same core values? What are they?

Yuval Noah Harari in his famous book "Sapiens" (5) says that *Homo sapiens* is primarily a social animal and that gossip is key for social cooperation (knowing who hates you, who is sleeping with who, who is honest…). According to him, to keep harmony *"there are clear limits to the size of groups that can be formed and maintained in such a way. In order to function, all members of a group must know each other intimately. (…) Most people can neither intimately know, nor gossip effectively about, more than 150 human beings. (…)* (To) *manage to cross this critical threshold,* (is possible) *by believing in common myths."*

Is the IBF unity a myth? What's the place of gossip in our field? The pandemic and the increasing number of members could lead us to a crisis. How can we go through it without meeting "in person"?

What is a myth? *"A myth is a fable that we take seriously,"* says André Comte-Sponville, a French philosopher (6). *"A narrative which, in an allegorical or metaphorical mode, aims to answer contradictions, questions, in particular, those of the origins" (7)* write Roland Chemana and Bernard Vandermersch, two psychoanalysts. *"Mythology is a constantly renewed translation of main collective principles which govern humanity beyond time and space"* claims Joël Schmidt, historian and writer (8).

Gossip is possible through email and of course through social networks in our IBF family as everywhere else! According to Yuval Noah Harari again, it looks like a good point! Indeed, gossip maintains the link and avoids indifference. We just need to be careful not to hurt people, which is easier to repair when you can share a drink together. It's also valuable even if a bit tricky, to bring these comments back to the group, as a result this last could keep coherence and grow up!

Bion explained that in a group, there are two levels: one is rational, focused on a task with rules, roles, aims…It's the place where difference is acceptable. The second level

is unconsciously full of phantasms, emotions. The group mentality wants to show uniformity and is more afraid of diversity. A big group desires to be united in a collective ideal embodied by its chief. (9) This could kill creativity or worse lead to dictatorship!

Michel Delbrouck (10) inspired by René Kaës writes: "The institutional psychic apparatus is made possible thanks to a community of renunciations, to unconscious alliances and to denial pacts: we all agree to collegially renounce destroying the fundamental principles that govern institutions, society and particularly to not necessarily castigate its founders (kill the father) but to improve and maintain in a healthy way the founding information of institutions (laws, rules, charters, etc.).[…]The attacks of the frame, the non-respect of the rules, the breaches of the codes constitute as many signs of the negative pact thus emerging from the unconscious of some individuals with the risk of extension to the group."

Our external realities are different depending on our country of origin, our cultures, our practices. We are not identical. The balance between cohesion and difference is therefore delicate. To maintain it, groups like the IBF also require "ritual ceremonies" (or Totemic meal referring to Freud) like this congress. They are essential to maintain our togetherness and to avoid confusion. Human beings need sensoriality. In our small groups as in this large group that constitutes the IBF, a warm climate, even in times of silence, allows the stream of life.

Speaking of Odysseus and his return from the Trojan War, Jean-Pierre Vidit writes: "Isn't Homer's genius to show us that conflict is at the very heart of man? ... he [Ulysses] had to deal with thoughts of guilt, shame and remorse at the awareness of his destructive ardour ..... To restore harmony in Ithaca, you must first be yourself in harmony or, failing that, do whatever it takes to find it again ... This change must pass, as with Ulysses, by a time of pause ... Then, helped by other ideas, he will find the necessary resources for this renewal ... "(11)

These times of change are times of pause. We therefore need to be imaginative to reinvent ourselves without losing our soul. We've started successfully with several zoom meetings. Other paths remain to be explored. This involves courage, curiosity, work, will, patience and mutual respect. It takes time and the result often provides more questions than answers. Doubts and contradictions are on the road. **Human relationships, confidentiality, safety, respect, no judgment, flexibility, awareness are our core values, they matter most**, **they give cohesion to the IBF**.

People need to give life a meaning. "*Whoever has a "why" can take any "how*" says G.W. Allport (12). My sister showed me how taking care is so important although curing is so often impossible. She has taught me to look beyond the first impression, she's taught me that cleverness, wisdom doesn't come only from our brain but also from our heart, she's taught me to open myself to others, above all if they are different.

She died at the age of 20 and I still miss her!

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1.2 Let's talk about pushback

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Abstract

The use of pushback is currently presented as « the » way of leading a Balint group. In France leaders follow the original method of leading a Balint group, without pushback. In this presentation the authors question the use of the pushback and discuss its consequences. To pushback, or not, can have different effects on the group process: on the presenter, on the participants, and on the role of the leaders. The authors propose that leaders consider the use of pushback with flexibility - more as a tool than a rule.

Introduction

The theme of this Congress invites us to reflect on the sense of some adaptations introduced in the way we lead Balint groups. Among these adaptations, the pushback is currently presented as "the" way of leading, as if the Balint group process had always been this one, namely:

1/ the presenter brings a case
2/ the group ask some factual questions
3/ the presenter is asked to pushback
4/ the group works on the case while the presenter stays silent and listens
5/ the leaders invite the presenter to come back and to talk if he wants to.

In France, the usual process is similar to the Balints' original model:
1/ the presenter presents a case, without interruption.
2/ the leaders invite the group to work on the case: the participants can ask questions, speak of their fantasies in whatever order they want.
3/ the presenter stays in the group. He is free to participate in the discussion.

We have precious reflections by A. Tyndale, J. Salinsky, D. Watt and A. Elder about these different ways of leading a Balint group [1-3].
Rather than examining the points "against" and "in favour" of the "sitting out" model", we'd like to propose a reflection about the impact of pushback on the group process and the role of the leader, at each step of the process.
Our aim is to bring back Balint core values into the discussion during these "transitional times" in order to enlighten our understanding of "flexibility" and to reinforce cohesion based on "*an agreed conceptual framework for the difficult task of Balint group leadership*» [4].

The presenter "pushed-back"

In the "pushback model", the presenter knows that he will be given just one occasion to present the case and its key elements before being silenced by the pushback.
How does this rule affect the presenter's thoughts and the way he presents the case?

Balint proposes that we treat the presentation of a case much as we might treat the narrative of a dream: with its omissions, changes of direction and ambiguities… this is the material of the group's psychic work, its free associations.
This invitation to free association could be given to the presenter at the outset of the case narrative. In Freud's own words:
« You will observe that, during your narrative, various ideas will arise, ideas that you would like to reject because they have passed through the screen of your criticism (…) Do not give in to this criticism and speak despite everything, even when you are reluctant to do so or precisely because of it ». [5].

In the pushback situation, the presenter is no longer part of the discussion: he is deprived of the possibility to spontaneously add information and/or to share his associations with the group. It's the time of profound listening to the associations and emotions of the other participants, and also to his own emotions.
It is assumed that the presenter will be in a good condition to listen to the group work and to think about the case, but is this so? Perhaps we should consider that the presenter might experience this position rather differently? He might feel side-lined, sometimes criticized or judged by the group, without having the possibility to respond or interact.
A medical student once compared the pushback situation to the way patients are treated during the "professor's visit" in the hospital: we talk about someone "as if" he was not there! It could sometimes be experienced as violent! "

The pushback is supposed to protect the presenter from being "bombarded" by the group's questions and to provide him time to be in contact with his inner feelings. Isn't protecting the presenter (and the other participants) from intrusive questions part of the leaders' task?

On one hand, this point is linked to the group atmosphere, to the way in which each participant expresses himself, asks questions and makes comments… On the other hand, the way participants act and the way the presenter experiences these interactions can also reflect an aspect of the case and/or of the position the presenter takes in his relationship with the patient.

Sometimes very emotional cases are presented to the group. The pushback can then be very protective for the presenter and help the group work.… or not! The presenter may also feel alone if pushed-back: in this kind of situations, being present in the group may help to experience the group's holding capacity, the feeling of belonging…

The presenter "sitting in"

When there is no pushback, the presenter has more time. He knows that he will be allowed to answer questions and add some elements to the initial presentation. Would he have presented the case the same way, knowing that he would be silenced after the narrative of the case?

Throughout the session, the presenter stays in the group: as all the other participants, he can freely associate on the case, saying whatever he wants, whenever he wants. He may feel some "pressure" from time to time, or experience difficulties regarding other participants' remarks. But being conscious of his feelings, observing his reactions to the group discussion is an opportunity to better detect his own attitudes, defense mechanisms, responsive patterns…
Why should the presenter be out of the group to listen to his emotions? During the consultation, he is required to be present and attentive to the patient's needs.
In this sense, "sitting in" during the group work should be seen as a "training" to exercise his capacity to listen to his emotions, perceive his reactions, understand what is going on in the relationship and find the most appropriate attitude to keep in touch with the patient.

The leaders' work in the pushback setting

With pushback, leaders are mainly the keepers of the rules at the beginning of the session. Firstly regarding the time for the case narrative; then regarding the time for "clarifying questions": their amount, their "suitability". Sometimes, to keep this frame, leaders become censors: only factual questions are accepted. We often hear: "maybe you should keep this for the group after the clarifying questions". This is rarely challenged. Could this be compared to a "school master" rebuking a pupil who has not listened carefully to his recommendations?

The leaders' task is also to stop the questions at the right moment: too quickly and the group may have too little information and rapidly go « off track », too late and the participants may have begun to "fantasies" about the case… It is up to the leaders to establish that the group has "enough information" to work on the case.

In the setting of a Balint group, what does it mean to have "enough information?" What kind of information should we have about a case in order to work on it? Should we have, as leaders, a kind of "check list"? Which are the "suitable" questions?

An argument in favor of the pushback is that the group can easily work on the case, instead of asking for more and more information.
But isn't it the leaders' work to point out to the participants that they are questioning the presenter again and again, without bringing their own associations, thoughts and feelings? Isn't it the leaders' task to observe (and to deal with) these particular defensive reactions of the group?

In the pushback setting, these interactions between the presenter and the group – which may give precious information about the doctor-patient relationship- can't occur, except in the very last minutes of the session.

Once the presenter pushed back, the leaders maintain the frame and invite the participants to work on the case. The delicate thing is for them to see when they can bring the presenter back into the group. To avoid this, some leaders propose that the presenter will come back "X" minutes before the ending of the session.
What about the psychic temporality in this strictly organized setting? Doesn't it interfere with the group work? How does the presenter experience this "waiting time"?...

J. L. Sternlieb's suggestion *« (…) is to invite them to return to the group "when they are ready."* » [6]. What are the effects of this solution on the leaders' position and on the group's dynamics?

When the presenter comes back, there is usually a silence. At that stage, isn't there a kind of anxious expectation among the leaders and participants? : "what is he going to say? "have we done a good job?" Do they, consciously or not, wait for a "good appreciation" from the presenter?
The group and the leaders may then become pupils who could be rebuked… they may feel rejected or judged…How much do we think about the impact of these feelings (which are seldom expressed) on the group dynamics?

No pushback: the leaders' work

When there's no pushback, there may be some clarifying questions all along, intertwined with fantasies. Free association is the rule. Leaders may allow themselves to have a free-floating attention.

The presenter's presence enables the group to explore the memory lapses, incongruous descriptions and repetitions in the narrative. The leaders « just » have to let the participants do their part: respect and listen to each other. They have to be attentive to the group dynamics and the patterns of the participants' inter-relationships, presenter included.
Indeed, in the "sitting in" setting, other issues can arise: a one-to-one discussion between a participant and the presenter which excludes the other participants, a flow of questions directed to the presenter who has no way to escape them, invasive questions… In these situations, leaders have much more work to do: pointing out this dynamics, inviting the group to think about its reactions, establishing a link with the case, «(…) *as the detailed interaction between doctor and patient is revealed in the parallel between the reactions of the participants in the group and the presenting doctor*." [4].

Participants in the pushback setting

When there is a pushback, participants have, as ever, to focus and listen carefully to the presenter, but they must think quickly: each of them may be allowed to ask one or two questions to the presenter, rarely more - and it should be a "clarifying" one!

These remarks arouse two pitfalls: the first one has to do with the psychic temporality. The way the participants listen to the case presentation is impacted by the "clock time": they know that they have a short time to react, to think about the case, to let questions come… The second one, is related to the content of the questions: there are "good" and "bad" questions and maybe all the participants don't agree about what "clarifying" questions mean…

This point introduces a major problem: if the leaders undertake the rule of censors, how does the participant who has asked a "bad question" can feel and react? What about the effects of this censure on the other participants' reactions (staying on the background, trying to ask the "good question" to please the leader…)?
Indeed, we should consider the effects of this kind of intervention on the groups' transference and counter-transference movements.

When the presenter is pushed back, participants are invited to free associate about the case. In doing so, they are speaking *about* someone (named "the presenter") who is there, carefully listening, but allowed neither to interrupt them nor to address their comments.

We wonder about some aggressive remarks and comments emerging during the group discussion - owing to the presenter's absence – which are taken for granted as expression of fantasies or associations… Could we make the hypothesis that the main risk is that the group could sometimes derail? That it could have some very fancy

ideas, very far away from the case, without any possibility for the presenter to react or give the group new elements?

We can think that the presence of the presenter in the group may be a boundary for some participants' fantasies and unconscious projections on the case, which are not really related to *this* case… but rather to their *own* questions.

Sometimes very emotional cases are presented to the group. The pushback can then be very protective for the presenter and help the group work.… or not! The presenter may also feel alone when pushed-back: in this kind of situations, being present in the group may help to experience the group's holding capacity, the feeling of belonging…

No pushback: participants

When there is no pushback, a participant presents the case, taking the time to deploy the narrative, without interruption, and then the others ask questions, make comments, associating freely on the case. There is no real segmentation of the work between the presentation and the group work: clarifying questions, fantasies, emotions are all mixed up and can arise anytime.

This can help participants to be spontaneous, to share openly their thoughts, questions whenever they want. In this configuration it may be easier to install a creative working atmosphere.

As they express their emotions, speak out loud their thoughts, share their associations, participants are conscious of the presenter's reactions to these exchanges. This attention to the presenter is a "practical exercise" on how to help someone to look at a situation differently, to adopt other points of view, to take into consideration some aspects, which were not seen before. Exactly as all the participants have to do in real life, in the consulting room, as they listen to their patients.

Final considerations

Has pushback become "a new Balint orthodoxy"? Indeed, if the leaders' training around the world shows this technique as "the" way to lead, what about the Balint core values, as reminded by A. Elder:
«(…) *1) the doctor–patient relationship as expressed to the group by the presenting doctor, 2) the relationship that develops between the participants in the group and the presenter as the case is discussed, and 3) the relationship between the leader(s) and the work of the group*» [7].

If in the group process one cannot observe the interaction between the presenting doctor and the group, how to perceive «*the phenomenon of "parallel process" in which the presenter and the group mirror the interaction between patient and doctor*» [2]?

Is leading a group without pushback more challenging for leaders, less comfortable for the presenter and more rewarding for participants?

Keeping in mind the Balint core values implies that leaders should *also* be trained to lead a group without using pushback. This is not about tradition, but about transmission! If leaders are trained to lead without pushback, it may become a tool, a technique that could be used - or not. Seeing Pushback as an optional tool implies that leaders know why and when to use it and measure the impact of this choice on the group work.
«Leaders must find ways of leading that suit them but know why they make that choice and what the relative merits and drawbacks are of their approach» [4]. If so, pushback could be a tool, rather than a rule.

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1.3 Memories, recollections, traces, dreams: in search of Michael Balint and Anne Cain

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Abstract

This paper examines some key psychoanalytic concepts such as: memory, recollections, traces, and dreams and their use by Michael Balint and Anne Cain in promoting the technique of free association in Balint groups and in the later development of Balint psychodrama groups by Anne Cain.
The paper will explore the tension inherent between the adherence and attachment to core concept of psychoanalysis and its theoretical nucleus, maintaining a coherent and cohesive theoretical framework, and the further flexible use and modifications of psychoanalytic techniques in their application to Balint group work.
This technical flexibility was exercised by Michael and Enid Balint when setting up their research cum study groups at the Tavistock and by Anne Cain in the merging of psychoanalytic psychodrama techniques in her work, which is the foundation to Balint psychodrama.
Clinical vignettes will be used to illustrate some of the ways in which a group might be dealing with and elaborating questions of memory, recollections, traces, authenticity, dreams and free association in the understanding of the doctor-patient relationship, both in classical and in Balint psychodrama groups.

As leaders of Balint and Balint psychodrama groups we would like to look at one of the aspects of psychic elaboration in Balint's work by questioning the place of memory, recollections, traces and in their reference to dreams. "The way the doctor reports about his patient with all the holes and folds in the history, with all the omissions, second thoughts, later additions and corrections, etc., including the sequence in which these are revealed, all tells a tale-similar to the manifest content of a dream- familiar and fairly easily intelligible to us Psychoanalysts. The tale is of course, about the doctor's emotional involvement, his countertransference[5]"

If we wish to walk along the footsteps of Michael Balint, we would also like explore more specifically these aspects in the group work in Balint psychodrama as developed by Anne Caïn[6], a psychoanalyst and psychodramatist from Marseille.

Psychoanalytic psychodrama[7] owes much to Jacob Levy Moreno, from whom it takes the essential elements of his technique developed from the 1930s onwards, but differs in spirit from it. In psychoanalytic psychodrama the play and its dramatization are no

[5] BALINT M., (1966), *psycho-analysis and Medical Practice*., Int.J.Psycho-Anal. 47, p 60.
[6] CAÏN A. (1994). *Le psychodrame-Balint. Méthode, théorie et applications*., La Pensée Sauvage. Grenoble.
[7] CORCOS M. et alia, (2012), *Current developments in the practice of individual psychodrama in France*., Int J Psychoanal 93:561-584.

longer in the service of reaching catharsis, but participate in the elucidation and elaboration of unconscious phenomena and, in our Balint work, highlights certain aspects of the counter-transference of the care-giver.

Before Moreno, Sandor Ferenczi[8], in 1921, described psychoanalytical treatments during which he used, albeit exceptionally, staged scenes of situations experienced by his patients and scenes involving changes of role. During a session Ferenczi asked his patient, a young musician suffering from phobias, obsessive symptoms and from a dreadful stage fright, to get off the couch and repeat a song exactly as she had seen it performed by her sister, i.e. accompanied by expressive and unequivocal gestures. While this will have the effect of mobilizing her affects, Ferenczi adds, "It is amazing how much this little interlude helped the work; memories came to her that until then had never been evoked and concerned her early childhood. "

As psychoanalysts, when one looks at the problem of memory, it is most often with reference to a distant past, that of childhood, which is largely repressed, but leaves, as a testimony, screen memories, reminiscences, and memory traces. The beginnings of psychoanalysis are linked to the discovery of the importance of recalling childhood memories, memories that are often charged with affects or even of traumatic origin. This recollection was then considered likely to provoke healing.

In psychoanalysis, recollection refers to the psychological action that produces a memory in the strict sense of the word. Although Freud did not have an original and unified theory of memory, he made a large contribution to the manifestations of memory. Freud does, however, come to show the need to recognize that there is an unconscious memory, that there are unconscious memory traces, although this term seems insufficient to evoke that memory which is remembered without being recollected.

