

## Mutiny on the Balint? A Reflection on the Relevance of Balint, 50 Years Hence

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The authors of the paper “Mutiny on the Balint” in this month’s issue of *Family Medicine*<sup>1</sup> report on an exploration with their family medicine residents of the purposes and methods of running a residency-based Balint group. A recent study from the United Kingdom by Pinder and colleagues<sup>2</sup> addresses similar questions, most importantly: What is the relevance of Balint groups as a method by which to train residents in the skills of humanistic medicine and professionalism?

Fifty years ago, Michael Balint published his first work detailing the experiences of meeting regularly with London-based general practitioners and the insights gained from those meetings.<sup>3</sup> Today, Balint’s legacy is one of global proportions, as evidenced by a 26-year-old International Balint Federation ([www.balintinternational.com](http://www.balintinternational.com)) with at least 23 national societies in countries ranging from the United Kingdom to Australia.

In the United States, Balint groups have been most commonly associated with family medicine residency training, but in recent

years this activity has expanded into psychiatry, pediatrics, internal medicine, and obstetrics and gynecology training. Internationally, Balint groups are extremely diverse. They may involve not only primary care clinicians in practice and in training but also subspecialists, nurses, and members of other helping professions such as clergy.

Internationally, there is a rich tradition of experimentation with the Balint method, ranging from “prismatic” Balint, in which the group may fill an entire lecture hall, to Balint “psychodrama,” where group members physically act out the roles presented in the case. In Germany, Balint group participation forms a significant and essential portion of training required for physicians to provide and bill for behavioral care. There is ongoing discussion within the European Academy of Teachers in General Practice (EURACT) regarding a formal recommendation for Balint groups to be a part of routine general practice education. In summary, here in the United States and internationally, Balint work is diverse, thriving, and continuing to inform medical education.

This international perspective is important background to a consideration of the questions raised by “Mutiny on the Balint.”<sup>1</sup> Readers might conclude from this paper that Balint methods are rigid, with a sole focus on the doctor-patient

relationship, and that issues and outcomes related to professional identity and safety are only a “side benefit” of orthodox Balint methods. If it is such an inflexible orthodoxy against which the authors and residents are staging a mutiny, I would guess that given the diversity of Balint work, much of the domestic and international Balint movement might be considered to be in “mutiny.” Clearly, as the authors of “Mutiny” suggest, the goals and outcomes of a group of resident learners in 2006 will be different from a group of practicing UK general practitioners in the 1950s. There is indeed much to commend in the authors’ approach of clearly defining boundaries between Balint-type case discussions versus professional development. The importance of this distinction is embraced within Balint circles, and some programs have even developed a separate group experience focused solely on professional development.<sup>4,5</sup>

If Balint work has become more diverse, and less insistent on orthodoxy, what then are the current hallmarks of Balint groups, and can we continue to further the goals and development of the Balint method without losing its essential characteristics? I believe we can, if we continue to uphold two constants of Balint work: (1) specific doctor-patient relationships as the focus of Balint group sessions and (2) an

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informed focus on the safety of the group's experience.

The doctor-patient interaction remains the critical crucible in primary care, where two people come together with a common focus on health, well-being, and the alleviation of disease. The communication and relationship between these two people are critical to the mutual understanding that is necessary to reach accurate diagnoses and proper therapies. A safe, well-functioning Balint group provides residents with a flight simulator-like environment where they are able to present to a group of peers an emotionally vexing patient-physician relationship in which the mutual understanding has gone astray. With the group, they experience an opportunity to unpack the facts, emotions, and possibilities of the relationship. Solutions, indeed multiple solutions, may emerge to the dilemma that is presented. However, these solutions arise through an exploration of a specific relationship.

Through the presentation and discussion of multiple specific relationships, topics of professional identity, balance, emotional responses to patients, etc, are frequently explored in depth. A list of the ways in which Balint group participation addresses specific competencies of the Accreditation Council for Graduate Medical Education (ACGME) is available on the American Balint Society Web site (<http://americanbalintsociety.org/>

ACGME.htm). By rooting the discussions in a specific relationship, a Balint group frees the discussion from the abstract and the theoretical, giving residents the opportunity to apply their understanding directly to their patients' care.

Safety of the group experience also remains an essential of Balint work. Unfortunately, in the opinion of this author, much of what has been communicated as orthodoxy in the past resulted from our own uncertainty about where the boundaries of safety lay. This "beyond here lie dragons" sort of line on the map was often drawn in reaction to fears of what harm might be done in the name of Balint. As has been described elsewhere, the safeguards maintained within a Balint group are similar to those of many other small-group formats.<sup>6</sup> However, because the frame and contract of Balint work, especially within training settings, is on professional interactions and behavior, intensely personal explorations of the sources of members' reactions and emotions are discouraged. Leaders also act to protect the member who presents a case from excessive cross-examination by other group members, recognizing and reinforcing to the group that if the presenting members had the answers, they would not have need to bring the case to the group.

A focus on specific doctor-patient relationships, the issues raised by them for our professional selves, and an observance of important

boundaries of safety characterize current Balint work. These basic ingredients leave a great deal of freedom for groups to work productively. Rather than a mutiny from Balint, which might leave us like the crew of the *Bounty*, aimless and destined for ignominy at best, we should learn from each other, setting sail together on a voyage of discovery of how we can continue to better understand and be of service to our patients.

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