ELSEVIER

Patient Education and Counseling 72 (2008) 5–11

Patient Education and Counseling

www.elsevier.com/locate/pateducou

A qualitative analysis of student Balint groups in medical education: Contexts and triggers of case presentations and discussion themes

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Received 28 June 2007; received in revised form 8 January 2008; accepted 12 January 2008

Abstract

Objective: No previous rigorous qualitative studies exist on student Balint groups. The aim of this study was to explore the contexts and triggers of cases presented in student Balint groups and to clarify the themes in the group discussions.
Methods: Fifteen student Balint sessions in two groups were organised. Nine female students participated. A grounded theory-based approach with thematic content analysis of the field notes was used.
Results: We identified five triggers for case narrations (witnessing injustice, value conflict, difficult human relationships, incurable patient, role confusion) that originated from three distinct contexts (patient encounters, confusing experiences in medical education, tension between privacy and profession). Four main discussion themes could be identified (feelings related to patients, building professional identity, negative role models, cooperation with other medical professionals).
Conclusion: The concept of case in student Balint groups was wider than in traditional Balint groups. Feelings related to patients and to one's own role as a doctor were openly discussed in groups. The discussions often touched on professional growth and future professional identity as doctors.
Practice implications: The Balint groups may support medical students' professional growth process. This topic warrants further study in more heterogeneous student groups.
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Keywords: Medical education; Student Balint groups; Professional growth; Qualitative research

1. Introduction

Michael Balint contributed towards a broader understanding of the importance of a doctor's personality as a tool in doctor–patient encounters. For Balint, the doctor's person, her feelings and reactions constitute a key diagnostic and therapeutic instrument. To promote the use of this instrument, he introduced a method of work tuition for general practitioners.

Traditional Balint groups are seminars with 5–10 general practitioners meeting weekly for a 1.5-h discussion over a 2–3-year period with a psychoanalyst psychiatrist or other comparably trained group leader. The groups are oriented to enhance their members' self-knowledge and understanding of the transference and counter transference phenomena in a safe and supportive atmosphere. The participants are offered an opportunity to reflect upon their work using case reports and group discussions. In traditional Balint work, cases are limited to patient cases [1].

One goal of Balint group work is to offer an arena to refine the initial emotional experiences with the aid of tutored reflection [1,2]. In being able to talk about a case, Balint group members reveal inner experiences and feelings. In this way, members expose their self-reflection to other members of the group in a safe non-judgmental environment. Group members benefit from the reflections of others and in comparing their experiences with the stories of colleagues [1,2]. Group discussions on feelings have the potential to make one more aware of feelings, thus enabling them to be analysed, organised and subsequently controlled. Emotions and feelings in clinical work can benefit patients if they are tolerated and understood by the doctor [1].

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0738-3991/$ – see front matter © 2008 Elsevier Ireland Ltd. All rights reserved.
doi:10.1016/j.pec.2008.01.012

Elements of professionalism have been (well-) described in the literature [3], and medical schools aim to teach these elements effectively [4–6]. The elements of professionalism comprise, in addition to competencies in knowledge and skills, also attitudinal, cultural and societal dimensions [3]. It has been suggested that teaching a cognitive foundation for professionalism is inadequate. Medical schools should establish an environment where the process of socialisation in its positive sense can take place [5]. Promoting professionalism may include for example support for self-awareness, maintaining a balance between personal and professional roles, recognition of ethical dilemmas and exploring and resolving interpersonal conflicts in professional relationships [3]. The Balint method can be applied to support these processes.

Balint groups have been used for family practice residents [7] trainees and medical students [8] and in continuous medical education (CME) [9,10]. Modifications of the traditional Balint method have also been implemented to respond to the needs of participants. For example, young doctors have brought up topics other than traditional patient cases, such as difficulties in reconciling their scientific hospital training with the human uncertainties of general practice [11]. Descriptions of Balint groups or Balint-like groups have been reported from several countries, and in general the experiences of the groups have been positive [12–19]. In student groups, the themes discussed and the contexts of cases have tended to be broader. Students may present doctor–patient encounters or some problematic issues emerging during their studies rather than their own experiences with patients [19]. The duration of student Balint groups have been shorter than in traditional Balint groups, and the leader may be more active in describing her own experiences [18]. Key learning issues in students' groups have been to gain understanding of the doctor–patient relationship [16,18], to support professional development, to affirm physicians' identity and to help resolve professional role conflicts [7,19,20].