This memory will appear, among other things, in dreams, but also in symptoms. It is from this observation that Freud developed the technique of free association. Although, associating is most often, if not exclusively, centered on verbal discourse, it should be noted that in a 1913 text Freud[9] understood "by language, not only the expression of thoughts but also the language of gestures".

Gradually, a more important place has been given to different communication channels (verbal, vocal and miming/ gesturing) in the associative process, both in the individual and the group situations.

[8] FERENCZI S., (1921),: *Weiterer Ausbau der „aktiven Technik" in der Psychoanalyse.,* Internationale Zeitschrift für Psychoanalyse. 7(3).233-251,.and (1955), *Further development of the „active therapy "in psychoanalysis*., in. Further Contributions, Hogarth Press, London.

[9] FREUD S., (1913) *Das Interesse an der Psychoanalyse. The Claims of Psycho-analysis to Scientific Interest*., Standard edition. Vol XIII (1913-1914).

Balint's approach is based on free association, but the associating that is solicited and promoted among the group members in response to the presenter's account is a process of association which is focused on the care giver-patient relationship.

The group situation in the Balint group, as in any group, produces specific effects, some of which can be obstacles to free association: to the phenomena of individual censorship are added the normative constraints of the group but also the constraint linked to this focus on the caregiving relationship, the centering on the professional Self of the participants.

Free association, in Balint psychodrama passes not only through the verbal interventions of the presenter and the participants, but more specifically is deployed in the action of the play.

Recent advances in brain connectivity research are providing evidence supporting the convergence of neuroscientific findings and psychoanalysis. Psychoanalytic psychodrama further emphasises the common ground between embodied cognition and psychoanalysis by means of the spontaneous re-enactment of the bodily self in the intersubjective interaction of the participants during performed scenes (Scorolli[10]).

In her theoretical and clinical writings as well as in her practice, Anne Caïn had shown us how much she, like Freud, had remained attached to a conceptualization of memory which could be described as archaeological, but she nevertheless had gone beyond.

In a Balint psychodrama group, the presenter of a case sometimes manifests a certain trouble when he/she is asked to reconnect with his/her first meeting with his/her patient. This proposal will be made by the lead director after the presenter has, as in any Balint group, presented a case. Sometimes the participant comes to the group with the memory of a recent event that has caused discomfort, distress, questioning or an intense affect that marked a recent encounter with his/her patient. He/she may also come with the request to rediscover this singular moment in a psychodramatic play. His/her story will have provoked questions, clarifications, and already a first network of associations on the part of the other participants. Listening to the presentation and the associative channels within the group will regularly prompt the leader to propose to the presenter to reconnect with the beginning of their relationship.

The memory of a first meeting is sometimes very vague, at times so distant. Perhaps the presenter will try, not to find but, in his/her own words, to reconstruct this moment. He/she may also trust a method that he/she had already experienced and that had allowed him/her to realize that it will encourage the emergence of memories. Since

10 SCOROLLI C., (2019): *Re-enacting the Bodily Self on Stage: Embodied Cognition Meets Psychoanalysis*., Front. Psycho., 10-492

Freud's and Ferenczi's earlier work, we know that acts of recognition and remembrance require a certain motor activity.

On numerous occasions Anne Cain had insisted on the movement of the body, on this mobilization which facilitates the memory, or even the lifting of repression: "The specificity of psychodrama appears when the body comes to surprise the speech, allowing the past to establish itself in the present and the repressed to reappear". The play will allow the body to speak, but this mobilization is also an opportunity for the protagonist who finds a lived moment to modify his or her memories as the play evolves.

We have known since Freud that memories are not immutable but are reconstructions of the past that we recreate.

Marcel Proust[11] was close to Freud's thinking, and by describing memories that could be triggered by chance sensations (the sensation of uneven slabs in the courtyard of the Guermantes's hotel, reminiscent of Venice and, of course, the madeleine that takes the narrator back to his childhood in Combray), shows how present and past come together, with impressions of the past impinging on the present.

Memory does not exist without its context, of which the setting and the frame are part. The importance Anne Caïn gives to the setting and the frame is not, however, only linked for her to the fact that it encourages remembrance, or even recollection. Re-creating the decor with objects representing or symbolizing elements from the past is an important element in fostering a wealth of memories. Many of the objects represented in the play are part of the physical world that has been apprehended through movement, explored through motor acts. Anne Cain even speaks of "memory objects". She also writes that: "The placement of simple 'photographic' memories in the scenery of the game becomes the most revealing element of the doctor-patient relationship".

The passage through play and the setting in motion of a body, which for Anne Caïn does not lie, a body that is very close to our historical reality, seems for her to be the royal road (as is the interpretation of dreams for Freud) to encourage the emergence of unconscious elements at work in the caregiving relationship. From this primary material which relates to a first form of memory, the memory subjectively lived, and as such inscribed in time, we move on to another form of memory which is that of fantasy. It is not the memory of an old fantasy, but of a fantasy which is actualized in the present[12]. The highlighting of these fantasies is stimulated by certain aspects of

11 PROUST M., (1927) *A la Recherche du Temps Perdu. Le temps retrouvé*., Editions Robert Laffont. Collection Bouquins, Paris, 1987, Tome 3, pp 702-712.

12 ROUSSILLON R., (2003) *Historicité et mémoire subjective. La troisième trace*., in ; Cliniques méditerranéennes. 2003/1 (67) 127-144.

the method, by dubbing, soliloquies, even by missed acts in the play. These fantasies are not necessarily interpreted in the work of comprehension by the group, and are in no way related to the personal history of the presenter.

Balint psychodrama is trying to find as closely as possible through the play moments that which took place in the encounter between the caregiver and his patient. In thus focusing on reality, it allows the original situation not only to be found and reconstructed but also to be recreated with the participation of the members of the group. The play will also make it possible to highlight the gaps between what the story reveals and what we discover about the care giver-patient relationship, for example in terms of empathy and other unconscious feelings.

Bartlett[13], a British psychologist, wrote already in the thirties: “recollection is not a reactivation of innumerable inanimate and fragmentary traces. It is an imaginative reconstruction or construction that forms the basis of our attitude towards an active globality, composed of past reactions or experiences. The memory is only rarely faithful".

At the end of a group session the presenter of a case, which seemed to us to have been well worked out, allowing her, with the help of the whole group and through several scenes, to better understand certain complex aspects of her relationship with one of her patients, tells us: "in fact I believe that it didn't happen like that in reality". There didn't seem to be any desire in her, pre-conscious or unconscious, to disguise reality. Nor had she given us any reason to think that this intervention could reproduce in the group an aspect of the relationship with a patient that would have left her, after the impression of a good job, feeling disillusioned. She did not question the fact that, despite the distortions that might have been acted out in the scene, she had had access to a more authentic understanding of her relationship, to another less historical truth, one that was relatively close to an emotional truth.

In telling you this we would like to point out that even if psychodrama deviates from a historical reality, it is no less likely, with all the mechanisms that participate in the dynamics of a session, to allow us to be as close as possible to what we may have experienced. It is not only a reconstruction of the past, but also allows us, sometimes even in the play, to be the experience of a transformation and a new elaboration of the relationship. *Thus, the tender gesture of a presenter towards the one who played her patient, a spontaneous gesture and not a reproduction of the past scene, came to tell us all that she had been unable to think and to recognize her feelings towards a patient, which sent her back to an image of herself. This gesture could also be understood as an attempt to make amends to her patient.*

13 BARTLETT F.C., (1932). *Remembering. A study in Experimental and Social Psychology*., Cambridge University Press. Reprinted: 1977. Quoted in: Rosenfield, I. (1988). *The invention of memory: A new view of the brain*, Basic Books. New York. 1988.

Anne Caïn does not seem to have taken up in her writings the recommendation of Michael Balint, for whom the understanding of the presenter's discourse in the Balint group should be considered as the manifest text of a dream. The associative work of the group could thus be likened to exploring and uncovering the latent content.

In a recent Balint group conducted on Zoom, the presenter spoke of her patient: a young woman who, since she had returned to her country of origin on the other side of the world, she also sees on Zoom.

The therapist said she was finding it difficult to feel close to this patient even though her story brought up feelings of empathy and concern for this young woman who was feeling trapped by her family of origin, her domineering father, and the cultural and social expectations from her.

When asked to describe her patient the presenter spoke of a very pretty and dainty young woman who is always beautifully turned out, looking like a little princess.

As the presenter was not able to use the camera on her computer, the group was following her voice only. When the presenter finished her story and became silent, the group became silent too. After a long silence, group members slowly started speaking. The session took on quite a dreamlike atmosphere with long silences and members joining in by throwing very brief comments, after long pauses.

One member said it seemed to him, he had heard the presenter say: "In a far far away land ... once upon a time...". He was quite sure the presenter hadn't actually used these words, but he felt as if he were listening to a fairy tale ....Another member said: "Yes, I had also felt like we were told a bed time fairy tale, we had fallen asleep and were dreaming…" .Then another said that the image of Cinderella came to her mind . The group thought the presenter was in the patient mind like Cinderella's fairy Godmother who had come to rescue her from the situation she was in.

The group then reflected further about what might stop the presenter from feeling close to the patient and how overwhelming might be the expectation of being a Fairy Godmother with her magic wand.

In the dreamlike atmosphere of the group, it seemed to have reproduced the unconscious fantasy present in the therapist - patient relationship: the patient unconscious fantasy that her Fairy Godmother would magically turn the pumpkin into a carriage whisking her away to the awaiting ball, and the therapist unconscious feelings of helplessness and resistance when faced with the expectation of being magically omnipotent.

Here, unlike in a classical Balint group and even more so in a Balint psychodrama group, the body was not present, nor any other sensory experience, except for the voice. The group state of reverie and the regression to the dream like semi-sleepy state, facilitated an associative chain of unconscious images. While being further removed from the reality of the doctor-patient consultation, it nevertheless

allowed the group to find traces of the unconscious fantasy shared between the therapist and her patient.

Didier Anzieu[14] (1975) proposed a model of group understanding based on the dream model. For Anzieu the group is like a dream: the place where the unconscious desires of its members are imagined to come true. Understanding the group according to this model has had an important impact despite the questions it raises (Kaës[15]).

François Berton[16], based on the notion of dramatization, one of the mechanisms of dream work described by Freud, and of stage work, describes Balint's group work in psychodrama as comparable to dream work. He seems very close to Anzieu who wrote: "Human subjects go to groups in the same way as in their sleep they enter into dreams" but he does not however evoke group work as the realization of unconscious desires.

Noël Montgrain[17] also believes that the play in Balint psychodrama "introduces a space, which in many ways resembles the space of dreams". For Montgrain, both the scenery and the staging are "like the diurnal remnants of the dream, which is situated at a confluence of current conflicting reality and unconscious conflict."

The psychoanalyst Thomas Ogden[18] describes clinical teaching and supervision as a form of collective dreaming in which the members of a group individually and collectively enter. His participation in a Balint group in the UK has greatly contributed to the development of these views.

"The experience in the Balint group that I have described has stood as a model of analytic teaching for me. The feeling (palpable sensation) that Dr. J's question, 'Why not have a cup of tea with the daughter?' evoked in me, as I look back on it, was that of a clearance created in which there was time—dream time—in which people may be able to live and dream an experience together. What can happen in that clearance is unique to the situation and to the people living it."

It is deliberately that in this work we have not referred to essential aspects of an understanding of the group's work that determine the production of a case narrative, the associative work of the whole group and the possibilities of case development. The method of free association is, together with transference, the constitutive process

[14] ANZIEU D., (1999), *Le groupe et l'inconscient*., Dunod. 3rd edition Paris.
[15] KAËS R., (2001), *L'analogie du groupe et du rêve : implications et développements*., in : Psychologie clinique et projective. (1), pp 3-16.
[16] BERTON F., (1993), *Le rêve dans le psychodrame-balint.*, in : Psychothérapies. Vol. XIII, 1993, no 1. 23-27.
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of the psychoanalytical situation. The different forms of transferences at work can play an important role in the dynamics of the group and in the elaboration that the facilitators make of it in the aftermath of the session. Furthermore, we have not discussed how the group associative process is a mechanism for relaunching the activity of the preconscious (Kaës[19]).

Through this brief journey we wanted to suggest that our work in our Balint psychodrama group, despite the concern we put into finding and reconstructing scenes from our professional lives as close as possible to what was experienced, is a reconstruction made up of condensed, displaced events, and that this reconstruction mobilizes different forms of memory. If it sometimes comes close to dream work while being a reworking of the original experience, it is likely to bring us closer to the truth of the unconscious affects and conflicts that we experience in our role as care givers. It is also through dreaming that we can have access to an implicit memory, which testifies to our oldest experiences.

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Chapter 2

2.1 A Balint 'training-cum-research' project for trainee psychiatrists and general practitioners in New South Wales

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Abstract

The paper describes the process of development and practice of a trial of a Balint 'training-cum-research' project for trainee psychiatrists and general practitioners in New South Wales. The author and his co-researchers developed this project in the context of two trainee psychiatrist's scholarly research projects towards examination for Fellowship of the Royal Australian and New Zealand College of Psychiatrists, working toward a trial of separate on line Balint groups for trainee psychiatrists and for general practitioners, in New South Wales, Australia, with the researchers working collaboratively under the author's supervision. The paper explores the process up to end of the fourth of each of eight intended meetings of the 'research-cum-training' groups, with cohesion as an ideal and flexibility necessary to construct and carry into practice a research training experience that may lead on to further development of Balint work for these practitioners in New South Wales.

The Brussels 2022 Congress of the International Balint Federation explores the theme—Balint Core Values: Cohesion and Flexibility. The drive for cohesion in Balint clinical reflection group work might implicitly involve an intention to form a group that could stick together, a sustainable working group. The issue of flexibility might arise when those factors considered Balint core values might conflict with the possibility of a sustainable, cohesive, ongoing clinical reflection group, or even with 'training-cum-research' groups as Michael Balint describes them (1), even those with defined and limited life spans like those that were the subject of Parker's & Leggett's (2, 3) research with Australian medical students on clinical rotations in psychiatry.

Efforts to establish a shift in health care culture towards one that is consistent with the Balint core values of patient-centred care, focussing on the emotional and psychological aspects of the clinician-client relationship, may necessitate flexibility with respect to practice, leadership and training in Balint work. This is especially so in settings where there is no established tradition of Balint work; experienced or accredited leaders are in short supply; where tyranny of distance and fears of contamination such as those prevailing during the Covid-19 pandemic prevent or limit face-to-face meetings; where clinicians are working in settings in which health care environment and culture are at odds with what have become the traditions and rules of national societies; and where health care cultures are substantially closed to input from outsiders and defensive of their own hierarchical management, supervisory and quality assurance traditions.

A setting that carries all of these limitations is that of psychiatrist training in Australian public mental health facilities. Looking towards establishment of Balint

clinical reflection work in this context, McKensey & Sullivan (4), provided a group of nine Australian trainee psychiatrists with the opportunity to participate in a series of three ninety-minute Balint clinical reflection group meetings, and then to provide written feedback. This feedback was entirely positive. The researchers reported that the trainees felt supported by their colleagues and helped towards experiencing less stress and anxiety in clinical engagement with their patients. The trainees reported progress towards greater depth of understanding of the patients' experience of doctor-patient interactions. McKensey & Sullivan concluded that, even within the public mental health training setting, a cohesive clinical reflection group could form, enabling psychiatry trainees to make use of Balint work.

My own experience working to establish Balint clinical reflection groups for psychiatry trainees and mental health clinicians in inpatient and community mental health settings (5,6, 7,8,9,10) suggests that cohesion and sustainability are not as readily achieved at McKensey & Sullivan may have hoped. Nonetheless, with a strong emphasis on flexibility, adaptation and innovation, and with the interest in the project initiated by psychiatry trainees, rather than driven by external leaders motivated by their apostolic functions, a current project that intends to be within the tradition of Michael Balint's 'training-cum-research-seminars' is in progress at the time of writing.

Two Australian advanced psychiatry trainees are working to provide themselves with opportunities to be both participant researchers and coleaders respectively of 'training-cum-research' Balint clinical reflection groups under my supervision, one for GPs from all over New South Wales, another for trainee psychiatrists within the North Sydney RANZCP rotational training scheme. My co-researchers Dr Iman Eftekarzadeh Mashhadi and Dr Anupam Punj have consented to being named and having their projects and their experiences in the group meetings and leadership discussions mentioned in this paper. They have offered their critical reviews of it, contributing to its revisions prior to submission.

I previously assisted in clinical supervision of Dr Eftekarzadeh Mashhadi during his training rotation in consultation-liaison psychiatry. Then I served as supervisor for his psychodynamic psychotherapy training case, with supervision initially occurring face to face when we worked at the same hospital, then via Facetime when his training rotation led him elsewhere in the North Sydney network. In the course of my supervision, he was influenced by Balint's thinking and that of other British Independent psychoanalytic theorists. While working together at Wyong Hospital on the New South Wales Central Coast, he became aware of my Balint clinical reflection group work there, regarding which I presented at the 2019 International Balint Federation Congress in Porto (10). He heard more about Balint groups from other registrars in the North Sydney hospitals and clinics who were aware of the work of Sydney psychoanalyst and Balint leader Leonie Sullivan, including McKensey's & Sullivan's pilot project with psychiatry registrars (4).

Dr Eftekharzadeh Mashhadi was aware, through a Whatsapp group for trainee psychiatrists in his North Sydney network, of interest in the formation of an online clinical reflection group. This interest was fuelled by the way in which health service administration has curtailed or closed most face-to-face educational meetings, including my Wyong Hospital Inpatient Mental Health Unit Balint clinical reflection

group (10), other than for those focused on Covid 19 related themes, such as handwashing and use of personal protective equipment. The trainees were expressing feelings of fatigue and frustration at the loss of the educational meetings previously available as a venue for collegial interaction and support, and at the way in which the corporate culture seemed to have moved its focus away from concern about the quality of patient journeys, clinician-client interactions and quality assurance in clinical care, almost exclusively towards infection control measures.

Given that work pressures for me and for the trainees, as well as for the potential participants, seemed likely to make sustained commitments to meet uninterrupted during ordinary working hours unrealistic, we began to meet at the same time on Wednesday evenings, to consider the scope and design of the project, try out various electronic platforms for the group meetings, address issues of education and leadership in Balint work, work on recruitment of the group members, design structure and boundaries of the groups, develop methods of evaluation, design and construct research protocols to submit both to the RANZCP scholarly project committee and the Human Research Ethics Committee of the North Sydney Local Health District. I took them through an introduction to Balint group work presented in Power Point, adapted from one that Dr Rich Addison offered at the American Balint Society's Leadership Training Intensive at Portland, Oregon, in 2012 (11). Drs Punj and Eftekarzadeh Mashhadi each adapted this further in designing their own presentations to be delivered at the first of eight meetings of their own trial Balint clinical reflection groups. We met for more than a year, working on these things together, before we came to a point of readiness for the trial of the two series of group meetings to begin.

