What do Medical Students discuss in Balint Groups?
(Themes of the cases presented in Balint groups for Medical Students.)

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Introduction:
The Balint groups were for students in their 1st clinical year. All participants were volunteers who came to the group in their own time. Each group met for 1 hour per week for a period of 3 months. This paper discusses the themes presented at three separate groups, from sixty-three cases. Seventeen themes were identified by the author, in her experience, many of these are commonly discussed in Balint groups for experienced doctors, but others are specific to student groups.

The 10 identified themes specific to or particularly important to students:

1. Students' role
2. Confidentiality
3. Consent
4. The very ill patient
5. Death and dying
6. Revulsion to patients
7. History-taking
8. Professional boundaries
9. The Student-patient relationship
10. Doctors' behaviour

These above themes will be discussed in this paper with examples of cases to illustrate them.

Other themes commonly discussed in most Balint groups:

11. Anger in patients, doctors and students
12. Frustration
13. Distressed patients
14. Denial
15. Quality of life
16. Diagnoses
17. Challenging assumptions

This list is mentioned for the sake of completeness.

1. The Student's role:
Students frequently described incidents where they felt they were in the way, for example when a seriously ill patient was being assessed by a doctor and there was no role for the student. On the other hand, there were other occasions when the student was given specific tasks to do and felt a useful member of the team.

They are aware that they are "at the mercy of the patient." One student described his first attempt to take a medical history. He approached the patient ready to ask her permission when she suddenly said: "No! I said no to the students yesterday, I say no today and I'll say no

tomorrow, I will not speak to students!" The group laughed with him, but they realised how upsetting it was for him to be rejected by his first patient. Later, they began to consider the situation from the patient's point of view. Perhaps she was not feeling well and there may have been many other students approaching her that day.
Another particular difficulty is how to deal with questions from patients or relatives. The students understood the relatives concerns and felt frustrated if they knew the answers, but as students, were not in a position to give them.

Other concerns apply to the teaching they receive in the clinical setting. A student described a situation when he had been asked to take a history from a patient in the respiratory clinic. The patient told him all the medication he was taking, even gave him a list, but the student was surprised he did not have an inhaler and so asked him specifically about that, but the patient insisted that he did not have one. When the patient saw the consultant she asked him the same question and he promptly took four inhalers from his pocket and put them on her desk! After the patient left, she spoke to the student and chastised him, without asking him what had happened. The group asked him if he had explained what the patient had done. The student said he had not because "we are told not to blame the patient." When he was asked how he felt, he said: "wronged!" Further discussion in the group helped him to understand that perhaps his history taking could have been better, perhaps the patient had not understood what he meant, but the feedback from the consultant in this case had not been helpful. The group discussion revealed that clinical teachers often say either: "Good!" or "No that is wrong" without more specific explanation. The students are aware of the time constraints on the doctors, especially in a busy clinic, but such feedback is unhelpful to the students.

2. **Confidentiality:**

Having been taught the need for privacy when talking to patients, a student described an encounter with an elderly patient from whom she wanted to take a history of constipation. The patient was on an open ward with only a curtain to separate her from the other patients and was hard of hearing. The student wondered what she could do in such a situation.

The difficulty of maintaining confidentiality was discussed. A patient admitted to a student that he had exaggerated his symptoms in order to gain admission. He was an alcoholic who wanted an in-patient detoxification and knew that he would be offered it as an outpatient, so he told the doctors that he was suicidal. What should the student do? Tell the doctors or collude with the patient?

A young man was on the ward after a heart attack. The student clerking him admired some beautiful flowers by the bed and the patient told her that his wife had brought them for him, but he was upset because they could not afford them. He went on to explain that she had schizophrenia and he was desperately worried about their one year old daughter, he was afraid that she might be taken into care. The wife then came in and the student felt very uncomfortable having heard so much about her, but without her giving permission.

3. **Consent:**

There were several experiences of difficulties about informed consent. One patient was brought to the group who was to undergo surgery for an aortic aneurysm. He was determined that he did not want to hear about the risks, but the doctor was trying desperately to explain them to him. What should one do in these circumstances? They knew it was the doctor's duty to explain, but it seemed almost cruel to the patient.

Another example was on a ward round. A man in his sixties in severe heart failure asked the consultant if he could go home. The consultant told him initially that he was not well enough, but then reluctantly agreed, warning the patient that he was likely to be readmitted in a day or two. The patient said he thought that he would be better off dead than in hospital. The consultant then told him "I'll put 'not for resuscitation' in your notes. The student was shocked as there had been no discussion and no suggestion that the patient should discuss it further with anyone. He did not feel that the patient had been in a position to give informed consent and so afterwards the student asked the consultant about it. The consultant was clearly "displeased" and replied: "It is what the patient wants."