Rigorous scientific research on Balint groups is scarce. A Swedish study evaluated experiences of doctors participating in Balint groups and compared them with those of non-participants. The participating doctors had better satisfaction and a higher sense of control at work than their controls [10]. Another study suggested that explicit training of communication skills was more effective in improving the skills of "breaking bad news" than traditional Balint group training [21]. To our knowledge, no qualitative studies on student Balint groups have been published.

1.1. Aims of the study

In exploring the typical index cases and discussions in medical students' Balint groups, we asked the following questions:

1. What were the contexts from which the cases were presented?
2. What triggered the student to present the case?
3. What were the main discussion themes among the groups?

2. Methods

2.1. Organisation and participants of the Balint groups

We organised two separate student Balint groups for medical students at the Faculty of Medicine, University of Helsinki, between 2002 and 2004 in collaboration with the Finnish Balint Society. Each group session was led by a trained psychoanalyst who was an experienced Balint group leader (E.M.) and one co-leader (M.A.T. or C.M.). The co-leaders were clinical teachers in general practice. Students were recruited by advertising the course for clinical students by email. The groups were open to all medical students who had completed at least 3 years of the 6-year medical school curriculum. Prior to the groups started, the participants were informed about the Balint method and the purpose of the sessions. In addition, the participants were asked to commit themselves to all sessions organised for the group.

Nine medical students participated in the two Balint groups and signed an informed consent. All participants were females. The female/male ratio in our medical school is about 3/2. The first group ($N = 5$) met a total of 10 times, once every other week, and the second group ($N = 4$) 5 times, once a week. Each session was in the afternoon and lasted 90 min. Table 1 describes the structure and organisation of the two groups.

2.2. Materials

Data consist of participant observations from all 15-student Balint sessions by the group leader (E.M.) and the two co-leaders (M.A.T., C.M.) based on notes made by them during and immediately after each session. Notes were made on both presented cases and discussion contents. The individual notes of the leader and the co-leader were compared and discussed by the leaders to agree upon the content before final transcription.

2.3. Data analysis

We used a grounded theory [22]-based approach to the data to find emerging issues and themes from the transcripts. Three of the authors (E.M., C.M., M.A.T.) first read the notes individually several times and coded the discussion issues as they emerged from the data. The individual codes were compared in data-analytic sessions, inconsistencies between the individual codes were resolved through shared reflection and discussion and a consensus of the findings was negotiated

Table 1
Structure and organisation of the student Balint groups

Group	Period	Sessions	Participants
1	Autumn 2002–Spring 2003	10 sessions every 2nd week	Five female (6th year) students
2	Spring 2004	5 weekly sessions	Four female (three 6th year, one 3rd year) students

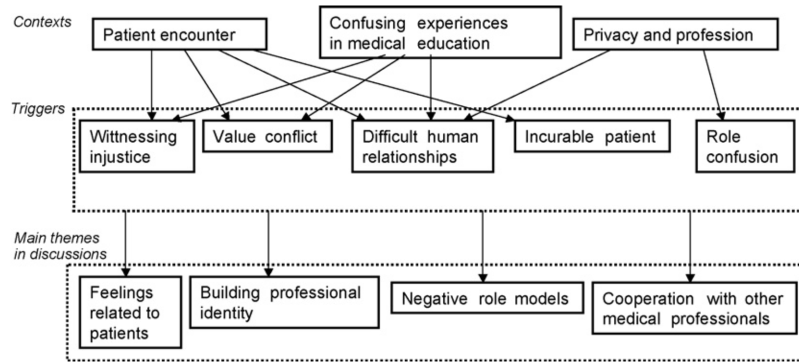

Fig. 1. Cases in student Balint group discussions: the contexts, the triggers of narration and the themes.

following the principles of thematic coding [23,24]. The issues were then grouped into main categories in data-analytic sessions by all four authors. In the next phase, contents of each category were analysed and organised into themes. Tabulations were used to determine frequencies in the categories [25]. Attention was also paid to deviating phenomena.

3. Results

3.1. General

In the 15-student Balint group sessions, the students ($N = 9$) produced 28 different cases. On average, each group member presented three cases, and although there was some variation in bringing up cases each student presented at least one case and all group members participated in the discussion. Two cases were usually discussed in one session. The cases were often intertwined and each discussed themes from different viewpoints. The analysis produced three categories of perspectives on cases and group discussions. First, the cases derived from different contexts of students' lives. Second, different conflicting incidents from students' experiences triggered presentations of the cases. Third, the cases produced various themes in-group discussions irrespective of the context of the case or triggering event (Fig. 1).