I pondered the question: how can I offer these two doctors a brief supported Balint co-leadership experience and the opportunity to experience Balint work as a participant in their own projects? While the two projects would be different, and would be written up separately for examination purposes, the three of us could act as a research team together, with each of the doctors co-leading with me their own research group in alternate weeks, while joining as a participant in the other's group, again in alternate weeks. That meant that the trial, once commenced, would run for a minimum of sixteen weeks, with eight meetings for each group, including an initial education meeting. Dr Punj would be a participant in Dr Eftekarzadeh Mashhadi's group for trainee psychiatrists, and Dr Eftekarzadeh Mashhadi would be a participant in Dr Punj's group for GPs, as he had also qualified as a general practitioner. The three of us would meet virtually for fifteen minutes before commencing each group meeting of forty-five minutes duration, and again for fifteen minutes after the close of the group meeting, to reflect on the leadership process.

At the time of writing, both the projects have been approved by the local health district ethics committee and the RANZCP scholarly project training committee. The two groups have each had four of eight virtual meetings, via Classnika, a new encrypted online educational meeting platform designed by Ramtin Shams (12). There were initially eight participants in the trainee psychiatrist group, plus the two leaders. So far one participant has dropped out, and attendance has varied from week to week. The GP group also began with eight participants, with similar variability in attendance. The first round of Likert scale structured and unstructured

feedback evaluation forms have been issued to group members and received by the researchers, with a final round to be issued at the end of the eighth meeting.

Both groups are significantly transcultural in leadership and membership, reflecting the cultural and linguistic diversity of the medical profession in Australia—Anglo-Celtic, Persian, Indian, African, Chinese, other Middle Eastern, other European and other Asian. Very few are Australian-born and, for most, English is a second or subsequent language. The trainee psychiatrists are all living and working in greater Sydney, whereas the GPs are from all over New South Wales, with representation of urban, regional and rural practices.

After the third meeting of Dr Eftekharzadeh Mashhadi's group, in which Dr Punj was the presenter, she expressed an epiphany of relief and excitement at finding how much she benefitted, feeling supported and validated by the group, and also stimulated towards a deeper understanding of her patient and the systems that influenced the presentation of the case.

In the next meeting, of Dr Punj's group in the following week, a GP presented a case which troubled and puzzled him, a case of a woman who had recently been stood down from her job as a teacher for refusing to be vaccinated against Covid 19. She returned frequently to her GP, and they had virtually the same conversation every time. He felt torn between his empathy and affection for the patient and his duty to support the public health campaign. He feared that she would leave his practice in frustration at his continued disagreement with her stance, but she kept coming back and repeating the scenario over and over again. All of the group, including the leaders, not least me, were deeply moved and troubled by this case. The GPs commented on how the group already seemed to be helping them bear with shifts and inconsistencies in public health policy and their Covid 19 fatigue—one week consulting face to face, the next by telephone only; in one practice consulting face-to-face with surgical masks, in another always in full personal protective equipment; one month facing a huge public demand for vaccination with no access to the recommended vaccine for most age groups, due to publicly promoted fears of the Astra Zeneca vaccine, the next seeing that vaccine widely promoted and readily available for all adults via walk-in clinics, then the following month having an abundance of vaccines available and few patients taking up the opportunity, while needing to supportively respond to the patients taking a stand against sanctioned mandatory vaccination.

In the most recent meeting, that of Dr Eftekharzadeh Mashhadi's trainee psychiatrist group, the case was one in which the culture of the doctor-patient relationship in the presenter's country of birth and original medical training was one in which the authority of the doctor is deeply respected by patients' families. In the hospital in Sydney, she was faced with bearing the brunt of a family's anger when the parents experienced the presenter's senior excluding them from decisions about their daughter's care in the hospital. Even by the time that I called for questions of matters of fact, I became aware of my mistake in suggesting that the presenter would be pushed back to let the group work the case for her, and I reversed my decision, acknowledging it as a mistake, and inviting the presenter to remain in the group, overting the way in which excluding her from the discussion could reinforce the sense of disempowerment and cultural alienation she experienced, something that most of the group had in some way referenced in previous meetings, especially with respect

to the invidious position of trainees at the front line carrying out the directions of their senior consultant psychiatrist supervisors.

In the leadership discussion afterwards, Dr Eftekarzadeh Mashhadi and Dr Punj commented on how much they and their colleagues valued my acknowledgement of the problems they as trainee specialists face in mediating between patients, their carers, nursing staff and senior psychiatrists, including feelings of fatigue and disempowerment. They told me that their colleagues in the trainee psychiatrist group, with whom they interacted with frequently in the course of clinical work, on-line training meetings and their Whatsapp support group, were already asking if it would be possible for the group to continue after the eight meeting trial, as they felt supported in their struggles, by the group and by its leaders, and also challenged to that deeper understanding of what it means to consider the possibility that, as Michael Balint puts it, 'a new psychiatry must be developed based on overall diagnosis under the aegis of patient-orientated medicine' (1, p 211).

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2.2 Becoming the kind of doctor that you want to be. A qualitative study about experiences and development of professional identity in Balint group work.

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Abstract

The benefit of Balint group work has been difficult to determine. Qualitative studies provide new angles for research.
The aim of this study is to explore how participants in a Balint group for at least 1.5 years experienced the group work and how they were affected by their participation.
Focus group interviews were conducted with a total of 19 members of four different groups with certified Balint leaders. A thematic analysis was performed.
The main themes that emerged were: Investigating emotions, Development of the physician's identity as well as Safety in the group and with the leader. The group felt like a safe place in spite of different leadership styles.
Conclusions: Participation in a Balint group can help doctors to build their professional identity by means of a deeper understanding of doctor-patient relationships. The method seems to be robust enough to give room to flexibility within a coherent framework.

Today, there are great demands on both young and more experienced doctors. Our work must be both efficient and well done, while at the same time we are exposed to ethical stress. The severe Covid-19 pandemic over the past year has taken a heavy toll on many colleagues. From time to time, it is necessary to stop and reflect on our experiences (1). There are various reflection models in healthcare – the Balint group is one.

We know that many doctors who have participated in a Balint group are satisfied (2), but have they really benefited from the work in the group and if so, how? A 2015 review of existing studies (3) provided no conclusive answers. The quantitative studies were (too) small and, in addition, differed from each other. There were indications of increased psychosocial competence and reduced risk of burnout, but only after about 1.5 years of participation. The difficulty of gathering sufficiently large comparable groups was highlighted, as well as the need to identify more appropriate dependent variables. Increasing the understanding of the essence of Balint group work is still necessary, for which qualitative exploratory studies were recommended (3).

Our study aims to explore how participants in a Balint group over a period of at least 1.5 years experienced the group work and how they were affected by their participation.

Through a network for Balint leaders, we contacted the participants from four groups. In all 20 doctors consented to participate in the study after verbal and written information. No group had the same leader and they worked in four different Swedish cities. All participants had been in the group for at least 1.5 years and all had, when possible, met every second week for 90 minutes. Four focus group interviews were

conducted by the first author (ELR) without the respective leaders. Two groups were for general practitioners (GPs) or GP residents, one for hospital doctors and one for a mixed group comprising residents in various hospital specialities and GP residents. The interviews lasted about an hour and were recorded. After four interviews no new data or themes emerged.

The groups were asked the following open questions: How did you experience participating in the Balint group? What was good and what was bad? and Did anything change over time?
Follow-up questions were asked as needed.

The interviews were transcribed verbatim (29,360 words). All personal identifiers were removed or changed so that the participants could not be identified.

The transcripts were read on several occasions by the authors separately. The text was analysed drawing on thematic analysis as described by Braun and Clarke (4). Initially the authors individually coded the data as well as identified and reviewed the themes. This was followed by several discussions among all the authors, which resulted in the themes and subthemes presented below. No analytic software was used.

Results

Three themes were identified: **Investigating emotions, Development of the physician's identity** as well as **Safety in the group and with the leader**.

Investigating emotions

Relieved by expressing emotions

Most participants experienced reduced anxiety during or after a Balint group session. It was possible to reveal "forbidden" feelings and thoughts, such as becoming angry with and feeling reprimanded by the patient or not wanting to see her/him again. They felt calmer and more stable when thinking about the next meeting with the patient.

"… you feel a little bad about some things, but then when I come here and find out a little more about it, somehow it becomes clearer … easier to handle." (Participant Group 1)

They soon felt calmer when faced with difficult or less successful encounters. "Now I can talk about it in the Balint group." (Participant Group 4)

Analysing emotions in order to understand

In all four groups, there were doctors who took the exploration of emotions one step further; they had learned to reflect on their own emotional reactions. They could "taste the feeling and get it back". They also developed their understanding of the patient's or co-worker's reactions and became more tolerant and flexible towards others' diversity of expressions and cognitive styles.

"That you sort of, well, orient yourself in relation to your own feelings. And this 'Whose feeling is it?'. That´s extremely exciting." (Participant Group 4)

Development of the physician's identity

Developing their professional identity was a significant issue for most participants who were either younger specialists or 3-5 years into their residency.

Insight into emotional reactions facilitates patient encounters

The participants claimed that they increasingly understood that each individual interprets and reacts differently to a situation. They became less obsessed about doing "the right thing". They could accept what had taken place and learn from it. An increased emotional awareness seemed to make them more secure and thus able to provide a safer meeting place for their patients. The group participants believed their diagnostic ability improved when less mental energy was required to cope with difficult encounters.

"I think that, for my part, the big eye opener has probably been that I'm more curious about the difficult cases. 'But why has it become like this?' instead of 'I cannot solve this!' …So, that makes the job much more fun when you are actually curious and reflect a little. 'What fate has this patient had in life? Why this? ', instead of' 'This bastard comes and destroys my day'." (Participant Group 2)

"I do believe that the security I feel has trickled down to the patients too, sort of." (Participant Group 1)

"I think I have become a better diagnostician. My thoughts are not as cloudy anymore." (Participant Group 4.)

Becoming the kind of doctor that you want to be

The participating doctors obtained help to understand what kind of doctor they wanted to be and then to become that doctor. They felt proud of their profession.

"Yes, but what has changed in me is that I have developed my role as a doctor. My identity as a doctor has become clearer… How I want to care for my patients and encounter them. And the consultation and such." (Participant Group 4)

"I also feel that coming here contributes to a sense of pride in our profession. It becomes so clear when you are here. I also feel happy and strengthened. In some way being part of a group like this defines our profession more clearly." (Participant Group 2)

A sustainable working life

The groups expressed a belief that Balint work might make them more resilient.

“I actually experience a much better quality of life since attending the Balint group! Because I have gained a completely different perspective on the job. It's like taking time to feel in a different way instead of just hurrying on.” (Participant Group 2)

“Sure, it's about a sustainable working life. They [the administration] may not think that they want doctors with self-knowledge, but they do want us to continue to work.” (Participant Group 4)

We believe that the most interesting finding is the potential to develop one’s identity as a doctor and gain pride in the profession, based on being the kind of doctor one would like to be rather than concentrating on salary and academic position. Strengthening one´s professional identity and self-esteem may contribute to a sustainable working life. The concept of professional identity has mainly been studied in students in medical schools and other forms of education (5,6). It could therefore be interesting to investigate the concept in connection with studies of Balint group work in trained physicians.

Safety in the group and with the leader

A warm and safe atmosphere in the group was essential for everyone. The members of the four groups in the study trusted their leaders. The collective group experience was equally important.

“I feel that I have never been able to learn as much about my profession as I do now since I started attending this group. Because all of a sudden, I take part in the vast knowledge and experience of other colleagues’ medical lives and learn so much from hearing their stories and how they think.” (Participant Group 2)

Protective framework

The fairly structured framework of Balint group work was initially perceived by some as somewhat unusual and rigid but quite soon as leading to security. Confidentiality was necessary to enable the participants to open up. In other conversations about patients and treatment, such as at clinical meetings or coffee breaks, they could not expect the same level of concern from their colleagues.

“But I also think that you could not have these discussions during a coffee break even if you had an hour… During coffee when you say something like: ‘hearing that was terribly hard…’ you may get the response: ‘well forget about it, that’s not our bloody business’.” (Participant Group 1)

Room for different leadership styles

It seemed that the four group leaders worked in somewhat different ways within the framework. The participants found it interesting to discuss their leaders. They were clearly appreciative but also made some critical remarks about the leadership. The leader should not talk too much but at the same time not be too passive. They should help the group to keep to the structure agreed on.

"The discipline is not always so good. We come in and then sit chatting for too long." "The structure has become looser during these years. That is bad." "Yes, we need to tighten the structure." (Participants group 2)

When several members were absent and the group was small, they liked it when the leader joined in and participated in the group work. They appreciated a leader who could open up areas/raise issues they had not considered before. However, they felt ambivalent towards a leader who provided too many of her/his own interpretations.

"Well, I think sometimes she/he has gone into the wrong side-tracks. She/he stops us when we do that but does not stop her/himself. Sometimes I almost said stop. I feel a little ashamed that I haven't dared to." (Participant group 1)

One leader had a more confrontational style. Such interventions could sometimes hurt but at the same time made group members really question their beliefs and actions.

"It hurts there and then, but in the long run it develops your personality a lot. Stimulating discussions, really." (Participant, Group 1)

By the end of the interview, two groups began discussing taking more responsibility for the sessions. For instance, one group might tell their leader that they needed more help to stay within the framework and not digress by discussing irrelevant matters. Another group resolved to contradict their leader more often when she/he presented interpretations or opinions with which they did not agree.

A few participants, who had previous experience of a (voluntary) Balint group for students, made an interesting remark about its leader, whose style contrasted sharply with that of the four leaders in the present study. The leader had been very silent, making them feel uncomfortable and scrutinized. They opened up but got nothing back. Unfortunately, we have no information about that particular leader's background. However, the leaders in our study created a secure place for reflection.

Our impression was that all four groups had learned a great deal, especially about patient-doctor relationships, despite some differences between the respective leaders, which might be insignificant. As in psychotherapy, it is the commitment of the leader/therapist that matters. More importantly, the four leaders in our study are all certified. Their competence includes group dynamics, cultural awareness (of a doctor's professional life) and psychological/psychotherapeutic competence.

In our study, no doctor reported any one-sided negative experience. Loyalty towards their leaders and the whole idea of Balint groups may have made them reluctant to express negative critique, even though the interviewer had no connection with the respective groups or workplaces. Nevertheless, it is reasonable to assume that those who stay in the group for three semesters will thrive. However, we cannot exclude that the group members that did not volunteer to participate were less satisfied. It is

well known that the Balint method does not suit everyone. Participation requires a certain mental stability and an open mind. There is a risk that a participant who does not fit in will suffer or at least have a negative experience (7). In terms of leadership, there is a fine balance between creating a pleasant environment where no development takes place and challenging (or failing to protect) group members to an extent that makes them close up or quit. In our study, the results support the robustness of the Balint process despite some discomfort among group members.

We assume that other themes may have emerged, had we interviewed groups where all members had attended the group for a longer period or if more participants had been older, more experienced doctors. In a previous study of a Balint group project for anaesthetists, young and very experienced colleagues were mixed in the groups. A theme discussed was the breaking of hierarchy barriers. (8). Another frequent topic was the difficulties attending experienced by hospital doctors. This was only mentioned in one of the groups in our study, which was for doctors in a surgical speciality.

In conclusion, doctors who wish or are motivated to join a Balint group are likely to gain professionally by their participation. This seems to be a good way to develop a secure professional identity. The method seems to be robust enough to give room to various leadership styles.

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2.3 Balint work as medical counterculture

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Abstract

An important, but little acknowledged core value of Michael Balint's work concerns the questions he raised about medical epistemology. In 1957, when he published **The Doctor, His Patient and the Illness**, medicine was dominated by specialists and the perceived value of technical bioscience. Balint's work demonstrated that materialist empiricism was insufficient in generalist practice. He offered an alternative epistemology underpinned by Aristotelian phronesis (instead of techne), abductive inference (instead of hypothetico-deductive) and particular case-based deliberative decision-making (instead of rule-based deduction from generalizations). Balint's theories, both his overt insertion of psychodynamic theory into medical care, as well as this more covert pointing toward an alternative epistemology, were a strong part of the mid-century response to the dominance of technical biomedicine. Balint groups deserve an important role in medical education because they are one of the few ways to safely

A spicy debate appeared in the British *Journal of the Royal College of General Practitioners* in the late 1970s, highlighting an aspect of Balint work that is little recognized today. Peter Sowerby's essay, “The doctor, his patient, and the illness: a reappraisal” called into question the merits of Michael Balint’s book and seminars.(1) He used philosopher of science Karl Popper’s concept of "empirical falsification" to argue that because Balint’s psychodynamic ideas cannot be refuted, they aren’t “scientific.” Balint's kind of knowledge, he argued, is more akin to literary knowledge or myth. Most of the patients in Balint's book, he argued, should have been treated for depression.

B. R. Barnett directly responded to Sowerby with “Balint, the doctor, and the fear of being unscientific."(2) This essay was based on Thomas Kuhn's depiction of "normal science" as an ideological construct whose theories might shift given a different sociocultural paradigm. Barnett argued for addressing complex psychosomatic causality over simplistic diagnostic labels like depression, and he observed that "the seminar is par excellence a place to think, feel, and silently deliberate on one's own practice." Barnett concluded that "The work of Michael and Enid Balint and their associates approximates what Kuhn has described as 'revolutionary science.'"

These two papers illustrate Balint's important role in a broader sociocultural conversation concerning epistemology, calling into question the sufficiency of scientific empiricism to create an understanding not only of our relational world but of our physical world as well. By pointing out the value of psychodynamic theory to understand primary care, Balint opposed what was becoming a hegemonic presence of technical biomedicine in healthcare. Through his research seminars, he highlighted the insufficiency of biomedicine to address the problems that patients bring to doctors in general practice.

In this essay, I describe how Balint groups implicitly depend on ways of knowing alternative to the biomedical paradigm that has come to dominate modern healthcare. I hope to show that the tension between epistemologies is still unresolved, harmfully weighted toward technical biomedicine, and that our healthcare systems would improve by overtly recognizing Balint's alternative as the core way of knowing in general practice.

Biomedicine

Medicine in Europe from ancient times through the late-Renaissance was based on the teachings of Hippocrates and Galen; thereafter it was gradually replaced by medicine that was based on enlightenment rationality, empiricism, and positivism that aimed to control nature through use of technology; in medicine, this control consisted of knowing and managing objectified disease and the objectified human body.