Another example was of a patient whom the student felt was being coerced by his relative. She saw an elderly man on admission because of rectal bleeding. He was very co-operative and she felt that she had taken a good history, but when the patient's son joined them he told her that his father was demented and his problem was in fact carcinoma of the prostate. He went on to say that his father did not want conventional treatment, he preferred herbal remedies. The student later saw the patient alone and found that he would like to have any treatment that would help, including the recommended chemotherapy. However, when the doctor saw the patient, the son said firmly that his father made it clear that he did not want treatment. The student was able to explain her concern to the doctor who promised to consult the patient without his son.

4. The very ill patient:

Students have several concerns, how can you approach a seriously ill patient?
How do you answer their questions? This may be particularly difficult if you do not know how much the patient knows, and what do you say when it is very serious?
A student approached a patient having read that she was awaiting surgery for a pancreatic tumour, but after taking her history she told him that she had already undergone surgery and had been found to have inoperable carcinoma of the gall bladder. Although he had prepared himself that she might have a serious illness, he was shocked to find that she already knew the bad news and he did not know how to react. He said he wanted to run away, but he did stay with her and was amazed how she helped him to speak of other things.
What happens if they cry? One student was reacting sympathetically to a patient when he burst into tears. She was devastated, "My very first patient and I made him cry". In fact she stayed with him and was able to see that in fact it had been her sensitivity that had enabled him to cry.

5. Death and dying:

The students were aware of the risk of them being completely detached from both the patient's and their own emotions in their effort to remain "professional". Indeed sometimes they saw this reflected in doctors' behaviour. A moving story was told by a student who was in the Accident and Emergency Department when a 50 year old man was brought in by helicopter. He had taken cocaine, swallowed bleach and then jumped from the fifth floor of a building. While being treated for his severe injuries his heart stopped and she was asked to do the cardiac compressions, it was the first time that she had carried out resuscitation on a real patient. Soon afterwards he died, the doctors just stated that he was dead and to her horror the whole team moved on to the next case, leaving her alone with the dead patient. There had been no discussion and no one had asked her how she was. She wondered if the patient's history had influenced the doctors' behaviour.

The group asked her how she had coped and she said that when she got home she had spoken to a non-medical friend who had reassured her that she had done what she could to help the patient.

6. Revulsion to patients:

Another issue raised by students was that of coping with their feelings of revulsion on seeing some patients. This may be because of disfigurement or poor personal hygiene or because of prejudices demonstrated by the patient.
One student described seeing a man with a terrible facial disfigurement, she was shocked when she first met him. She needed to take a history from him and as he was with his wife, would have preferred to speak to her rather than the patient. However, she managed to overcome her horror and speak directly to the patient. To her surprise she found that when he began to speak to her she did not even notice his disfigurement.
Another student had been in the Accident and Emergency Department when a very badly burnt woman was brought in. Her hair was charred and it was impossible to tell the colour of her skin. When she was being examined, ash fell on the doctor and the student – she wanted to cry. When she went home she telephoned her mother and burst into tears.

An unkempt and smelly old woman had been seen in outpatients, the doctor knew her and explained that she comes about her swollen ankles, but will not accept any help from the nurses or social services. When he asked her how she was, she said "bloody awful". The student had been impressed by the doctor who had treated her with respect. The group speculated about the possible reasons for her refusing help, was she ashamed? Or afraid of losing her independence?

Another student described a patient on the ward who continually made racist and sexist remarks on the ward. He referred to a nurse as a "black bitch" and told a student that she had "nice breasts". How could one treat him professionally?

7. History taking:

Many difficulties with history taking came up in the groups. For example it was not always possible to find a patient who was willing to be seen by a student. Often the students were asked to see patients in pairs, this had both advantages and disadvantages. It was easier to cover a full history, they were less likely to forget something, but on the other hand it was more difficult to speak about sensitive issues when there were two students present.
Sometimes it was difficult to believe the patient's story. A young man on the ward had severe abdominal pain, but he was a known drug addict and the staff did not believe him. The student was concerned that he might be in genuine pain and was troubled as he kept on asking her to get him more morphine.
There were other examples of different students (or doctors) obtaining different histories from the same patient, or the same student getting different stories at different times. On these occasions the students found it difficult to maintain a professional attitude.
Perhaps the commonest difficulty they experienced was the conflict between trying to listen to the patient's own story and taking a full systematic history. How useful were the standard questions? How could they interpret the patient's answers or stories? How could they get silent patients to speak, or garrulous ones to stop talking? Another issue was how to cope with patients who deny or exaggerate their symptoms.