3.2. Contexts of cases

We found three contexts for cases. The most usual context was a ''*patient encounter*'' either during medical studies or as a medical student working as a substitute doctor during university vacations. Seventeen cases belonged to this group. Traditional Balint groups accept only patient cases. However, we found it necessary to also accept other contexts. Five cases originated from the context of ''*confusing experiences in medical education*''. This typically comprised rude behaviour or an attitude of a teacher or another medical professional in the hospital that had confused the narrator. Six cases dealt with the impact of being a doctor on personal life; we call this context ''*privacy and profession*'' (Table 2).

3.3. Triggering incidents for the cases presented

The triggers for presenting cases were related to ethical questions, values or difficulties in human life. We grouped the triggers into five groups. The most common triggering factors were ''*an incurable patient*'' (seven cases) and ''*difficult human relationships*'' (seven cases). The former trigger was related to students' encounters with seriously ill or dying patients. The latter trigger emerged from experiences in which a student witnessed rude or humiliating behaviour of patients or professionals towards each other. ''*Witnessing injustice*'' (five cases) was a trigger in which a student had either experienced personal unfairness from patients or medical professionals or witnessed injustice in their patients' lives. ''*Value conflict*'' (four cases) was a trigger in which the student experienced inner conflict between his/her willingness to help and the limitations set by the system. ''*Role confusion*'' (four cases) was a trigger in situations where the student adopted the doctor's role in private life. One case could not be placed in any of the above categories (Table 2).

3.4. Main themes in group discussions

The themes discussed in groups with the aid of cases may be allocated to four categories: ''*feelings related to*'', ''*building professional identity*'', ''*negative role models*'' and ''*co-operation with other medical professionals*''. Each topic was typically discussed in association with several cases. We present examples of typical index cases with each category. The number of the case refers to information in Table 2.

3.4.1. Feelings related to patients

Students' feelings related to patients were discussed in association with 26 cases. Emotions were usually preconscious at the beginning of the discussion until the narrator could name the associated feeling. Negative feelings, such as aggression, dislike or humiliation, were brought up with the aid of cases in which a patient had behaved rudely. Students appeared to find it necessary to legitimate their negative feelings. Patients or relatives of patients who were angry, anxious or demanding evoked conflicting feelings in students. The students felt that it was their duty to try to understand and handle the anger of the patients or their relatives, although this was not always easy.

Table 2
Contexts and narration triggers of cases and themes of discussion in student Balint groups

Context	Narration trigger	Description of case	Themes in discussions			
			Feelings related to	Building professional identity	Negative role models	Co-operation with other medical professionals
Patient encounter						
1	Witnessing injustice	Raging patient	x	x		x
2	Witnessing injustice	Mentally retarded sexually abused patient	x			x
3	Difficult human relationships	A complicated childbirth	x	x		x
4	Value conflict	Frequently visiting patient	x	x	x	x
5	Incurable patient	A patient dying in ER	x	x	x	x
6	Incurable patient	A demented patient in EA	x	x	x	
8	Incurable patient	Tetraplegic patient	x	x	x	x
11	Incurable patient	Anorectic patient	x	x	x	x
12	Difficult human relationships	A patient with severe pain in ER	x	x		x
13	Value conflict	A patient with dizziness	x	x		x
14	Incurable patient	A "bad death"	x	x		x
15	Incurable patient	A "good death"	x	x	x	
16	Witnessing injustice	A dishonest patient	x	x	x	x
17	Difficult human relationships	A disturbed consultation	x		x	x
18	Value conflict	Confrontation with a demanding relative of a patient	x	x		x
19	Witnessing injustice	A patient complaint	x	x	x	
27	Incurable patient	Pain for 10 years	x	x	x	x
Confusing experiences in medical education						
9	Witnessing injustice	Being a medical student at a university hospital		x	x	
10	Value conflict	Demands of perfect performance in health care		x	x	x
25	Difficult human relationships	Rude treatment of a patient in intensive care unit	x	x	x	x
26	Difficult human relationships	A male patient in dialysis	x	x	x	
28	Difficult human relationships	Psychiatric wards		x	x	
Privacy and profession						
7	Role confusion	Student's lost friend		x	x	
20	Role confusion	Student's friend who is severely ill		x		
21	Difficult human relationships	Encountering a victim of irrational violence		x		
22	Role confusion	An accident of a young downhill skier	x	x		
23	Role confusion	A request to give medical advice during holidays		x		
24	Very personal (deviating case)	Death of a close person		x		x

Index case 1: *An incorrect appointment time was given to the patient by the office. The doctor in question was not in attendance. The patient was very angry and raged to the office staff. The student who was working as a doctor happened to be there and offered to see the patient at once. The patient shouted at the student, scolded her and blamed her for everything*.