In an eloquent essay in 1955, Henry Cohen described competing paradigms of illness as *ontological* and *biographical*.(3) Whereas ontological conceptions consider disease to be an object, or "entity that befalls a healthy person,” biographical conceptions

believe ill health to be a deviation from some norm where “a number of factors have influenced a man so as to make him suffer.”[4] For more than two millennia, Western medicine leaned strongly to the biographical as described in the Hippocratic Corpus, requiring intimate knowledge of the patient, their context and temperament. A cultural shift to an ontological conception arose with Enlightenment thinking, encapsulated in the works of Thomas Sydenham in the mid-1600s who wrote "Nature, in production of disease, is uniform and consistent; so much so, that for the same disease in different persons the symptoms are for the most part the same…" With this shift, it was possible to abstractly classify and taxonomize illness experience, to approach the matter "scientifically."

These two competing notions are not mutually exclusive and have often overlapped in the medical teaching of an era, "the dominance of the one or the other at different epochs reflecting the philosophy of the time... "[5] With the advent of germ theory, the ontological conception of disease eclipsed the biographical. It was partly in response to this imbalance that Balint formulated his research groups.

To outline problems with the biomedical objectification of the human body, I turn to anthropologist Arthur Kleinman and his essay "What is Specific to Biomedicine."[6] Kleinman succinctly describes the problem with our current overdependence on biomedicine. Biomedicine insists on strict materialism, preferably things that can be seen, or made visible with microscopes, MRIs and other imaging machines. It prefers single causal chains, using physical mechanisms, to explain pathogenesis "in a language of structural flaws and mechanisms as the rationale for therapeutic efficacy." The psychological, the social, the moral are not only irrelevant, but are claimed to obscure the more real physical phenomenon. Biomedicine prioritizes diseases that can be treated technologically, acute conditions over chronic conditions and tissue damage over suffering. Suffering, then, must be medicalized into "technical problems that transmogrify its existential roots," and converted into a symptom scale "so that an institutionally efficient technical fix (a drug) can be applied in place of a humanly significant relationship of witnessing, affirming and engaging the patient's and family's existential experience." Especially, biomedicine has "a peculiarly powerful commitment to an idea of nature that excludes the teleological," so the meaning of an illness is fully outside of its jurisdiction. A "curious corollary," says Kleinman, is that biomedical physicians are trained sceptically in a way that diminishes placebo response. Finally, biomedicine has, and continues to develop hegemonically "under the powerful regimen of industrial capitalism, practiced in bureaucracies where the rule of efficiency governs the lived time of the patient-practitioner encounter.”

There is no argument that Western biomedicine is highly successful within its own limited realm, producing diagnostic tools and therapies that can often prevent or fix material bodily damage. But as Kleinman points out, healthcare limited to this perspective can be harmful.

Generalist medicine

General practitioners (GPs) use and value biomedical technology, but not as the focus of patient care. Rather, we accept the problems (rather than diseases) that patients bring to us, and we deliberate, as engaged expert advisers, on the best way to alleviate these problems, often diagnosing objectified diseases in order to advise use of biomedical technologies such as pills and surgeries. But we know the value of watchful waiting. We know that listening alone is sometimes therapeutic. We know that a trusting relationship built through years of being present is essential. Our medical decision-making requires incorporating the patients' hopes and ultimate goals as the purpose for which an action is taken. We know that a problematic family relationship can affect physical health. We intuitively understand the value of placebo effect and the role of "doctor as drug."[(7)] We understand the need to view our patient population with generalized rules and algorithms, but never at the expense of the idiosyncrasies of the individual with whom we sit. We engage with the non-reduced complexity of our patients' life-worlds.

Epistemological principles

To further distinguish between the mindset of a general practitioner and that of a specialist, it will be helpful to point out how primary care deliberation makes use of three epistemological constructs far more often than scientific method.

In the *Nichomachean Ethics*, Aristotle described five forms of knowledge that underlie our actions, describing them as intellectual virtues. [(8)] Three are especially pertinent to this discussion. The first, **episteme**, is the intellectual virtue of knowing about "fixed things" and their properties, like stars, or atoms, or the basic principles of physical mechanics. It is factual knowledge that can be encompassed in textbooks and encyclopaedias. The second, **techne**, is know-how, the application of episteme toward a specific, known end such as the production of some thing. Techne characterizes artisanship, for example, cooking, suturing, intubation, or fixing a car engine. It can be taught through recipes, algorithms, flowcharts, or do-it-yourself YouTube videos. Medical examples include how to remove a gall bladder, how to treat with anti-hypertensives to achieve a systolic pressure less than 140, or how to set up a clinical workflow so that all women over 50 are screened for breast cancer. **Phronesis**, finally, is practical reasoning, deliberating about the best action to take toward some end when knowledge depends on circumstances or goals that might be changing or uncertain. It distinguishes the better choice from the worse when navigating between a rock and a hard place. Phronesis includes questions of teleology, not just how to attain a goal, but to what end - why and why now? According to Aristotle, all ends and actions aim toward the ultimate goal of human thriving (eudaimonia).

Phronesis is the form of reasoning most often used in a general practice encounter, whereas techne is more likely to be used as the physician becomes more specialized. Generalists deliberate with patients on the next best step to achieve a health goal,

aimed toward thriving, defined in their own terms, complex, uncertain, and often changing. Sometimes their goals require use of biomedical techne, but often not.

A second way to consider how the epistemology of generalists differs from that of empirical science concerns their different forms of inference. Positivist scientific method most often uses hypothetico-deductive inference, i.e., testing a hypothesis by first determining what should occur if it were true, then testing to see if the predicted result is observed. [(9)] In contrast, primary care decisions depend on a form of inference called abduction, or what philosopher C.S. Pierce called retroduction. Abductive inference starts with an incomplete set of observations and proceeds to their likeliest possible explanation. Given the complexity of patients' life-worlds and the uncountable possible hidden variables that might be affecting them, generalists nearly always navigate in the face of incomplete information. We gather information about the patient's problems - history, signs, and symptoms - and reason backwards to the most likely cause [(10)] and the best solution.

The third way of knowing is case-based decision making, or casuistry. Casuistry was a process for resolving moral dilemmas in specific real-life situations used by theologians as early as the 1300s. It is defined by the Oxford English Dictionary as "that part of ethics which resolves cases of conscience, applying the general rules of religion and morality to particular instances in which circumstances alter cases or in which there appear to be a conflict of duties." In the mid-seventeenth century, casuistry fell firmly into disrepute as morally relativistic, sometimes used to justify clearly immoral behaviour.

In their 1988 book, **The Abuse of Casuistry,** [(11)] medical ethicist Albert Jonsen and philosopher of science Stephen Toulmin ask us to reconsider the method, arguing that its misuse had caused its demise, but that its appropriate use can still be helpful. Jonsen and Toulmin draw special attention to the difference between principle, or theory-based decision making and the practical decision-making of casuistry. While theoretical arguments are idealized, atemporal, and necessarily certain and "True," practical arguments are concrete, rooted in time and place, and probable. Casuists inform their decisions by comparing previous experiences, maxims and paradigms to the case at hand. The resolution of a case is held only presumptively because it depends on the accuracy and quantity of circumstantial evidence, and on the strength of the precedent paradigms. Casuistry offers "the assurance of moral probability rather than certitude." Jonsen and Toulmin call for a revival of this method because they believe the core of moral experience is not mastering rules and theories but rather in learning to see how the ideas behind these rules work out in the course of people's lives. In her book **Doctor's Stories**, Katherine Montgomery Hunter describes how casuistry is characteristic of all clinical medicine, [(12)] and that when questions of teleology, of seeking the good, are a recognized part of the clinical conversation, all medical decisions are moral decisions.

The problem

General practice entails deliberating about the circumstances of specific cases when there is ambiguity, seeking more complete understanding and the best path forward. These methods are intuitively understood and used daily by GPs throughout the world. Unfortunately, phronesis, abduction, and case-based deliberation continue to be devalued in today's healthcare compared to techne, hypothetico-deductive inference, and rule-based algorithms of biomedicine. As Kleinman noted above, this is especially true of healthcare systems where for-profit medicine is allowed; technical solutions can be patented, commodified and sold in ways that deliberation and therapeutic relationships cannot.

Predictions that doctors will soon be replaced by computers [13] make sense in a world of technical biomedicine. Computers can be programmed to be far better than humans at techne but they will never be capable of phronesis. Yet, for GPs, the continued overvaluing of techne while marginalizing the phronesis skills central to our work is disheartening and contributes to burnout.

The counterculture

Over the past century, many have opposed the epistemology of technical biomedicine by proposing expanded models, especially in general practice. Psychosomatic medicine has carved out important places in many health systems. Psychiatrist George Engel used a systems approach to describe a biopsychosocial model. [14] Moira Stewart et. al. described an expanded patient centered model. [15] The establishment of Family Medicine in the USA in 1967 was another such attempt, hoping to reverse the heavy weighting of medicine toward technical specialties set in motion by the American Medical Association with its "Flexner Report" in 1910.

After 1957, Michael Balint's book grounded many of these efforts. In an essay recalling the early years of Family Medicine in the U.S., one of its intellectual founders, G.Gayle Stephens described the movement as "counterculture;" it's clear that he meant this in the sense of a Kuhnian paradigm shift, as an alternative epistemology to biomedicine.[16] In a later essay, Stephens wrote that "Michael Balint, to me the greatest [of my] teachers and the only one I ever met face to face, legitimized my life as a post-Flexnerian and gave me the courage and the tools to practice in that style."[17]

Phronesis, abduction and casuistry are important epistemological tools used by GPs, but we can also now see that these tools are how we create knowledge in Balint groups. We encourage creation of many alternative hypotheses to deliberate on which fits best within the specific circumstances of "this case." We explore the patient's hopes, desires and ultimate values (telos) to explain their behaviour, not to offer a single fix, but to better understand them and their thriving. Balint's theories about general practice were truly countercultural. His seminars introduced an alternative way of

knowing to that which had become hegemonic in medical culture. His seminars are still one of the few ways to practice phronesis skills in a safe environment.

Conclusion

In considering the core values of Balint groups, we normally think of their incorporation of psychodynamic theory and recognition of the doctor-patient relationship in medical care. A less recognized value is their emphasis on deliberative skills - phronesis, abduction and casuistry - in order to create understanding, epistemological skills that are central to the clinical encounter. Balint reinforces the fact that medical knowing isn't limited to episteme or techne, but that these are subordinate to phronesis, and that medical knowing is individually case based, not rule based. By better appreciating these values, generalist physicians can be more secure in their patient care and in focusing on the individual patient in front of them rather than on medical theories, rules or algorithms. This, in turn, allows re-valuing the therapeutic doctor-patient relationships that will help our patients thrive.

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chapter 3

3.1 Balint groups: the times, they are a-changin'

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Abstract:

The incoming of new Balint leaders is a challenge to the older generation leaders.
By examples from two Balint groups in Israel , we highlight some of the emotional complexities in the process of opening the door to the Y generation by the Dinosaur, the older generation leaders .

Prologue:

"Come gather round people

Whenever you roam

And admit that the waters

Around you have grown

And accept it that soon

You'll be drenched to the bone

If your time to you is worth savin'

And you better start swimmin'

O You'll sink like a stone

For the times they are a-changin' ..."

(Bob Dylan)

Introduction

That night it became apparent to us that we, the veterans of Balint are still considered as the pioneers or the sons/daughters of pioneers, and that we are now in a period of transition of generations, which requires a change.

We met in a hotel by the sea in Ashdod, Israel, for the annual Balint leaders' conference. The sound of the waves could be heard in the background and the atmosphere in the room was warm and friendly. As Balint members we have known each other for years. There was a surge of memories of similar warm feelings from numerous past leaders' conferences. Some of us have been part of Balint since its beginnings in Israel, but most of the participants are relatively new. This is the usual annual conference for Balint members, one of two that we hold every year. This time the topic is: Our fears and our strengths in leading a Balint group.

The idea of holding a meeting around the strengths and concerns involved in leading a group came from the realization that the circle of Balint leaders has widened in recent years with many new professionals, who were enthusiastic about the Balint approach and who wanted to learn leading, to join the older members. Some of them, doctors or mental health professionals, had already started leading Balint groups before joining the Balint society or the leaders' conferences. Possibly they were responding to a need they detected in their hospital or clinic, to provide an emotional response to the burn-out medical teams. How could the veterans, the pioneers, facilitate their incorporation into the Balint circle?

At the conference we divided up into small discussion and sharing groups, without a supervisor, which allowed for friendly intimacy. The members talked with each other in their small groups and later, a representative from each group shared their findings with the whole meeting. It became apparent that most of the conversation was about the concerns, and not about strengths.

New participants said: "I am a new here, you look like a closed group, how can I join the Supervisors group?", "There is something pioneering and magical in Balint, but as new leaders how can we pass on the 'magic' to the wounded medical system?". " I am new in Balint but not new in my profession, tell me about what it was like before I came."

Older members said: "We didn't talk about our life-cycle issues!" "What actually is a Balint group?" "There is a benefit to integrating the young people, as it opens the eyes of the older ones, "It is as though we were in a bubble and it's hard to get out of it, "We are like a family, so are the youngsters who have joined like the adopted children or like children born into the family? And what is the process they have to undergo?". An experienced pediatrician who is a newcomer to Balint laughingly said "I am waiting for someone to adopt me! I want to talk to the parents". Another older

member jokingly answered, “The parents also have problems!” Another veteran said, “we didn’t talk about our advanced stage in our life cycle in the group or the Balint society.”

There was an intimate atmosphere of close sharing which was friendly, almost familial. Unwittingly we also started talking about our beginnings in Balint groups in Israel. We asked ourselves what had originally attracted us to Balint. And what made us want to continue with Balint? When did we first become aware of Balint, who brought us to the Balint Society, who took care to push us, to share with us and to guide us? One of the older members told me in the coffee break: “I still remember the first Balint group I joined in Prof. Benyamin Maoz’s house in Beer Sheva, the family atmosphere. I was new at my workplace and a Balint group at the director’s house with strudel and tea warmed my heart and paved my way at work. Benyamin Maoz conveyed a fascinating message of flexibility in thinking along with keeping to Balint rules. That combination intrigued us.” At the conference some felt emotional because they had been at the beginning of Balint in Israel, some felt a bit like outsiders since they hadn’t been there from the start. The new members asked themselves how they could join the group of veterans, of pioneers.

Over the course of the evening, with the close friendly atmosphere, a wind of change crept into our hearts along with the wind from the nearby sea. Something had to change. We wondered how that understanding would affect the inter-generational transition between the Israeli Balint pioneers and the next generation of Balint members.

We should now like to demonstrate some of the issues by using two examples from Balint groups:

Supervision training group session with both old and new members

Group leader: "Why is everyone silent here?”

R.: "It’s a bit embarrassing, for several years we have been talking about the dilemmas involved in leading a Balint group and suddenly we have no case to present."

D.: "Are you afraid of the silence?"

R.:" No, but it is embarrassing that we don’t have a case."

Long silence…

B. (an experienced leader): "Recently Yael and I had a group that almost came together in a hospital here in Tel Aviv. We had already spoken with all those

responsible in administration who expressed interest, enthusiasm and desire. We, as co-leaders, were infected by their enthusiasm. However, the secretary eventually informed us that the budget would not allow for the formation of the group."

E. (relatively new participant): "At the last meeting when I saw that even Y. and R., who are such experienced veterans, had a group that didn't come into being, I lost a bit of confidence, but on the other hand it is also reassuring that there is such openness in the older generation to talk about the difficulties, that the veterans also have dilemmas. Along with the challenge there are also problems, and it is possible to discuss them here openly."

R. (new participant): "You are so idealistic and eager, but you are being taken advantage of! I feel that the initiatives for Balint groups are sometimes simply lip service, being paid by managers who want to come up with magic solutions for burn-out."

D.: "Although it may appear that everything is open here, we, the younger members, sometimes feel as though you are a closed group."

> Group leaders: (looking at one another and wondering how to address this): "We are asking ourselves how this is connected to the silence at the beginning."

T. (older member): "We are not a closed group, we do want to welcome new people, but maybe we ourselves still don't know how to open the door to them."

> Group leaders:" So maybe the silence is expressing what is difficult to express here."

Y.: "Because there are feelings that are difficult to talk about, and do we even have a mandate to talk about it since we are not, after all, a therapy group?"

A. (an older participant): "Professor Maoz always said that a Balint group that has been going for a long time is a bit like a regular therapy group…"

> Group leaders: "What you are saying also reflects the fact that in our group as well, there are old members, some of them before retirement, or already retired, as well as a number of new participants. Although it is flattering that we have new people who want to join, maybe something of the family atmosphere changes?"

Emotional turmoil in the Balint family

The Balint group had being running for six years. The ten participants came regularly, felt satisfied with the group meetings, often commenting that “we are like family”. Their presentations were filled with emotion and depth, and the atmosphere of support and caring by the Balint leaders was apparent. Therefore, it came as a somewhat surprise, when a crisis in the group took place. Doctor A presented a very complicated case involving sexual abuse. The discussion in the group was emotionally very turbulent, particularly since most of the group were female doctors. From our experience, the subject of sexual abuse generally raises very deep emotions of anger, frustration and sadness in Balint groups. The group discussion was filled with deep, intense feelings. Yet, after Dr A returned to the group, she felt that the discussion was insightful to her and the leaders were satisfied with the groups’ understandings. Everything seemed in place, until the following week when one member of the group discovered that the case was leaked out to others doctors who were not part of the Balint group. It did not take the group members long to discover who had broken confidentiality. This aroused a storm.

The group was now in crisis mode. The two group leaders conferred with one another and agreed to have a special group meeting to discuss the event and the tensions aroused in the group. At the next meeting the "leaker” felt very embarrassed about what she had done. She admitted that after the group session, she had the need to share a more personal issue regarding the sexual abuse case so she consulted a friend. She was frustrated that in the group the discussion was a little shallow because it didn't allow for a more personal issue to be discussed. She eventually left the group. This led to more group tension. In the “crisis meeting” emotions were high and there was even talk of disbanding the Balint group altogether. However, after a process of painful working through, it was decided that the group would continue. Questions were asked: Maybe the group members were too interconnected? A decision was reached: to try and enlist new members to the group.

A few meetings later four new members joined the group, all much younger than the nucleus of older members who comprised the group. As the group continued, it became apparent that there was underlying strain between the older members- the majority in the group- and the newer members who were younger in profession and age. They were enthusiastic, more goal oriented and more adapt to the “new Age” in family medicine. This led to tension, where the older group members felt themselves threatened by “these new invaders” these “new Turks.”

One older member felt she had to teach the younger ones didactyly. In reality the younger doctors, either saw their older peers as “icons” to be overly revered and admired, or revolted against these “oldies” many of whom were at the end of their professional careers. The new members wanted to inject new blood into the group, to bring in more of their younger colleagues .

At one meeting in which the “youngsters” never attended (there was a convention for young professionals at that time, preventing them attending that specific Balint group meeting), the” oldies” felt relieved and happy “to be back to

themselves". They spoke about how the group had changed since the new members had come into the group. Dr S, a female doctor in the group commented how the new generation of doctors are so different from them. Dr S remarked: "They are so dependent on quick service and throw- a-ways. Sometimes I wonder whether they are going to just throw us away together with our Balint principles. I also see how much they have difficulty in boundary- setting, so different from us who are careful not to make our group into a psychotherapeutic one. Who knows, if they don't get their way they may just up and leave us? This all sometimes scares me".