8. Professional boundaries:

These issues are common in most Balint groups. Does one behave like a Professional and risk being impersonal or like a friend when it is easy to be over familiar. The students found it particularly difficult to relate to patients of similar ages to their own, particularly of the opposite sex. How do you examine patients whom you may find attractive, or find you attractive?

The question of touch was often mentioned, a specific example is described below.

The situation occurred immediately after the terrorist attack in London. Patients who had come to the hospital with minor injuries were asked to remain on the premises for three hours after treatment to ensure that more serious injuries did not go undiagnosed and that they had time to recover from shock. During this time a student was allocated to each patient to look after them, fetch refreshments, help them arrange transport home and make sure they were interviewed by the police. A student in the group was allocated a middle aged business man dressed in a formal suit, who told her that he was "absolutely fine" and wanted to leave. Initially she felt intimidated but realised that his denial was probably due to shock. After a time he began to tell her about his job which was a senior position in a well-known museum. He had just begun this job and was still living more than a hundred miles away so he realised he was going to have difficulty in getting home, because of the serious disruption to all transport in London. He let the student help him and gradually his defences fell away so by the time he left he was looking very sad although he was very appreciative. In the group the student said: "I wanted to give him a hug", but she felt it would be unprofessional to do so. A group member said that perhaps it was she who needed a hug after such an emotional experience, she smiled and said that when she did leave the hospital she had met an old friend and he had given her a hug.

9. The Student – Patient Relationship

The students recognised the privilege of being able to enter the patients' lives and share some of their experiences and they were surprised how some patients were able to trust them even though they were not yet doctors. They often felt that they were giving nothing to the patient and were a nuisance, but an appreciative patient could help them feel that they were being valued. One example was of a seriously ill patient with jaundice who had clearly developed a good relationship with the student. He was an artist and after having his history taken he asked the student if he could draw his portrait, which he did, and presented it to him. The student was delighted and brought it to show the group.

10. Doctors' behaviour:

The students were often impressed by the doctors' respect for patients but uncomfortable with the position of power that they hold.

Many examples of doctors' behaviour came up in the group, some of which have been mentioned in this paper. For example, the approach to clinical teaching; good and bad communication with staff, relatives and patients, in particular with relevance to informed consent and patients' autonomy; the respect shown for a patient who aroused feelings of revulsion and difficulties in coping with death.

They also observed situations where they felt patients were being stereotyped. An example of this was given by a student who was working on a surgical ward. The junior doctor advised him not to clerk the patient in the single room because he was "schizophrenic" – he had tried to commit suicide by throwing himself in front of a train. At this stage in his training the student had no experience of psychiatry and assumed that the patient might be dangerous. One day the ward was very busy and the doctor asked this student to take blood for testing from this patient. He entered the room with trepidation, but the patient had smiled at him.

When he tried to straighten the patient's arm it clearly caused pain and the student was frightened that he would react violently, but he just extended his other arm and as the student bent over him to take the blood the patient said "you smell really nice". One of the group members asked the presenter if he had thought the patient found him attractive, but he said that was not his concern, he had been thinking of Hannibal Lecter in "The Silence of the Lambs"! However, afterwards the patient had been really appreciative and thanked the student for talking to him. As he left the patient said "you are a fantastic nurse."

Conclusion:
The group leaders were impressed by the willingness of the students to express their feelings and anxieties and felt that the primary aim of the group to "To provide students with an opportunity to explore the emotional aspects of their work in a safe environment" had been achieved.

When asked for feedback the students said they found that the Balint group had:

- increased their confidence
- improved their communication skills
- encouraged whole patient medicine
- encouraged reflection
- provided support
- increased their enjoyment of their work

We plan to continue these groups and will follow the students' advice by arranging the groups to consist of 6-10 members, continuing to offer them as an option in the first clinical year and preparing the students so that they know what to expect from the Balint method.

This paper would not have been possible without the inspiration of Dr Peter Shoenberg who decided to reinstate the student Balint Groups and acted as a Group Leader; the dedication of the other group leaders, Dr Andrew Chamberlin and Dr Sotiris Zalidis and the students' sensitivity, openness and ability to observe and reflect on their work.