Treating a lying patient was also a challenging situation. The students found it difficult to tolerate a patient acting falsely. Anger was usually the first reaction, and this was followed by a feeling of humiliation. Maintaining a professional attitude towards a lying patient was considered a professional challenge that also requires personal growth. Problems in communication with patients created insecurity, helplessness and frustration. Negative emotions generated anxiety, shame and guilt. These feelings were experienced as barriers to helping the patient. When students found a way to turn problematic communication into mutual understanding, the experience was regarded as one that helped to build a positive professional identity.

Students described how patients' suffering and death created feelings of uncertainty and helplessness, which were hard to bear alone. In these situations, students had expected support and help from more experienced colleagues. The cases most often discussed in these groups dealt with unmet expectations. The opportunity to share the emotional burden associated with the human and legal responsibilities of a doctor's role was considered valuable.

3.4.2. Building professional identity

Professional identity was a theme discussed in association with 25 cases. Positive experiences, success at work and

positive feedback from patients and collaborators in the work community were regarded as important factors in building a professional identity.

Index case 12: *A 70-year-old woman with severe pain was brought to the emergency. The patient had been in the same hospital for the same reason 1 week earlier. It was difficult to understand the patient's description of the pain, and the laboratory tests were not yet ready. The diagnosis was unclear, but the pain was becoming increasingly severe. The student in charge gave the patient an analgesic and took time to properly discuss the situation with the patient. This discussion helped to set the correct diagnosis*.

In the above case, the student made an independent decision to ignore the hospital protocol and gave the patient an analgesic drug before the diagnosis was set. She also took her time with the patient despite a busy emergency ward. With this decision, she took on a broader responsibility and more autonomy in her role as a physician. The students stressed the importance of determining their own boundaries as a doctor. They also appreciated humbleness. The inability to ask for help and difficulty in accepting help evoked many reflections. Omnipotence was considered a harmful attitude.

Index case 23: *A medical student was beginning her holidays far (away) from home and turned on her mobile phone at four in the morning at the airport just as the plane had landed. Within a few minutes, her mother called to tell her that her father, who had kidney cancer, had blood in his urine, expecting the student to tell her what to do*.

Many of the group members had encountered requests for help by friends or relatives. These situations were considered particularly demanding, often evoking feelings of ambivalence. It was difficult to say no, but to offer help was also not easy. The possibilities to ask clarifying questions or to examine a friend or a relative as a patient seemed limited.

3.4.3. Negative role models

Negative role models were discussed in association with seven cases. Medical teachers' arrogant behaviour evoked particularly strong emotions among the students. These teachers were seen as negative role models by the students, who did not want to emulate this style of being a doctor.

Index case 25: The teacher doctor had forgotten that he had promised to teach a group of medical students. He arrives half an hour late to the group unprepared for teaching and offers no apology. He takes the students to the intensive care unit for teaching. The patients are in the midst of having lunch. The group enters the room of an old woman who is eating her meal laboriously. The teacher completely ignores the patient as a person and without even looking at her introduces the group to the technical equipment attached to the patient.

When a medical student or a substitute doctor during summer holidays witnessed situations in which other doctors or medical professionals treated patients in an arrogant way, it was described as unbearable. Typically, the students tried to understand why the professionals had behaved as they did. The students felt they were left alone to deal with their anger after such occasions. Sharing these experiences in a group was described as helpful. Some attitudes and behaviour of teachers or other medical staff seemed dismissive and even cynical to the students. In the Balint discussions, the students became aware that they easily identified themselves with patients. Students considered this to be helpful in understanding patients, but they accepted that distancing is needed in clinical work.

3.4.4. Co-operation with other medical professionals

In general, the students felt that collaboration with other medical professionals was not problematic. Nevertheless, the position of a medical student or a young doctor in the medical community emerged as a leading theme in association with five cases.

Index case 2: *The student was taking care of a mentally retarded under-aged girl who was suspected of being sexually abused. The student placed a call to the hospital doctor in charge for a consultation. The response was: "At least, do not send her here!"*

Being humiliated by medical professionals in the role of either a medical student or a young doctor in a vocational job was described by some students. The students had experienced a need to discuss these situations with someone immediately or soon after the incident, but had not had the opportunity before the student Balint group.

4. Discussion and conclusions

4.1. Discussion

The students produced 28 cases for discussion in 15 Balint group sessions. Although most of the cases brought up in the discussions were about patient encounters, it seems that we need to be more open-minded about what constitutes a case in a student Balint group. The types of triggers stimulating students to present their cases were related to emotional conflicts or ambiguities. Despite the wide variation in contexts and triggers, the group discussions dealt mostly with confused feelings. Themes in the discussions often touched on professional identity. Student Balint groups may foster medical students' professional growth.