Then Dr Y, one of the few male members of the group commented: "At first, I was frustrated and angry with them, maybe even a bit jealous of them. I sometimes feel like a scolding parent towards a child. I see their mistakes, get annoyed with them for being so stupid. I have an urge to automatically correct them". Dr Y continued: "But you know, now I am able to look and observe them from afar. I say to myself that they must also learn from their errors, like I did, three decades ago. I have a further flash insight: I now realize how my own supervisor felt helping me to manage my cases so many years ago."

Summary and Discussion:

Opening the doors to new Balint leaders is a challenge set for the Dinosaurs, the older Balint leaders by the Y generation leaders. The examples showed some of the emotional complexities of this process. The older members, on their part, feel a certain lack of confidence. Is this lack of confidence the outcome of the vagueness surrounding the exact body of knowledge new leaders need to acquire in the learning process? Or perhaps the lack of confidence is related to the process they underwent when they first joined Balint? Most of the veterans started their journey with Balint out of a search for a professional base that would give them a feeling of support and belonging. They did so with enthusiasm, and an old-school, pioneering sense of vocation. They find themselves now at a stage either before or after retirement and feel a lack of confidence when faced with the newcomers. The assumption is that the motive for the young members to join Balint is similar to that of the old members. However, as is the way of the younger generation, like our own children, they want to do it their way, which is different from ours.

How do we teach Balint leaders? The old generation for the most part, learnt by first participating in a group and then co-leading with an experienced leader like in an apprenticeship. Thereafter came the theory. Is this the best way? or is there a need for theoretical studies before the practical phase of leading? How do we open the door for the younger generation? How is the wisdom and experience of the older generation shared with the younger generation today and how should the older leaders effectively pass on the baton on to the next generation?

Epilogue:

"Come writers and critics

Who prophesize with your pen

And keep your eyes wide

The chance won't come again

And don't speak too soon

For the wheel's still in spin

And there's no tellin' who

That it's namin'

For the loser now

Will be later to win

For the times they are a-changin'..."

3.2 Learning to lead: a New Zealand Balint River journey

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In 1997 my father and I went on an intrepid adventure paddling down our New Zealand Wanganui River in a canoe. We were outside in nature for four days, camping on the river bank at night, carrying all our food and equipment, supported by some very fit and energetic river guides. We were beginners to the paddling world, learning as the river took us along its varied course. We had to learn how to work together, calling code words of direction, sometimes battling the current, other times letting ourselves be taken by it, and practicing falling out. Gradually we settled into the rhythm of responding to the river, using less effort, tolerating each other's inadequacies and embracing this new and awe-inspiring world together. It's a wonderful memory that is a privilege to share, especially these days as I grieve his recent passing through the terrain of dementia and decline. He was in the front of the canoe in those days.

My Balint Leader Accreditation training began in 2012 and I completed the Leader Trainer pathway 8 years later (two separate qualifications). The Balint Society of Australia and New Zealand (BSANZ) have developed a rich and meaningful training pathway (see Appendix 1), and I am indebted to the many teachers and leaders in my Balint community who have supported me through the journey.

My medical training in the 1980's strongly privileged intellectual knowledge and critical thinking, both to identify what is going on with the patient, and what is needed to make them better. Although useful and necessary, too much dependence on cognitive knowing can overshadow the more diffuse, uncertain emergence of feelings, body sensations, images and other forms of knowing that are inherently present in any relational experience such as a Balint group. This was an important part of my early learning journey – initially more of an 'unlearning' as I gradually learned to let go of overthinking and 'trying too hard', and adjust to valuing other ways of knowing.

In this paper I will explore my Leader Trainer Pathway using the metaphor of a river journey – I am in my canoe, sometimes alone, other times with a co-leader, paddling with the two oars of analytical thinking on the one hand, and my own embodied experience of what is emerging in the present moment on the other. In addition, the navigation of a river invites the metaphor of bravely allowing ourselves 'to be taken' by the current, whilst remaining alert to the need for directing with both oars, in response to challenges such as obstacles, weather, rapids or sluggish points of turpitude.

I very much identified with the generous self-reflective writings of Jeffrey Sternlieb (2018), who explained how his own anxiety about being in a Balint group, decreased his capacity to feel other feelings related to the case. This long but powerful quote explains how letting go of competitiveness and social pressure helped him to 'get out of his head' and contribute more authentically:

> *My initial 'epiphanies' described my struggles functioning comfortably in a group. I became aware of connections that members of my group were making with each other, and it was a mystery to me how that happened for them and not for me. It took several Balint leader training Intensives for me to realize I did not need to impress anyone and that I could begin to connect with others by better listening. These observations helped me to realize that I rarely felt the anxiety I actually had because I had been busy avoiding that experience by over functioning in multiple ways. The truth that emerged was that I was anxious in all these social situations. My behaviour had successfully functioned to help me avoid experiencing most of my emotions, including anxiety, shame, and embarrassment. The ultimate result was a limitation on my connecting with members of my group. I was primarily in my head, busy entertaining others, trying to be smart and unintentionally keeping others at a distance. One additional "aha" was the awareness of my competitiveness and its impact of limiting meaningful relationships.*

To listen well we need to let go of this over functioning, and allow our own inner tensions of not knowing, anxiety, and other difficult feelings to be felt properly, and valued as a key part of the process.

Mindfulness meditation has been a powerful tool for me to learn to slow down and develop more capacity to tune in with my own inner experience, as well as to be more available in myself for the listening process.

One of my meditation teachers, Joseph Goldstein (2020) * says that the quieter our mind is, the more connected we can be, both to our own inner world and the world around us. This concept has been helpful in my own experience of Balint group leadership.

I understand mindful awareness as the tool by which we open to consciousness, allowing and including all that is happening **in each moment** of the journey, not only what we understand and appreciate, but also what is confusing, unwelcome or unpleasant.

During the early learning stages of mindfulness training, it is common to work very hard on the task of focussing on the breath and we can often feel a failure when the mind drifts away into random thinking. Finding a balance between the discipline of focus and regular practice (we get better and what we practice) and also letting go of effort to avoid strain and pressure is a dance that requires a constantly changing dynamic response.

Of late, letting go has been a key direction in the journey for me. In addition, it is helpful to remind ourselves, that developmentally speaking, we can only let go when we first have enough to hold on to.

Letting go can feel scary when we are very attached to being right and/or being in control.

Letting go requires us to be able to tolerate uncertainty - which usually means allowing uncomfortable feelings of some sort, *and at the same time* maintaining a very attentive curiosity to what is happening in this moment.

Letting go of "what should happen"

Letting go of trying too hard

Letting go of needing to be clever

Letting go of needing to get it right

Letting go of needing to say it first

Letting go requires trust – trusting the group to take us all somewhere, and trusting our co-leader as well.

Many sportspeople know about this balance between focus and letting go. They report that there is a fine balance between trying their absolute best and letting

go of strain of too much effort – many use the phrase "being in the zone" or the paradox of "effortless effort".

Here is a short mindful awareness experiment, which invites you to move your awareness from physical sensations to emotions and then to thoughts

So, begin by closing your eyes, settling into your chair, aiming for a relaxed and upright posture
A good way to settle into the practice is often to take 2 or 3 slightly slower, deeper breaths
As you inhale, connect to your body on the inside, notice any sensations
As you exhale, relax, let go of any thoughts or concerns you might have, let go any tension.
Couple more slow deeper breaths.
Allow your breath to return to normal

Begin to notice the sensations of breathing in a general way… just open your awareness to whatever sensations draw your attention and let your awareness settle there for a few breaths.

If you have random thoughts coming in, don't worry about it, that's normal……. just notice them, let them go, and with kindness return to where you were with your breath.

Now turn your attention to your body, and drift your attention around various parts, be guided by what feels easy to feel. Any areas of tension, pressure, temperature, ……. allowing it to be 'as it is' ……undemanding attention. Maybe softening…relaxing around any difficult sensations if you can.
See if you can tell the difference between ***experiencing*** *the sensations and* ***thinking*** *about the sensations.*

Now moving to feelings……. familiarise yourself with any feelings coming up. maybe boredom, anxiety, or peaceful…or more subtle – no need to even name it. …and for these few moments, just allow it, accepting "this is how I find myself at the moment"
Feelings often come with physical sensations (maybe an ache in your chest…. or a cold sensation in the belly) See if you can tell the difference between experiencing the feeling in your body, and thinking about the feeling……..

Now moving to thinking……. perhaps to begin with allow yourself freedom in your thoughts. Like letting a dog off its leash, let your thoughts be free for a few moments.

Sometimes when we do this our thoughts seem to stop…whatever is happening in your mind, see if you can just allow it and open to the experience …not resisting anything

Notice if you can shift from thinking the thoughts, being involved in them, and then later following the thoughts in more noticing way. And then go back and forth between the two for a while.
Then to finish, one slightly longer deeper breath, feeling the chair beneath you…and slowly opening the eyes.

So how can Mindfulness help the Balint Leader?

Whether in a Balint group or sitting with our patients/clients, I am sure many of us have had the experience of being captivated by a story, sometimes pulled irresistibly into an unconscious enactment of something in the story that is too hard to bear consciously. This is all part of the dance of the Balint dynamic. With an increased capacity to experience more than just our thoughts, it becomes possible to pause at such times….to simply turn my attention to the feelings and sensations in my body. Most commonly I just follow the sensations of a single breath and that steadies me, it wakes me up to notice what is happening in this moment. This capacity to tune in and value whatever arises, can become a gateway by which we allow everything to be potentially meaningful. Being present in this way can provide the Balint leader with a rich field of information within which we can potentially navigate a shared journey as a group, ideally toward a meaningful relational experience.

As Andrew Elder (2007) says our task is to notice 'how things **are** between (presenter) and the patient, not how they ought to be'.

One of my co-leaders is a very 'embodied' Balint leader, and from her I have learn to value and take notice of my somatic experience. Some examples could be as follows:

- A heavy ache in the chest as someone in the group finally, albeit briefly, identifies with feelings of loss. I realise it's important to not allow the group to flit over this sad moment – we need to pause and allow it, to make space for the uncomfortable feelings that are easily hidden.
- A flash of cold tension across my chest as I identify danger in the story; I become more alert to how this might become enacted in the group.
- Random pain in some part of the body is often informative in a metaphorical way, sometimes it comes as the group is captivated by some puzzling issue, and the leader can simply say "something painful" and wait to see if the group takes it up.

In this way, I find that my own somatic experience can reliably be a portal to the inner world, including the information coming from my current breathing pattern. If nothing else a strange unexpected sensation in my body causes me to pause, sometimes it feels like it 'breaks a spell' and wakes me up again, to then intellectually question "mmm…. what about this feeling could relate to the case?"

Thus, as a Balint leader, I am learning to consciously use my mind in both modes, what Barbara Oakley calls "Focussed and diffuse" (2018), often alternating between the two, in response to what is needed. Sometimes I choose which mode to be in, at other times it happens by itself. However, the more awareness I can bring to the process, the more I can navigate between the two, and respond to what is needed at the time.

My co-leader has also helped me to let go of needing the group to 'get somewhere', to try too hard, or strain to direct them into a particular area. When things are hard, uncomfortable or there are unwelcome feelings – **there is nothing wrong!** Like a child play therapist who says "yes!" to everything in the play story, I can allow the group to express itself organically. Trusting the group to enact something in this way, means that the group can "mature" a direction more fully, and meanwhile there is still an observer part of my awareness noticing what is emerging.

An example is of a case whereby there was a strong theme of 'reverse racism' towards the Pakeha (dominant culture) presenter in a Māori (minority culture) organisation. There was a feeling of frustration in the group, having to walk on eggshells not to upset minority groups, and tension was developing as the group started to split into 'us and them' – the politically correct versus 'we're all the same, we should be treated the same'.

It felt tempting to try to correct them or re-direct them, as I was experiencing my own intolerance of the growing tension across my arms and chest. Although it was hard to let the group continue, it all felt very meaningful. This was a time that I had to "sit on my hands" and just bear it. My co-leader mentioned feelings of guilt and shame; there was an uncomfortable silence. The silence felt meaningful. We then noticed and named that it seemed like the group had silenced the presenter, and enacted a parallel process of colonisation. As we returned to the relationships, gradually the group began to connect with the hidden feelings of inadequacy and shame in both Māori and Pakeha.

The ideas I have explored in this paper are not new; in the 1960s Tom Main used the slightly cumbersome but descriptive word Coenaesthesia to describe this subjective experience and Diacritic to describe intellectual thinking. His purpose was to point out that we need the balance of the two: '*One danger is of being clever but insensitive; the other is of being sensitive but unthinking….*'

So, as I come to the end of this part of my river journey
I look back over the terrain and remember
the initial careful learning of Balint rules and guidelines, practicing with the guidance of skilled leaders and supervisors overseeing my progress.

Then
taking the plunge
launching my canoe into the river
initially paddling with intense focus
holding on with tight hands
feeling at the mercy of the current
the unexpected obstacles and the weather.

Occasional openings of space and beauty
awe and wonder mixed with pain and sadness
passing along the way.

Then
Letting myself be taken
Allowing the rocks to divert and surprise
Sometimes a bump
a crash
holding and being held
eyes together
and then apart.

Thinking
Feeling
Dreaming
Breathing

Something is happening
and I am at once
being happened to
and then
a paddle to the left and to the right
the river bank approaches
the case is closed.

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* Personal communication: part of a guided meditation that Joseph Goldstein offers on an app called Insight Timer. Here is the link: https://insighttimer.com/josephgoldstein/guided-meditations/quiet-and-connected-mindfulness-meditation

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Appendix 1: Balint Society of Australia and New Zealand (BSANZ) Leader and Leader Trainer pathway.

Becoming a Leader and Leader-Trainer

The BSANZ Leadership Accreditation Pathway is a supervised two-year training programme available to members of the Balint Society of Australia and New Zealand.

Doctors, psychotherapists, psychoanalytic psychotherapists, and other health workers are eligible to enrol in the training programme.

For leadership training requirements see:
https://www.balintaustralianewzealand.org/wp-content/uploads/2021/06/BSANZ-Leadership-Accreditation-Pathway-Requirements-June-2021.pdf

Becoming a Leader-Trainer see:
https://www.balintaustralianewzealand.org/accredited-leadership/requirements-for-leader-trainer-accreditation/

3.3 Teaching in Balint groups: how flexible may the group be without diverging from its sources?

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Abstract

In Balint Groups we study the doctor-patient relationship, *the doctor´s access to their emotions considering the relationship at every consultation*, its implication in the diagnostic and therapeutic processes and the doctor´s role as a medicine.
Teaching is usually seen as disappointing, and we intend to use the methodology to *acquire new skills and not to learn some more theories*. Do not teach, said the Balints.
We are in training groups, not in psychotherapeutic groups, so the author believes that the leader, assuming himself as a coach, without giving lessons, could take on questions and lead the group to answers. Can the flexibility of the method accept "explanations according Balint"?
Based on a case that occurred in a Balint session, the author intends to discuss teaching in Balint groups, what this means and what are the possible consequences for the group, for the leader and for the methodology.

Introduction

In its early days, Balint Groups had a strong psychoanalytical inspiration, according to the training of their leaders. "*The approach adopted by the Balints - no teaching, no case notes, mutual exploration within a clear framework to facilitate free association and observation of shifts in feeling – was profoundly psychoanalytic*" (1). They aimed at analyzing "*the doctor´s unconscious speech who exposes in his relationship with the patient and the illness"* (2).
"The aim was that elusive 'limited but considerable' change in personality" (1)
This analytical tendency has been changing along the time and today we probably may understand them as task groups, whose purpose is to study the doctor-patient relationship, "*the doctor´s access to their emotions considering the relationship at every consultation*" (3), its implication in the diagnostic and therapeutic processes and the doctor´s role as a medicine (4).
Even in this kind of group, let's say less "profoundly psychoanalytic", there are blockages in its dynamic, due to participants' difficulty to elaborate on certain consultation happenings.
One of the possible consequences of these impasses, and issuing an effort to unblock them, the leader runs the risk of deviating from the purity of the method, for example to teach about clinical phenomena, namely those that are fruit of Balint´s and his successors' work.
Yet, in a context of training and coaching, is it so strongly incorrect the flight to teaching? What would it mean if, through the course of a group, the leader escapes to teaching?
Based on a case that occurred in a Balint session, the author intends to discuss teaching in Balint groups, what this means and what are the possible consequences for the group, for the leader and for the methodology.

The case

A patient was very angry on the phone, because for 4 months he hasn't been able to get an appointment with his doctor to expose some health problems. The Health Center had adopted very restrictive contingency measures against the Covid 19 pandemic, and had practically "closed its doors". The health unit justified that they were following the instructions of the National Health Service, and that the restrictive measures adopted were common to the other health units.
And so it was, in fact. Many of the consultations were discontinued, doctors turned to attending their patients by phone or by email or, in certain cases, by video-consultation. They took the fight against the pandemic very seriously, but they forgot that there were other patients with non-Covid 19 pathologies. And the presenter said that he was also very angry because he knew several other similar cases of patients requiring medical appointments and that were not able to get them at all. Then, they had to resort to alternatives. In this case, the patient was led to seek consultation with two other doctors and one specialist and all of them gave him medications and proposed other therapeutic solutions from what have not resulted in any benefits. They all were unable to solve his problem. He felt dissatisfied because of the unresolved

problem, and lost because he wanted to talk with his family doctor about his problem and he couldn´t do it. Even the specialist he had consulted with hadn't understood very well the problem and did not give a satisfactory answer to the patient, so he became sad and lost. He went from one doctor to another, several times, without a satisfactory answer to his problem.
And the presenter himself became dissatisfied and also angry and sad about the situation.

The discussion

The group discussed the case with great ambivalence. On the one hand the group felt that the defensive mechanisms of the health units in the beginning of the pandemic were necessary; on the other hand, they thought that many people may have been harmed by preventing them from having a medical appointment with their family doctor.
The group members understood the emotions of sadness and anger shown by the presenter. More than being angry, he felt frustrated, as he had difficulty in helping the patient, because he himself could not escape the restrictive rules of his own institution.
But the group went in circles with this, and could not move forward with the discussion. It seemed they couldn't see anything else ahead, except saying that they understood the measures taken by the institution, they understood the patient and also they understood the doctor´s feelings. And we walked around, all of us understanding each other, and everyone becoming angry and frustrated.
As leader, I presumed I could manage an immediate way-out, since the case presented similarities to the phenomenon of collusion of anonymity, described by Balint in "The doctor, the patient and the illness". Due to the pandemic, the patient walked from doctor to doctor, in a framework of interpersonal relationships, without being able to properly expose his problem and even to solve it. The doctors, themselves, had ended up diluting their responsibilities in the action of the others. And none of them could help the patient.
The problem was exposed to the group, but initially it seemed that they didn´t understand. Then I decided to talk about this clinical phenomenon that may even have increased in those months of lockdown.
Although it was not strictly the case, it had unquestionable similarities and important practical implications and therefore I referred, briefly but clearly, to the collusion of anonymity.
But, I myself, even during the explanation, had serious doubts about my attitude that resembled that of a "teacher", and I became at the same time anxious and dissatisfied.
My co-leader had not any kind of responsibility for my decision. She looked at me while I was speaking to the group members, listening carefully, but in my mind it was as if she was asking me: "what are you doing?"
Actually, I've taken the place of a teacher in the group, following a personal decision and not a group decision. According to the group rules and the very essence of learning, I became angry and dissatisfied with myself.
Curiously, the group really enjoyed the "lesson". Despite this, I was still sorry to have done something wrong.