In traditional Balint groups, a case refers to a patient case [1]. The concept of a case in the student Balint groups here was broader; cases also included confusing experiences in medical education and how being a doctor affects one's personal life. The educational environment and the behaviour of other medical staff created confusing experiences that the students wanted to explore. It was meaningful to accept these cases into the Balint group discussion, as they were an integral part of participants' lives as medical students and affected their professional development. Our finding of the need for broadening the concept of case in student Balint groups is in line with previous studies [20,26].

For the cases presented, triggers typically arose from ambiguous emotions and inner conflicts experienced by the students. Several triggers found in our study have been reported earlier. For example, "incurable patient" [19,20] "difficult human relationships" including experiences of rude behaviour

of patients or professionals [14,18] ''witnessing injustice'' [18] and ''other ethical dilemmas'' [27] have been common themes in previous Balint groups. The triggers for narrating a case in a Balint group have not been rigorously studied to date; however, it is inherent to the Balint method that the triggers for presenting a case are conflicts or ambiguities frequently experienced in doctor–patient relationships [1]. Notably, only one case (deviating case) could not be categorised into any the above triggering groups.

The themes of our group discussion were similar to those in earlier Balint group descriptions. ''Feelings related to patients'' is a very common theme in Balint groups [9]. Discussions in previous reports have also included reflections on anger, being irritated, liking or disliking, hopelessness, anxiety and helplessness [18,27]. The common feature of index cases narrated in these student Balint discussions was that they created strong emotions and ambiguous thoughts in medical students. Patient cases were often associated with encounters with patients who could not take care of themselves, who were severely ill or dying or who had lied or showed aggression. Emotions and feelings were discussed in association with most cases. This probably originated from the Balint method itself.

Professional development was a major issue in students' groups and emerged in most discussions. Professional identity was discussed in association with patients, education and private life. Explicit discussions on professional identity should be encouraged since we know that medical culture is only partly conveyed and learned within the curriculum-based hours formally allocated to medical students [28]. As it stands now, values, attitudes and related behaviours considered important within the medical culture are often internalised by medical students via a ''hidden curriculum'' [29]. Dimensions of professionalism as described for example by CanMEDS [3] were intensively discussed in our student Balint groups. Thus, the Balint groups may facilitate professional growth.

Interestingly, negative role models were seen as 'bad examples' not to be copied. The internalisation of values and attitudes is therefore not automatic. ''Bad examples'' aroused strong emotions. Discussion about this made it explicit. Negative role models and related defences have been discussed in other student Balint groups [12–18] and in other studies on medical students [30]. The students in our study were not cynical and they valued the doctor–patient relationship. Both the active presence of the doctor as a part of the treatment [1,31,32] and core professional skills should be taught explicitly as well as through role models presented by medical teachers. Collaboration with other medical professionals has also been discussed in Balint groups [17,20]. In our students' experiences, collaboration with other medical professionals was usually not problematic. In some cases, the students had had problems and felt humiliated by more experienced colleagues. Similar experiences of humiliation have been described in other studies [20,30].

The participating students were satisfied with the Balint group work and felt that they had benefited from the course. In the discussions, students noted that the regular curriculum provides them with rare opportunities for open discussion about their professional growth.

4.2. Limitations and strengths

Although there were limitations in this study that might limit the generalisation of the results, this is the first systematic description of student Balint groups. A limitation is the method of data collection. We did not audiotape discussions, but relied on immediate field notes and ethnographic participation. Not audiotaping the sessions was a conscious decision. We wanted to ensure a free and trusting atmosphere in the sessions. The field notes are by their nature partly memory-dependant and can include interpretations by both the group leader and the co-leaders. All participants were females, further limiting the generalisation of results. Although our study population was small and the groups of students were selected, we systematically used qualitative methods to analyse the contents of the group discussions.

4.3. Conclusions

Balint groups for medical students may be valuable educational forums for fostering professional growth in the development towards a mature professional identity as a doctor. The student groups are modifications of the traditional Balint groups and should accept contexts other than merely patient cases into the discussion. These groups offer educational potential, allowing members to be accepted as they are and to share one's inner reality with others in a safe environment. A trained and experienced group leader is important for keeping the group goal-oriented.

4.4. Practice implications

The professional growth process of medical students may be supported by student Balint groups. The opportunity for medical students to share their inner feelings and ideas in an emotionally safe environment may have educational value. Further research is needed to evaluate the feasibility of student Balint groups for more heterogeneous groups.

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