The group ended with the presenter reentering and saying that he had better understood the problem, and that we must try to "reopen" our practice, not adding our fear to the fear that society already had about Covid 19.

The leader reflexion

Sometimes, clinical phenomena have to be explained and clarified, and we must not omit them. But when to explain them? And how? And by whom? And shouldn't there be another method of highlighting the phenomenon rather than through "explanation"? Assuming I was wrong as a group leader (according to strict compliance with the rules) what could I have done to highlight the issue? The Balints said: "*no teaching, no case notes, mutual exploration within a clear framework*". My "teacher explanation" was absolutely outside the scope of this mutual exploration.
Firstly I tried to unblock the deadlock, but the group didn´t work. So, as a defense mechanism against the anguish of the group impasse - I believe - I escaped to the teaching. As I went on, I became aware of my mistake, but as I was in progress, I couldn´t go back. So, my dissatisfaction and my *mea culpa*.
Surprisingly the group enjoyed the lesson! What does it mean? That they appreciate more conventional teaching methods, and that Balint methodology is still far from them?
But I return to the question posed above: within the limits of Balint, to what extent is the "teaching" by the leader acceptable? Or is it always to be disowned under any circumstances?

The supervision (*)

This level is what I call the fifth level of the Balint process. I believe that the Balint process has 5 levels of analysis. A case (first level) presented by the doctor (second level), discussed in a Balint group (third level), narrated by the leader (fourth level) and discussed in supervision (fifth level). This is an issue for another presentation.
By now, I want to report my supervision of this case.
Teaching in Balint groups is reason for wide discussion. Referring to psychoanalysis and psychotherapy courses that, by the time, psychiatrists used to do for the GP, Balint mentioned "*the results of these courses have been generally disappointing… hardly give more to the general practitioner than what he can get from reading books*" (5). The purpose was to acquire "*a new skill and not to learn some more theories and facts"* (5). But, as we are not in a psychotherapeutic group, but in a training group, I guess that the leader, assuming himself as a coach, without giving lessons, could take on questions and lead the group to answers. Is it wrong to assume that leaders, in this course, often fall to an explanation "according to Balint"?
In this context, do we still see this "teaching" as reprehensible? And does this coaching profile, instead of the classical teaching style, remove from teaching in the Balint groups the negative burden that I gave you in this case and that affected me so strongly?

When I feel that the group "is not prepared" or is not able to "move forward in the discussion", for me this represents a clear call to the transfer master-apprentice. And, here, the question arises: either in a Balint group, in the doctor-patient relationship in the office or in a leadership group, is it absolutely unacceptable to break out of the rule of not teaching? In other words, cognitively does it make sense the tendency in Balint Groups to the rejection and fear of leaders falling into what we call "teaching"? In Portugal we usually call the leader a "facilitator". Actually, in my country, after a dictatorship of 48 years, the term leader may still cause an unconscious fear, that gets through our collective unconscious, and people who use terms like leader, chief, authority, leadership, control, power, are not well accepted, because of their negative connotations. But "facilitation" is just an aspect of the leadership process, and in this setting they are not different concepts. In our leadership training we have discussed the concepts of leader, facilitator and conductor of a meeting, and this discussion is perhaps endless, and they are possibly different aspects of the same purpose. Sometimes it is appropriate for the leader to put themself in the "shadow" of the group, and be a facilitator, or a conductor. But never failing to lead and enlighten the discussion. And at other times the cognitive clarification of the case, or of the theoretical concepts arising from the case, can surely highlight feelings. Can this attitude be considered as negative or forbidden? Can this attitude constitute in an "apostolic complex"?

In a recent session of international leadership training, I was confronted with some inputs (**). It was very interesting the issue explaining the fact that the group had "appreciated the lesson". Probably this group would expect something more "didactic", and in this case, we could presume that the group was not prepared to understand what the aim of a Balint group is. "*Moreover, such teaching is gratifying indeed to both. The specialist can shine, and the practitioner feels enriched and reassured*". (5)

On the other hand, such a lesson could be a kind of treatment of the "inability to progress" dilemma. Like the doctor that treats the patient, the leader could also apply some therapeutic measures in the group. But is teaching an acceptable form to "treat the group"? Balint wrote: *"this gratifying collusion is disappointing in the long run because in reality it is too facile and does not give the means of effecting therapeutic changes."* (5).

Seeing this problem under the lights of a parallel process, I've presumed that the leader who teaches is like a specialist who was called in a hurry to support the helpless doctor/leader and better clarify the poor group/patients. Eventually generating a new phenomenon, an apostolic function of the leader and, in the same context, perpetuating once more the teacher-student relationship within the group itself.

Conclusions

This case revealed several phenomena that need study and evaluation:

1. The call to the group-leader transference.
   Leadership is under enormous difficulties, as diverse as the diversity of the problems posed in each Balint session. Many times, the narrator and the group transfer emotions to the leader, who has to be attentive to this process.

2. The helplessness of the leader and the flight to "teaching", as a refugee against the psychological pressure.
   We know that doctors show defensive mechanisms in the relationships with their patients (6), why not also the leaders? In this context I admit that he leaves aside the presenter and deals only with the group (presenter included).
3. The difficulty of the leader in guiding the group to discuss according to a more heuristic process of "conduction" (question-answer-new question-new answer and so on). Actually, the Socratic method or dialogue.
   In a coaching process we have learning based on the own abilities of each participant, so when the leader intends to promote new learning, perhaps they must use this kind of "teaching" (7) (8).
   Much of this process is influenced by some fears in the group, for example the fear of being observed, even by our peers, the fear of exposing ourselves to others, not only professionally but also personally, the fear of being incompetent or stupid or the fear of being affected in our self-esteem. So, in this circumstance, the leader's lesson might be a well-being and a relief!
4. The leaders' countertransference, accepting the role of a master and revealing an apostolic function, is a matter of utmost importance and can affect the future of the immature group, even if it expresses its liking for this "lesson".
5. Teaching as a possible group treatment facing the illness "inability to progress" – and the leader as a group therapist (**).
   This way of "treating" a hypothetical "disease" lessens the group, does not allow it to participate and access to the creativity zone, and changes the basis of the methodology.
6. Balint Groups allows a doctor to choose the path of personal development, acquiring sensitivity and ability to accede to emotions in the office, both of the patients and of themselves, in an adult-adult relationship and aiming for the *limited but considerable change in his personality* (4). Essentially, nobody can "teach" this sensitivity and ability, it depends on the aptitude of each doctor to re-image his practice and see the "*two-eyed-medicine*" (1), created from the rationality of the science and the emotionality of the relationship.

Finally, participants must be perfectly informed of the goals and methods of the Balint Groups, so they cannot expect the leader´s enlightenment or any external enlightenment. Only their wisdom and their ability to lead with their own and the patient´s emotions are valid in this learning and training context. The leader himself must have the very same awareness of his emotions regarding the case presented and the group dynamics. And if he decides to leave his strict facilitation function, he has to be aware that he emerges as a genuine leader and conducts the group through a process of teaching concepts. And be careful not to become a bad leader.

Notes:

(*) From my supervision process with Fernanda Jesuíno (Scientific Committee of the Portuguese Balint Association).
(**) From de discussion in the "White Group" in the online IBF Leadership Conference, Serbia, September of 2019

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Chapter 4

4.1 Can Balint groups fill a gap in undergraduate medical curricula?

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Abstract

Emotions play a fundamental role in the professional development of doctors, but teaching medical students about the role of emotions in illness and relationships with patients can be challenging. Balint groups involve a case presentation and discussion focussed on the emotional component of patient interactions. This study aimed to assess whether a Balint group helped medical students to gain a better understanding of the role of emotions in the doctor–patient relationship, and whether students believed that the group provided a valuable educational opportunity. Voluntary 5-week Balint groups were offered to third, fourth and fifth year medical students on clinical placement at University Hospital Hairmyres. Sixteen medical students chose to participate in the Balint groups. The majority of students agreed both that Balint groups helped them to think about the place of emotions in patient encounters and that participating in a Balint group was an important part of their training as a doctor. Students overwhelmingly indicated that Balint groups provide an aspect of training that is not currently addressed elsewhere in the medical student curriculum.

Introduction

Empathy is a key skill that the General Medical Council (UK) requires of doctors.[1] Concerningly there is evidence that empathy declines during the clinical years of medical school.[2] The ability to empathize requires the ability to identify, understand and share in the emotions of others.[3] It has been noted that emotions are not given explicit attention in most undergraduate medical curricula.[4] This may be because knowing how to teach medical students about the place of emotions in medicine can be a challenge to educators.[5]

"At the center of medicine there is always a human relationship between a patient and a doctor" asserted Michael Balint, a psychotherapist from Hungary.[6] In the 1950s he and his wife Enid set up Balint groups for general practitioners in London. Balint groups aim to provide a supportive forum for participants to reflect on their experiences of being with patients and the emotions involved in these.[5]

More recently Balint groups have been utilized for a variety of doctors, including those in their initial two years of working and those training in general practice and psychiatry.[7,8] Proposed benefits of participating in Balint groups include reduced compassion fatigue and burnout.[9] Limited studies trialling Balint groups in medical student populations have suggested that they can effectively elicit discussion about the emotional aspects of relationships with patients and improve students' empathetic ability.[5, 10]

The aims of this study were to determine whether Balint groups run for medical students in their clinical years:

helped students to gain a better understanding of the role of emotions in the doctor-patient relationship.
were perceived as a valuable educational opportunity by students.

Methods

Balint groups were offered to 3rd, 4th and 5th year medical students from the University of Glasgow who were undertaking clinical placements at University Hospital Hairmyres between November 2018 and February 2019. Each hour long Balint group session was run on a weekly basis for 5 weeks (the duration of clinical placements). Participation was on the basis of voluntary informed consent. The groups were led by two doctors who had experience of participating in and leading Balint groups. The leaders received supervision from a consultant psychotherapist who was accredited as a Balint leader by the UK Balint Society.

Each session followed a traditional Balint group format, with the students and leaders sitting in chairs arranged in a circle. The leaders asked that one student volunteer to describe a patient encounter that had continued to occupy their mind. The group then had the opportunity to ask the presenting student to clarify factual aspects of the encounter, before the presenting student moved their chair back from the circle and exited the discussion. The group discussed the case, with the leaders directing them towards focusing on the relationship between the student and the patient, and the emotions experienced by both parties. Towards the end of the session, the presenting student was invited to re-enter the circle and discussion.

Following each 5-week group, participating students were asked to complete an anonymous questionnaire about their Balint experience. The questionnaire (which was adapted with permission from Atkinson and Rosentock[11]) entailed responding to a number of statements on a 5-point Likert scale and providing written feedback to open-ended questions about the group. The Likert scale responses were analysed quantitatively using descriptive statistics. The free text responses were analysed qualitatively using thematic analysis, which involves searching for common statements and views which can be grouped together in themes.[12]
Ethical approval for the study was granted by the University of Glasgow College of Medical, Veterinary & Life Sciences Ethics Committee.

Results

Balint groups were offered to 41 medical students who were on placement at University Hospital Hairmyres during the study time frame. A total of 16 students volunteered to participate, all of whom were in 4th or 5th year. Therefore two 5-week Balint groups were run, one for 4th year students (n=6) and one for 5th year students (n=10). The groups were attended by 6 male and 10 female students, all of whom were aged between 20 and 30. All of the participating students completed the feedback form.

Students were asked to respond to four statements on a Likert scale to determine whether the Balint group helped them to gain a better understanding of the role of emotions in the doctor-patient relationship. The majority of students either strongly agreed or agreed that the Balint group helped them to explore their feelings about patients (86%), helped them to see things from the patient's perspective (56%), helped them to make sense of the feelings that doctors may have when seeing patients (94%) and was a useful space to think about the doctor-patient relationship (94%).

To assess how valuable an educational opportunity they felt the group provided, students were asked to respond to two further statements. Most students (69%)

strongly agreed or agreed that participating in a Balint group was an important part of their training as a doctor. The vast majority (94%) were in agreement that Balint groups provide an aspect of training that is not currently addressed elsewhere in the medical student curriculum.

Students were asked to provide free-text comments about the most helpful aspects of the Balint group. The main themes that emerged were that the group enabled students to learn from shared experiences, provided a space for reflection, made students feel less isolated in their experiences and created a sense of camaraderie amongst the students. When asked about challenging aspects of the Balint group, students identified a difficulty sharing emotional experiences, the voluntary nature of participation in the discussion and the small number of attendees.

Discussion

The majority of medical students who participated in a Balint group agreed that the experience improved their understanding of the role of emotions in the doctor-patient relationship. This finding is consistent with other studies that have demonstrated that the Balint approach can improve students' understanding of the relational component of patient interactions and their emotional insight.[5, 10] Whereas Parker and Leggett[13] noted that medical students appeared ambivalent about the educational value of Balint groups, students in this study largely valued Balint groups as a training opportunity. This study builds on current research by highlighting the perception of medical students that Balint groups provide an aspect of medical education that is not otherwise available to them.

Some of the benefits of participating in a Balint group described by students in this study mirror those noted elsewhere, particularly the designated space that they provide to discuss emotionally charged patient encounters and the opportunity to discover that other students have undergone similar experiences.[5, 11] A novel advantage identified by students in this study was the opportunity that the Balint experience provided for them to bond as a group. Other studies have similarly highlighted the vulnerability involved with discussing distressing patient encounters and the discomfort of tolerating silences as challenging aspects of medical student Balint groups. [5, 11] Some students voiced a desire for Balint groups to include multidisciplinary team members and more senior doctors. Sargeant and Au-Yong[8] noted that including medical staff with different levels of experience enriched Balint groups. As professionals and students from other healthcare disciplines also develop therapeutic relationships with patients, including them in medical student Balint groups could likely add further depth.

A limitation was the low number of participating students (n=16). It would therefore be difficult to make generalizations about the value of medical student Balint groups based on this study alone. Students who declined to attend the groups were not asked why this was, and this would have been useful to know. It is interesting to note that the popularity of the Balint groups increased with each year group. Brazeau and colleagues[5] identified limited clinical experience as a reason why students did not perceive Balint groups as useful. As students in 3rd year at the University of Glasgow have just started clinical placements, this may partially explain why they did not wish to participate in Balint groups. Balint groups may be best implemented for 5th year medical students who have greater clinical experience.

A further limitation was the potential for selection bias. It is likely that students who chose to attend the Balint groups were those who already perceived discussing emotions and relationships with patients as valuable. In other studies of medical student Balint groups participation has been compulsory.[13] This was not possible in this study due to the terms of ethical approval but doing so would elicit a greater number of participants and provide a more balanced view of medical students. The next step is to discuss with the university whether a Balint group can be incorporated into one clinical placement, allowing greater student feedback to be sought.

Conclusion

Balint groups can provide an innovative means of educating students about the role of emotions in the doctor-patient relationship. It is difficult to find examples in the literature of any other initiatives used in medical schools that aim to do this. This aspect of training, which has been highlighted by students as missing from their undergraduate medical education, is of paramount importance given the evidence about erosion in empathy that occurs during the clinical years of medical school. The results of this pilot study highlight the value of making Balint groups more widely available to medical students or, better yet, implementing them into medical school curricula.

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4.2 Shame and attachment- the body and the Balint group.

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This paper explores the genesis of, and the dynamics involved in setting up an extensive new Balint Group project offering groups to all the health care staff in the Sexual Health Department of a large UK Inner city training hospital.

The idea for this project was born out of a recently established Balint Group, which was offered to staff within the department. This had been set up as a result of a recommendation from a junior doctor who had been in a vocational training scheme group co-led by me in another training organisation. The senior clinicians in this new group found that the resultant broadening and deepening of their understanding of the dynamics of highly emotionally charged clinical interactions, was very helpful to both them and their clinical practice.

As a result of the restrictions imposed during the Coronavirus pandemic, this group took place online. Several of the clinicians during this time of tremendous pressure in the health service had also been redeployed to ICU and other front-line roles. Their case presentations were extremely powerful and could be heart breaking in their intensity, as they conveyed the pain, trauma and fear that they were holding on behalf of, their patients and their absent families, as well as supporting their colleagues. They also had to manage their own anxieties about possible infection and transmission that often entailed separation from their own families in order not to expose them to

unnecessary risk. Some clinicians had the role of communicating by telephone between the staff of the ICU and the families of the patients, as the ICU did not have the time to do this work of updating the families about the patient's condition. This was harrowing work, presenting in the Balint Group, describing the uncertain outcomes for these patients as their health trajectories ebbed and flowed.

I was approached by one of the consultants who were instrumental in the organisation of this Balint Group to ask if I would consider being leader of a project offering Balint groups to all the Sexual Health departmental staff. This proposed initiative was to include up to sixty people, including doctors and nurses of all grades, as well as health care assistants. (HCAs). There were six senior clinicians, who had all been members of the initial group (four were doctors, one a senior nurse and one staff psychotherapist) who were interested in leading three groups under my supervision as well as a group that I would lead. I had found all these clinicians to be insightful and thoughtful, as well as highly motivated to offer to their colleagues something they had found so useful personally and professionally in their very pressured working environment. These clinicians were familiar with, or had led other reflective practice groups, but had no significant experience of Balint Groups as members or leaders. They were also looking ahead to their own professional development and further training in Balint work.

There were several decisions to be made early on, and these were made in consultation with the senior clinicians who took on the complicated administrative task of organising the timing, makeup and distribution of the leaders, group members and locations. These tasks included finding private spaces and computers for all involved in a busy clinical environment. The thoughtful communication that was required between members of the leadership team echoed the themes of this congress about the need for flexibility and compromise to maintain cohesion. As a result of lessons learned from previous experience, at times I had to reiterate the importance of maintaining boundaries and, as far as possible, consistency in the makeup of both the group membership and the designated leaders. The decision was made to offer the groups as voluntary attendance within the existing CPD framework and the department agreed to fund my involvement in the project. This decision came under pressure at times as the attendance figures waxed and waned during the first few months, but this has been maintained up to the present.

One of the initial concerns that I felt and voiced was that the enthusiasm of the group leaders might not be matched by the attendance of the invited department staff who had had no previous experience of Balint group work. My experience over many years of work in medical settings had been that the particular sort of reflection that Balint Groups offer can be something of a "slow burn"' meaning that attendance and participation can be very low initially. There were some conflicting feelings in the leadership team which in some ways echoed the unconscious dynamics of the department and the work they were engaged in. Issues of power and control in relationships could be a central feature of clinical presentations in the groups and in

some ways echoes of this arose in discussions about how the groups should be managed. There were lively debates about whether we should invite people to attend the Balint groups as non- compulsory CPD or to frame attendance as compulsory, including sending emails asking them why they were not attending if this was the case. The numbers were low in the first few months 15-20 members spread over 4 groups, and there was a potential split in the leadership group thinking between wishing to act to change the situation by making it compulsory, and a concern that this might be an action born out of anxiety and a desire to demonstrate the "success" of an initiative which was, after all, being funded by the Hospital Trust. The decision in the end was made in a creative way to "do what we do with other activities " and make it optional and allow for organic growth over a period of time.

The group leaders expressed tension in the supervision sessions, between holding the structure and boundaries of the groups firmly, while recognising that a very formal structure could feel persecutory to some people who were new to this type of group work. They expressed the difficulty of feeling their way along this tightrope between flexibility and rigidity, while appreciating the value of the specified time for clarifying questions, the opportunity provided for thinking as a group by the presenter "sitting back" and then re-joining for the last ten minutes.

Balint work is relatively counter-culture in terms of traditional medical and healthcare training and practice, which can cause a degree of conflict and confusion about the purpose of the work, as well as a fear of somehow getting it wrong. I was also cognisant of the sexual health setting and the possible counter-transferential issues of shame, loss of control and fear of exposure, both to be contained and worked with in the groups as well as internally by leaders who were relatively inexperienced.

It was suggested early on by the consultants that the groups should initially only be offered to the doctors in the department. Various reasons for this were put forward, that nurses and HCAs might feel disempowered in a hierarchical setting with doctors they were working alongside, who had higher status and roles of authority. I found myself standing up for the principle of inviting all staff partly because my experience of being in large staff groups was that a great deal could be learned from hearing the emotional experience of other health professionals which might otherwise be misunderstood or diminished. My experience was that this interaction could be very valuable in engendering and enhancing an appreciation of each other, both as colleagues and as human beings.

The setting up of this project has felt very valuable and interesting in increasing my own understanding about the powerful nature of the work in this particular setting, and my continually expanding appreciation of the courage and resilience of the clinicians who do this work. It is a reminder of the ways in which human sexuality and the surrounding thoughts, emotions and actions are at the very core of human existence. Our earliest human stories, codes of conduct, and structures of power and hierarchy, can, at their heart, be seen to emanate from the wish to control and regulate sexual desire, behaviour, and its consequences. This cultural inculcation of shame

around sexuality, the diversity and differences of bodily desires, systemic misogyny and homophobia, contribute significantly to the silence and shame around sexual disease and the silencing of experiences of sexual violence, exploitation and abuse. `Conflicts and fears around the powerful role of mother and the female body, and the resultant need to control and coerce, arise both in case presentations and the group dynamics of the leadership team.

The World Health Organization (WHO, 2015) stated "that we cannot consider sexual and reproductive health concerns such as HIV and other sexually transmitted diseases, sexual violence, sexual problems, unwanted pregnancies and unsafe abortions, without considering discrimination and inequality" . Roederer and Flowers (2018) writing in the editorial of a special Sexual Health edition of The Journal of Health Psychology (2018) suggest that this inclusive definition of sexual health demands an imaginative sexual health psychology that theorises the individual as embedded within their psychosocial, sociocultural and geopolitical contexts.

Many of the patients who attend this inner-city hospital have histories of oppression, poverty, and intergenerational trauma. The ways in which these histories enter the consulting room with the patient, need to be understood as they can lead to enactments, misunderstandings, and anger that can arise in both clinician and patient, which when not understood can radically affect the outcome of the consultation. There were presentations which encapsulated this, clinicians felt frustrated and angered by patients from minority backgrounds seeming to be dismissive and rude as they continued to speak on their phones as they came into the consultation, or reacting to the clinicians questions in an unco-operative way. This could lead to initial group discussions about how "they" were unappreciative of the clinicians' work and aggressive in their attitudes and the clinicians expressed their difficulties in working with these dynamics.

I find it very important in working with groups and individuals to ascertain the relevant demographic information about the patient in terms of socio-economic background and ethnicity. As a result of my own history and research, I am aware how important this information is in contextualising the patient's behaviour and our own understanding and reaction to it. My own perspective is that it is vital in healthcare that we have an understanding of the cultural systems and resultant systemic ways of thinking within which all our institutions are embedded. This leads to the recognition that systems that reinforce inequality are therefore in the cultural air we breathe and take for granted, and in understanding this we can reduce the often persecutory individualisation of these issues, as we confront powerful historical narratives and see this as something we can tackle together as we strive towards ethical practice and equity in access and treatment for all our patients regardless of background.

The group members were able to think much more compassionately about their patients who exhibited this 'difficult " behaviour when they could contextualise the patient's behaviour within the possibility of historical social powerlessness, individual

and trans- generational trauma, sometimes daily experiences of discrimination and racist behaviour towards them, and an understandable fear of people in authority such as healthcare clinicians who had power over their minds and bodies. When the group could think about the possibility of their patient's behaviour as resulting from deep seated anxiety and feelings of shame, and therefore defending themselves and even pre-empting the possibility of the clinician's misunderstanding and hostility towards them, the clinicians could empathise more with their patient's predicament, the atmosphere of "them and us " receded and they could think together about how they might work towards incorporating this way of thinking into their interaction with their patients.

I have become aware through my doctoral research about racial inequalities in medical training, that discussion about these factors can give rise to anxiety and uncomfortable feelings in group members, and therefore can be silenced and avoided unless they are clearly put on the table for discussion in a safe and containing atmosphere.

It became clear after a few months that although the groups were small they were diverse, a mixture of nurses, doctors and HCAs as well as clinicians of different backgrounds and ethnicities, and there was a sense of an increasing depth to the case presentations and discussions. Smaller groups did mean that the group leaders were under pressure to become more active in the groups. When the challenges of this were discussed in the supervision groups, the leaders were able to talk about being "pulled" towards becoming a member of the group, and how the role boundaries could become blurred as the leaders sought to relieve their own anxieties about the wellbeing of the group wanting to reassure the group members. There was discussion about how much of them to reveal and whether it was ever appropriate to bring in their own experiences. This led to a dialogue about the sense of deprivation that a leader could feel if they weren't able to bring their own cases. This highlighted the importance of support for themselves and their learning by being part of a Balint Group and attending Balint training days.

Another theme of this work, which emerged in presentations, was in the sometimes-volatile atmosphere of consultations when the clinician had to refuse some treatment or medication because of the danger to the patient. This could lead to difficult issues of power, coercion and control, which can reverberate between patient and clinician and particularly so if patients initiate a complaint against the clinician. This situation is an anxiety that can arise in many aspects of healthcare and it is always difficult when someone is called to defend their decision-making after the event.

When we are called to attend legal proceedings, or have a complaint made against us, or come before a disciplinary body we can feel intense shame even when we are clear in our own minds that we are not at fault and have nothing to hide. This shame can also make it difficult to share this information with colleagues and those closest to us. The shame we feel when we come before authority figures can have deep roots in our own and in our family histories. We can automatically feel not good enough, not valued, like a small child before stern and/or arbitrarily unfair or prejudiced parental

figures, and indeed we are sometimes not wrong to fear this injustice being repeated in some settings. Shame is ubiquitous in the health care professions and clinicians are often carrying the unconscious (and projected) shame and guilt of patients, who can experience their illness, difficulties and vulnerability as shameful, as failure, and as a loss of health and a cherished identity. Clinicians can also be in receipt of these feelings from some colleagues and seniors, who may unconsciously defend against uncomfortable or distressing feelings by projecting them, using bullying or dismissive behaviour to get others, often junior, to experience and carry the burden of denied emotional pain. Facing the reality of healthcare work means recognising that clinicians cannot always fix things, that things will go wrong despite best efforts, and that some patients and their families may become angry or rejecting of their clinicians for reasons that are not always immediately understandable. Illness and potential and actual death can cause enormous storms of guilt and blame in patients, in families and in others close to them, as well as in the institutions charged with caring for them. Doctors and other healthcare professionals can get caught in this storm as targets of culpability are sought by the system. Understanding some of these factors and dynamics, even partially, in Balint and other reflective groups, with colleagues that we trust, can be vital and even lifesaving at times of distress.

I am aware that the leadership team of this project appreciate what I bring to the project from my professional training and my experience of working with groups of healthcare clinicians over many years. This appreciation and respect is returned in abundance as I observe the dedication, compassion, empathy and skill that they bring to their work day after day, often in the most challenging of circumstances.

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4.3 Leadership experience from web Balint groups across Brazil

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The Balint Groups are, for the most part, carried out with doctors and other healthcare professionals who have already graduated. There are reports of several positive outcomes for those who are often enrolled in Balint Groups, such as improved performance and attendance at a clinical meeting, improved feeling of competence, professional identity, self-confidence, job satisfaction and prevention of burnout syndrome. During the groups, there is a change of roles, leading healthcare professionals to leave their comfort zone and give a new meaning to their knowledge. The Balint Groups have also been carried out with medical students for years, demonstrating an improvement in the students' engagement with patients, family members and relationship with the patient. The cases referred mainly to interpersonal relationships with people in hierarchically different positions, such as teachers and residents, as well as socio-economically or culturally vulnerable patients. A recurring theme in discussions was the fear of not being able to maintain empathic relationships with patients and, over time, ending like the negative examples that presented themselves during moments of practical learning - as a student said: “I'm afraid of becoming an anti-example”. Other feelings that often arose during the groups were the impotence of being a student in a case and depending on other people to find solutions; and frustration with professionals when they don't consider the student or the person being cared for.

The groups were carried out remotely through virtual platforms, with weekly occurrence, between September and October 2021, lasting 1 hour each. Six concurrent groups were held, with 6 groups per week, totaling 36 meetings. I was the leader from all groups. Within the 40 students, 6 had already participated in a Balint Group; among these, 2 had regular contact with the Balint Groups, as a faculty subject. The meetings weren’t recorded due confidentiality; notes were taken as a "Logbook".

The meeting started according to the traditional Balint Groups, with the famous question: “Who has a case to share with the group?”. The presenter talked about the case based on free association of ideas, without notes. After the presentation, objective questions were made by the group. At this point, we usually were at the 15-minute mark. Then, the person who presented kept the camera on and the microphone off, in a movement internationally called push back, while the other members discussed the case from their perspective and feelings for approximately 35 minutes. After this, the presenter was invited back into the group for their final words on how they felt listening to the discussion and the possible insights. After 60 minutes, the discussion was finished.

At the beginning and end of the meetings, participants were instructed to answer to the Portuguese version of the JSPE-S (Jefferson Scale of Physician Empathy - Student Version) through a secure website. After the meetings, they were also asked to answer a questionnaire based on their experience with the Balint Groups, provided by the American Balint Society (ABS) and adapted by the Brazilian Balint Association (Abrabalint).

More than half of students agreed that groups would be better if performed in person compared to remote groups. A student reported: “It was a very new experience in the online format, which at first made me afraid to be in front of so many people I didn't know, but I got progressively more comfortable until I reached the point of wanting

more meetings and more moments of exchange. The Balint online format even surprised me positively. [...] Uniting the 4 corners of Brazil on a screen was awesome!"

The experience of this participant in the groups refers to a strong characteristic in these meetings, which is the presence of students from different parts of the country in the same group. The fact that Brazil is a continental country, with big differences between the four corners, made the experience into something that went beyond the contact with the patient and reached contact with new cultures and ways of seeing the same situations from different cultural skills. The heterogeneity of the groups favored bonding between the participants, as they recognized a bit of themselves in the other.

Student groups are challenging because cases are often unique, as students are unable to maintain follow-up and longitudinally in most cases. In all situations brought to the groups, no patient was seen or evaluated again by the same student. However, even though there is no longitudinality of cases foreseen by the traditional Balint Groups, it is understandable that cases are living entities within the students and remain there regardless of the physical reunion with the patient. There are and there will be innumerable cases that will accompany the students for a while. Of the 32 cases presented, more than 30% were cases experienced more than 1 year ago, at another time in the college and in the students' lives but carried great details and feelings as if they had been experienced recently.

However, the experiences with the groups lead to believe that medical students have a different ability to assess the patient's perspective at the expense of the teacher's or physician's perspective. This may happen because they are closer to the patient than the health professional, better understanding what it means to be a patient in different situations. The cases described by the students are even more challenging from an emotional perspective, due to factors such as uncertainty regarding their professional role, feeling of powerlessness and dependence during college.

It is mandatory to remember that all those groups took place during the pandemic in a country that dealt with COVID in a terrible way and had more than 600,000 deaths. All students were invited to talk about their perception of the pandemic and their relationship with the patients. One of the students said that it made her relationship with the patients better as she was more aware of her and the patients' feelings. All other students talked about being afraid of losing touch with the practice or being away from the patients and learning less than they could.

Despite the difficulties inherent in being a solo leader with medical students from every region of the country, and leading during the pandemic, this was a great experience for me and for the students, as all of them asked to keep participating in the groups. And furthermore, there was a statistically relevant difference between empathy scores measured before and after the groups, as is shown in the chart below.

Chart. Media Empathy Scores before and after Balint Groups

Enrolled year	**n**	**Media**	**SD**
Before	40	124,27	7,54
After	40	127,57	6,20

U Mann-Whitney Test p=0,01355

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4.4 Balint group: phenomenological approach to supervision focused at professional health carers' communication

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Summary.

The main topic of the article is the analysis of the phenomenological approach as an important way of research and understanding of various aspects of professional communication in the physician/psychologist's practice. The role of phenomenological analysis in the structure of the Balint group work is described, resources of the process are considered as the tools to increase effectivity of the Balint supervision and thereby to increase the communicative competence of physicians and psychologists.

Key words:

Balint group, supervision, health carers, analysis of communication, phenomenological approach.

Phenomenological approach turns out to be very productive in technology and effectiveness analysis of the Balint group, which focuses its work on analyzing the professional communication of physician or consultant psychologists with patients/clients. According to the works of many authors such as Ulanovsky A. M. (2009), Larkin M. (2015), Burlakova N. S. et al. (2017), a phenomenon in psychology may be considered in different meanings and aspects. As for the subject matter addressed in this article, the phenomenon can be identified as the observation result of certain manifestations and characteristics of a person's behavioral interactions and emotional reactions, the peculiarities of cognitive process and the expression of experiences, as well as their description and certain interpretation, respectively, identifying the meaning, which helps to clarify many reactions, experiences, relationships and styles of interaction that are not clearly expressed in communication. Considering the possibilities of a productive application of the phenomenological approach, it is important to say that it gives a method that can be used in the practice of communication analysis without prior theory presented necessarily.

Internal changes, which allow physicians/psychologists to use their own experiences as a means of self-knowledge, may be considered as an important step towards changes in patient/client work. The permission for subjectivity given by the Balint work allows to think, experience and act from our "Self", provides the opportunity to communicate with unconscious and therefore relatively closed in the process of working with the patient. The Swiss psychoanalyst Arthur Trenkel, presenting a report on the basics, specifics and prospects of Balint work at the 6th International Balint Congress (1984), reflects this process with the idea as following: "Changes in the doctor's work... can be viewed from different angles. At the end of the day, each person has own point of view, which is (and remains) the most important - personal point of view. However, where any angle of view reigns, a certain blindness inevitably appears. I present my point of view and when other people talk about their vision as about the same, they will help me get acquainted with my "blindness" and cope with it."

The group helps its participants to understand that person could be understood best through sharing the feelings and co-experience, not through rationalization. The last point latter inevitably leads to a distorted perception of the emotional reactions of another person, here similar to the way the physician, who represents his/her case in the group, used to rationalize the patient's feelings in therapy practice, thereby seriously transformed and distorted them in his view. The French poet and dramatist Jean Cocteau's quote can be considered an exact expression of one of the fundamental principles of the work of the Balint group: "Should the mirror

think before reflecting something? It does reflect without thinking prior! ". That illustrates the idea of the "meeting" not of the different knowledges, but of emotional "existences", resulting in a new mutual meaning. That constitutes an "event" in the Balint supervisor, since it is feelings that are the "organ" of a person's perception of the situation in all its complex, significance and importance. Experiences reflect here the system of relations between people involved into the professional communication. Such an approach to supervision doesn't imply questions like - "What does this resemble (or what looks like)?" or "What is the meaning (importance) we see in this? », since this is the rationalization of what is known in advance and what is taken as the theoretical basis. As part of the phenomenological method, we investigate what is in this communication, that may be presented to us not in the form of meaning, which is always different among different people, but in the form of an experience that can be shared with other people. Therefore, in such an approach, completely organic for the Balint group, it is quite legitimate to replace the question "How do you understand this?" with the question "How do you feel (experience)?" This allows to share experiences and reactions that occur in the group, their reflection, and possibly (but not necessarily) subsequent interpretation.

The idea of A.M. Ulanovsky (2009) that phenomenologically investigate a certain occurrence or process means studying how we experience it, regardless of how we analyze it and even what we know about it in a theory, from experience or what "common sense" tells us This is successfully implemented in Balint group. Therefore, the phenomenological approach in the Balint supervisor means a certain attitude to the analysis of the cases presented, aimed at "reconstructing" the experience and attitude towards them and to what happens in the professional communication that is presented in the form of story in the Balint group.

N.S. Burlakova et al. (2017) formulates the problem of a phenomenological approach as follows... " clarification of the structure of experiences, as well as the internal source that initiates the experience itself. Such a study would be phenomenological if the researcher plunged into the statement itself and studied its structure precisely from within its creation, within its internal dynamics. "

A.Langle (2009) notes that all that we see and experience are phenomena, so phenomenology is the way and form of learning the world around us: "This is not a theory of perception. This is a school of perception. " The basic principle of this approach is to accept how communication reveals itself and shows itself to us as observers without expressing its mistrust, suspicion and doubt of correctness or sincerity.

Unlike the supervision of "explanation what is done wrong and how to do it right and correctly" and so the supervision of advices, Balint group provides the supervision of "understanding", that is characterized by phenomenological attitude to the description of the internal landscape of the physician-patient interaction. This description is based on some principles and practice of a phenomenological approach to understand a person in general, as a whole and its most significant relationships with others - in particular. In this sense, it can be considered as a relatively new discourse, that arises in the Balint supervision, to solve the problem of a new approach to describing an already existing psychological phenomenona. This could also be labeled as the emergence of a new "language," which can describe what previous approaches in

medical or advisory practice failed to help. And in this regard, the phenomenological approach to analysis how the Balint group works is quite productive and even beneficial. First, this method allows to see phenomena as they present themselves to the observer. Second, this approach begins at the starting point and further aims to describe as unbiased and impartial as possible the phenomena that are explored in the Balint supervision in a certain way "to allow myself to see it." When it comes to communication analyzed in specific cases of group members, there is a kind of "release" of this new language, which allows to describe and make more understandable the problems of a particular patient and a particular physician in the process of their complex interaction. "First, describe and only then interpret and explain (if necessary)," is the principle underlying such an approach in the Balint supervision which often saves from the illusion of the correctness of hasty and superficial "non-conditional understanding" and a description of what in fact we do not see and do not understand (or understand, but all differently) in the analyzed clinical case.

The attractive side of the phenomenological approach in the Balint supervision is that it focuses not only on... " understanding experiences, but also on someone else's experience, except our own, which is later the source of either subsequent reflection or interpretation "(M. Larkin, 2015). An important feature of this experience is that it is always formed and developed in dialogue. And it is not just dialogic, it is also communicative, since this is always the experience of a certain interaction. Naturally, experience belongs to others, we understand this and accept, only while understanding our own experience, so this will result in a certain self-reflection and self-recognition. In this process, there will be counter, mutually enriching our movements - someone's else experience is understood because it is based on our own, and our experience is always understood through understanding of the "language" and the context of someone's else experience. So, these poles in the consciousness of the group members phenomenologically inextricably connect into a common and internally agreed the whole.

The ability to create a state of "open mind" in the group is critical for the case analysis using a phenomenological approach. It is quite difficult to verify it, since it inevitably includes existing physician- patient phenomena of transfer and counter-transfer and rather complex context, since all events are described in the life space of the person and in terms of who is experiencing them. This is quite true for stories presented in the Balint group. A. Langle (2009) gives such a practical recommendation related to the use of a phenomenological approach: it is necessary to maintain phenomenological openness in relation to oneself as a doctor. The position regarding oneself is to maintain actively a dialogue: "What does the way patient communicates tell me about him? - How does his experience affect me? -How does his style of presenting his experiences, his speech, or his silence affect me? - How do I perceive it and what does it cause in me? - What does that mean to me?" Answering these questions in specific, not abstract, not theoretical and not too rational way is fundamental to the physician. This particular analysis may already contain everything that the physician needs to hear inside himself, so the meaning of the Latin "con-crescere" is clarified for him – “to merge, connect”. Narrative or a description of the case presented in the Balint group can be considered a synonym for "a way to specific" in this case.

The phenomenological approach to the analysis of communication in the work of a physician allows to get answers to many difficult questions, in particular, related to setting, as an inevitable component and foundation of the physician-patient interaction. Setting is not only a "frame" in the space and time of which a therapeutic process takes place, it is not only prerequisites and conditions, but an important structure that has a very significant communicative and therapeutic significance, which can be revealed more deeply by turning to phenomenological theory. Successfully applied in the Balint group, it allows you to answer several questions, such as how correspond the session time, the time experienced by the patient and the time experienced by the doctor, relation of mental realities of the patient and the doctor in the area of therapeutic interaction.

Answers are frequently unclear, and those are only part of the questions that seem to frequently, perhaps even constantly arise in the therapeutic process. We constantly feel ourselves as a part of the psychological common reality that forms each time in interaction with the patient, not only at a certain period in a certain place established by the setting, but also in the thoughts and feelings of the doctor, as the patient becomes an "internal object" which may "not let to go" for a long time, in our experience - sometimes for years.

Various authors analyzing the phenomenological approach to describing and understanding human experience, the conditions and context in which it is expressed and presented in the communication, since the experience exists exclusively in a certain context (M. Larkin et al.), cite provisions important for analyzing the process of work of the Balint group:

1) a person lives and realizes himself in his experience, therefore, a prerequisite for a constructive phenomenological approach is a description of the social (professional) and dialogic situation in which this experience is born, since it is always dialogic. This means that it appears, expresses, experiences and is understood in a specific professional situation. Naturally, experience, if it is generated not only by a certain external influence but also by interpersonal interaction with another human age, always has a process of internal dialogue that exists within self-consciousness.

2) tendency to a description and a coherent understanding of experience and its context should be realized in the conscious listening process.

3) it is necessary to describe and understand this experience and its context in the process of analyzing this experience and its subjective significance.

These two processes (description and understanding) are closely related and intertwined, so it is not always clear what is primary in their relationship and what is the consequence. But they can be conditionally separated and therefore, becoming visible to the group, they can become conscious and available for discussion. The phenomenological approach to the analysis of communication in the Balint group provides useful base that allows physician not to focus on the necessity to find "impeccable and error-free" solutions to his difficult task, not asking for easy-to-perform advice, but facilitates his condition by understanding, what is really needed - not to know, what to do with the patient, but what happens between them, how he himself experiences it, how he relates to this experience, how he expresses it to his patient and how he becomes more understandable to him. That leads him to be a “drug-doctor”.

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Workshops

Workshop 1:

The working group for educators – is it Balint?

Workshop Presenters:
Joan Fogel, Belinda Moller

The Working Group (WG) for those working in schools and higher education – as teachers or with teachers – has been meeting for 5 years. The co-leaders are both Group Analysts, one a Balint Leader and former teacher and the other a Balint Leader in training and an organisational consultant. They met on a Balint workshop weekend; the WG puts the Group Analytic and Balint frames together.

The WG was, eventually, named with Wilfred Bion in mind: the 'work' is to discover what goes on in educational institutions. Of the eighty on our mailing list - teachers, head-teachers, school counsellors, child psychotherapists, special needs coordinators (SENCO's), teacher trainers, medical trainers, academics, researchers, and psychologists - a maximum of 15 was meeting for 2.5 hours termly (every four months), alternating between Dublin and London but now, in the pandemic, on Zoom for 1.5 hours. There are a few regular attenders from both Ireland and the UK but no two groups are the same.

Group Analysis and Balint cohere both in the co-leaders' minds and in the WG's structure which, especially in the last pandemic months, has been flexible in meeting the challenges not only of the external world but also of the group itself.

Group members reflect on what might be going on beneath the surface of their conscious awareness. The Balint case provides a window. The reflection continues into the notes which members supply following each group. With the theme of the conference 'Balint core values: cohesion and flexibility' in mind, does the flexibility of the WG extend beyond the boundaries of what can be called Balint?

In this workshop we will invite participants to meet as the WG does, to experience it and to reflect upon its content and upon itself.

Co-leaders' introduction – a brief history and rationale of the WG……5 mins
Participants' introductions – why this workshop; what's on their minds……15/20 mins

A Balint
case……35/40 mins
Joining the
threads……10/15 mins

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Workshop 2:

Balint 2.0 and its ongoing relevance

Workshop Presenters:
Frank Meumann, Donald Nease, Albert Lichtenstein, Joy Humphreys

Learning objectives

- Share the history and ongoing work of Balint 2.0
- Discuss how Balint 2.0 informs ongoing work
- Participants will have the opportunity to reflect on the importance and unique role of Balint 2.0 in the worldwide Balint movement.

500-word description:

The COVID-19 global pandemic has rapidly moved what were isolated efforts at online Balint groups into a mainstream activity as many existing groups transitioned to meeting online and new groups have formed which have never met in person. As members of the International Balint Federation's Balint 2.0 Task Force, the workshop leaders have been at the leading edge of the move to online Balint groups,

having hosted the first groups in collaboration with the WONCA Young Doctors Movement, published data on the first groups and assisting with transitions by leading a series of seminars for group leaders in April through the current time.

With this workshop we wish to bring focus on providing online Balint groups to younger doctors who don't have access to Balint in any other way.
There is a diversity this group brings (and doesn't know any different) – race, colour, language, years of experience, age, background, nationality, - are all present without apparent judgment or subtext/unconscious dynamics affecting the group.

Session plan (workshop can be held online or in the room)

Time	Activity	Notes
(2')	Introduction of speakers	All
(3')	History and Background of Balint 2.0	Brief summary of the history of the WONCA group (Albert and Don)
(10')	Discussion of the current group	Presentation by the current leaders (Joy and Frank) with commentary from current members
(40')	Break out groups (up to seven people per group)	Moderated by each of the presenters 4 groups Explore: a) Is Balint 2.0 serving a unique function that advances the Balint movement worldwide? b) Are the cross-cultural aspects unique and important? c) Is Balint 2.0 important as a way to bring younger doctors who are familiar with technology into the Balint movement? d) What is the role of the IBF in continuing to foster the Balint 2.0 work in a pandemic/post-pandemic world?
15'	Plenary discussion	Open discussion of themes arising from break out groups
5'	Summing up	Key points of learning

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Workshop 3:

Pro bono Balint-groups in healthcare system, "engage yourself for 75 minutes! "

Workshop Presenters:
Judit Popovics, Judit Erdős

The values experienced in the Balint group such as trust, attention to each other, presence, intimacy became essential in the uncertainty, isolation and overload caused by Covid. After the invasion of Covid our Hungarian National Balint Society considered it important to play a social responsability role in helping healthcare professionals with online pro bono Balint groups.
Online groups are started in 2020 and they are still running today, where more than 120 doctors, psychologists and social workers have been participating across the country. In addition to experienced Balint Group leaders attending, there are also health care workers who have just met the Balint Group for the first time. Groups running in parallel are led by permanent group leader pairs, who have recieved Balint group supervision and individual supervision provided by the National Balint Society.
This structure is a challenge for the group leaders to be flexible enough to introduce the Balint group method to as many healthcare professionals as possible for the first time, and to preserve the cohesion, the values and sustainability of the Balint Group. As a result of all this during the joint supervision of the group-leading pairs a cohesive, intellectual workshop was established within our National Society. By getting to know each other in different roles (case presenter, group member, leader, co-leader) the personal relationships within our National Society have also been enriched.

During this workshop in the form of a thematic group we would like to continue the thinking we started together in our Society to extend it along dilemmas similar to the following. Can a Balint group process be formed from these pro bono meetings? What makes a person who sits in a group come back again? How can a group norm be passed during one single session? How does the commitment to one session affect the commitment to the method along the values of Balint?

Those who have similar experiences or who are interested in starting pro bono groups are welcome to attend the workshop.

Planned course of the workshop:
10 mins: topic introduction
15 mins: getting to know each other, sociometric tasks
10 mins: raising dilemmas
20 mins: small group discussion
20 mins: reflection, summary

Workshop facilitators:
Judit Popovics, psychologist, Budapest – Hungary, juditppvcs@gmail.com
Judit Erdős, general practitioner, Gävle -SWEDEN, doktorerdos@gmail.com

Workshop 4:

Cultivating empathy with Balint groups at undergraduate education

Workshop Presenters:
Jéssica Leão, Priscila Castro, Gabriela Pina, Fernando Almeida

In the beginning, Balint Groups with students were not conducted. Even Balint thought that students were not mature and experienced enough to do so. However, other experiences have shown that the student-patient relationship can have desires and repercussions just as necessary to be discussed as those of the doctor-patient relationship. From this new vision, the Ascona Student Prize was born in the 1960s. It encourages the sharing of these experiences.
The cases described by students are challenging from an emotional perspective. There is uncertainty about their professional role, as well as feelings of helplessness and dependence during college. Medical students systematically address the relationship between themselves and patients as a relevant part of that patient's care and therapeutic plan.

The leader, therefore, must be prepared for the challenges and the specificities of working with this public. Thus, the workshop "Cultivating empathy with Balint Groups in undergraduate" aims to: 1. share the experience of a Brazilian leader of online Balint groups with medical students and 2. encourage discussion about the potential of these groups for the formation of students and, consequently, of more empathic doctors.

The workshop will last 75 min, will enhance the maximum of 25 participants, and will feature six moments of interactions and exchange, according to the agenda below:
1. Getting to know each other (5 min)
2. Working with Balint groups at graduation: a contextualization (10 min)
3. Reading of 2 feedbacks from two students in graduation Balint Groups + Wheel discussion about the potentiality of groups with students (20 min)
4. Division of participants into two groups, each will discuss for 10 min one of the questions below:
"Imagine yourselves having Balint groups during undergrad. What do you think might have been different in your education if you had had this space?"
"Imagine yourself being the leader of this Balint group. What would your challenges be? What would you do?
After 10 min, participants come back together in a circle to share the discussion they had and the reflections they had.
5. Insights from experience with Balint Groups in undergraduate medical school (5 min)
6. Space for questions and feedback (15 min)

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Workshop 5:

Kissing under the waterfall –The intimacy and variety of supervision

Workshop Presenters:
Tove Mathiesen, Frank Meumann, Mary Wassink

1. **Learning objectives**

By the end of the workshop participants will:

a. Have shared experiences of Balint leader supervision (supervisor and/or supervisee) in online and face-to-face settings
b. Have reviewed their understanding of the need for Balint leader supervision
c. Be aware of the variety of supervision methods currently being used
d. Have generated ideas on how to promote Balint leader group supervision locally, nationally and internationally

2. **Program outline**

a. Introductions – name, country, Balint group settings 10 MINUTES
b. Describe what the workshop is about and what will happen 5 MINUTES
c. Ask participants about their experiences and methods of Balint leadership supervision 10 MINUTES
d. Set the scene: Talk about Balint leader supervision and why it is necessary 5 MINUTES
e. Participants divide into 4 groups and, using the 'Waterfall method', the groups will develop ideas on: How to promote Balint leader group supervision locally, nationally and internationally 30 MINUTES
f. Plenary discussion on what was discovered about the variety of Balint leader supervision and suggestion for progress on Balint leader supervision 10 MINUTES
g. Closure of the workshop 1 MINUTE

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Posters

Are Balint Groups useful for Acculturation?

Arun Kishore N Ravivarman; Sophie Atwood

Abstract
The NHS in U.K relies on several International Medical Graduates (IMG's) to be able to run the service efficiently. These IMG's struggle with barriers that hinder their adjustment and performance. There are no standardised induction programmes, those available do not address issues of acculturation.
Balint groups are a staple in Psychiatry training in the UK and have been known to be effective in addressing doctor patient relationships. There are no studies that address the issue of acculturation especially the issue of medical culture and how Balint groups might help with this acculturation.
Through a qualitative analysis of themes, this study reports the experiences of two leaders and ten IMG's who were a part of a 2year Balint group focussed on helping IMG's understand the system within the UK, develop bonds, facilitate communication, address the 'hidden curriculum' in the subgroups within psychiatry.

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Focus:
This poster is related to the twin themes of cohesion and flexibility through the inclusiveness of the programme and its flexibility in looking at the process of acculturation through Balint groups

Evaluating participant experience in Balint online sessions held during the covid19 pandemic – Lessons learnt and moving forward

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Poster submission, 150 words plus statement of relevance.
Statement of relevance: We hope this poster will inform both leaders and participants of future online groups of the benefits and pitfalls found by these members reflecting on their first experiences of online Balint. The response to adapting Balint groups during the pandemic demonstrated great 'cohesion and flexibility' and we believe the results of our interviews emphasise these core values and how they apply to the online Balint group and held these groups together at a globally challenging time**.**
Aims: From the outset of the Covid19 global pandemic a challenge was posed to reshape previously face-to-face meetings. One area that rose to this internationally was the Balint Group. We aimed to take a snapshot of the themes that some members and leaders have been identifying about their online group experience at this particularly challenging time for healthcare workers.
Methods: Members of 'Zoom-based' Balint groups across the UK were randomly selected for interview from a pool of volunteers facilitated by the UK Balint Society. The interviews and qualitative thematic data analyses were conducted by two academic foundation doctors who were not members of the Balint groups.
Results: Core positive themes identified when discussing virtual Balint were *ease of access, increased anonymity, attention to facial expressions*. Negative themes were a *lack of socialising* and different *group dynamic*. In these early sessions a frequent theme was the *increased role of the leader.*

Maintaining flexibility and cohesion in a hibrid balint group: a poster presentation

Our poster presentation addresses the efforts to maintain both values of Balint, flexibility and cohesion under the circumstances of a hybrid Balint group process. A 7-session Balint group was announced with personal presence, as part of a Psychotherapy-weekend, which is organized once a year. As the pandemic has gradually worsened we could start only in hybrid (three of our participants were projected by video connection on the wall of the room, and four were present together with the two Balint-group leaders). As a consequence of this sudden

decision by the organizers we felt like we were losing safety and control over the setting. Therefore, we initiated an extra meeting to adjust to the technical circumstances and to attempt to get back our competence.
The ratio of the virtually- and personally present participants made us face the next challenge: how to make cohesion within the group? We used techniques from psychodrama (marking out the whole space including the Wall, the chairs and the technical equipment as one unit) and used more active communication techniques to strengthen connection between participants on the wall and those present. We are aware that these instructions might not be in line with Balint technique but they resulted in the required group cohesion. So, this way the Balint work seemed to start off with bringing cases and mutual reflections within the group.
Unfortunately, at the end of the first day one of the leaders turned out to be a 'contact' of a Covid-infected person, so complying with the quarantine rules she had to leave the site and get connected online. This caused a 'mini crisis' for both leaders (with a harsh feeling of being expelled and being left), which we brought into supervision provided by the leader of the Hungarian Balint Society via zoom. Transparency and asking for reflections from each participant were our solutions. Literally and in reality we had to use our flexibility almost until 'we hit the wall': for the rest of the group process, one of the leaders was present personally on the site with the majority of the group, while the other was on the 'wall', projected by video (zoom) connection together with the other participants. These changes also had an effect on the dynamics of the group. On the one hand the online participants became much more active because they felt the closeness of one of the leaders who could share their perspective from inside as well as the difficulties of initiating connection to the others. On the other hand, this split situation required a more explicit communication (verbally) between the leaders than we were used to.
By the end of the sessions a kind of balance was established: each participant brought at least one case, and they could more freely react to each other due to their feeling that they were not led at all. The last case - about a client with psychiatric problems whose therapy was endangered by changing to an online platform - enabled the group to reflect again on the technique itself and on our efforts within this unknown situation - which were pending questions during the whole weekend. In our poster presentation we also reflect on the safety issues of the Covid-19 and the pros and cons of a hybrid form of Balint group, which is worthy of more attention in the future.

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The role of Balint groups on improving physician's empathy with their patients at Arak cancer's center.

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It is assumed that the participation of physicians in balint groups would increase good communication and empathy with patients. As a quasi-experimental research from the all patients in Arak Cancer Center in 2021 who had a disease record, 34 patients were randomly selected and divided into experimental and control groups. The experimental group consisted of 17 patients whose physicians were attended in balint group, for fifteen 90-minute sessions, once a week led by Alireza Memarian, certified balint group leader from German Balint Society and the control group consisted of 17 patients whose physicians did not participate in the balint group. The instrument used in this study was The Consultation and Relational Empathy (CARE) test and participants answered them in two stages, pre-test and post-test; mean and standard deviation were obtained through statistical data for the groups. Before the intervention, no significant difference in level of empathy were beheld. Patients in the experimental group whose physicians participated in the balint group expressed a high significant empathy level compared to patients in the control group whose physicians did not participate in the balint group.
Whereupon, Balint groups has been significantly effective on improving physician's empathy with their patients.

Keyword(s): Balint groups, Empathy, Cancer, Physician, Patient

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