Learning to Listen Differently

Introduction: Why I Chose Balint

When I first chose the Balint group as my Student Selected Component (SSC), I was drawn to it by a sense of mystery. The proposal described an opportunity to explore the emotional and psychological dimensions of the doctor-patient relationship. I had never been in a setting where I was encouraged, let alone expected, to talk about my feelings in relation to patients. I didn't entirely know what I was signing up for, but that uncertainty was, in a strange way, what enticed me. From the very first introductory email, it was clear this would not be a typical SSC. We were told that this experience was not about technical knowledge or textbook learning, but about exploring the human side of medicine, our reactions, vulnerabilities, and uncertainties.

What I discovered was a unique and confidential space where stories, emotions, and unspoken dynamics were brought to light. It wasn't therapy, but at times it felt therapeutic. The weekly sessions invited me to reflect not just on patients, but on myself, my reactions, assumptions, and internal conflicts. Over time, I began to realise how much I had internalised the expectation that medicine should be rational, composed, and emotionally detached. The Balint group challenged that belief, offering instead a model of professional practice rooted in emotional awareness and human connection.

Looking back, I now see the Balint group as one of the most impactful experiences of my medical training so far. Balint didn't give us answers, instead it gave us a mirror, and

sometimes that was harder to face. Moreover, it helped me give voice to the thoughts and feelings that often remain unspoken in clinical settings. It also helped me understand that emotional insight is not a distraction from professionalism, but it is, in many ways, at its heart. In this essay, I explore how these sessions helped me cultivate emotional insight, navigate interpersonal tensions, and grow more comfortable with discomfort, both within myself and in my interactions with others.

Finding My Voice in the Silence

In the early sessions, I often found myself defaulting to phrases like "we think" or "we felt," rather than using "I". It took several weeks for me to realise just how much I was hiding behind collective language. I suspect this was a defence mechanism, a way to avoid scrutiny or the discomfort of vulnerability. In medicine, I feel as though I am often taught to adopt a neutral tone, present cases factually, and mask emotion for the sake of professionalism. Speaking in the first person felt unprofessional, almost selfish – at odds with the neutrality expected in clinical settings. Yet, as the sessions continued, I noticed a shift. The more we shared our own personal reactions, the more trust developed within the group. And as others began to speak honestly, I felt safe enough to do the same. I now understand why we were explicitly told not to bring notes or prepare structured cases. It fostered an atmosphere of openness where cases came from the heart. That unfiltered sharing made room for authenticity, even if it initially felt risky.

There were moments of silence in the group that at first felt uncomfortable. However, these pauses soon took on a different meaning. One particular session still resonates with me: a presenter shared a deeply emotional case, and after their initial presentation, the room fell silent. It wasn't awkward, it was reflective. It held the weight of shared contemplation. No

one rushed to speak. That collective pause felt like an act of respect, a way of honouring the story that had just been told. In a way, it allowed all of us to process the material without rushing to fill the space. It made me realise how rarely we are given the time and permission to sit with discomfort.

I began to think more deeply about how I use silence when I am with patients. Do I rush to fill every gap in conversation with patients? Do I give them time to process, or am I too focused on the next question or diagnosis? The Balint group taught me that silence can be compassionate, and that it can convey presence more powerfully than words. It encouraged me to see not just what is spoken, but what is withheld, and to consider that as part of the patient's narrative too.

Looking back, I see the Balint group as the first space where I was not only allowed but encouraged to bring my full self into medicine. It has made me realise I want to be a doctor who listens not only to symptoms, but to silences, who notices not only facts, but feelings. This doesn't mean abandoning clinical judgement but expanding professionalism to include emotional curiosity and genuine human responsiveness.

A Case That Stayed with Me

One case that left a lasting impression involved a patient on the renal ward. The patient had been speaking cheerfully to the presenter, reminiscing about missed opportunities in youth, including the chance to experiment with recreational drugs. The presenter responded light-heartedly, saying, "It's never too late to try", to which the patient smiled. At first glance, it was a light-hearted moment – almost funny in its unexpectedness. But the group later questioned the appropriateness of the comment, and that discussion brought something into focus for me.

I kept thinking about why this case lingered. It wasn't the humour alone, but what sat beneath it. I began to realise that the patient might have been projecting something onto the presenter, perhaps a nostalgic version of his younger self. There was a longing in the way he spoke, not just about trying recreational drugs, but about time passed, missed chances, and unfulfilled desires. I imagined myself in the presenter's position, and I wondered whether I, too, might be seen by a patient as a symbol of youth and possibility. There was something deeply human in that exchange, and it stayed with me.

That case reminded me that medicine is often not about what is said, but what is felt. Beneath the surface of conversations lie unspoken narratives of loss, hope, identity, and regret. The patient's smile may have signalled amusement, but it also masked a sadness, perhaps even resignation. The mood shifted subtly after that comment, and that shift, while barely noticeable, carried emotional weight. It made me think about my own use of humour in clinical settings. When do I use it to connect, and when might it unintentionally shut something down? I began to question not just the words I say, but the emotions they evoke.

This case also made me reflect on my tendency to search for meaning in fleeting moments. Why did this encounter stay with me? I think it resonated with something within me – an awareness of how quickly time passes, and how we all carry regrets, even if we rarely name them. It reminded me of conversations I've had with older relatives, where humour was used to soften the ache of unfulfilled dreams. The Balint group helped me see that such emotional resonance is not incidental; it is worth paying attention to. In learning to identify these emotional cues in myself, I am learning to better understand patients. As Schön (Schön, 1983) describes, reflection-in-action allows professionals to learn from uncertainty – something I experienced viscerally in these sessions.

My Case: Emotion, Conflict, and Responsibility

When it was my turn to present, I chose a case that involved a nurse who had asked me to stop caring for a patient after they had been rude to her. She was clearly upset and went home after filing a complaint. I remember feeling caught in the middle, being uncertain of where my responsibility lay. Should I have stood by the nurse or continued to care for the patient? The initial meeting, where we voiced our expectations and hesitations, helped to normalise this kind of uncertainty. We were reassured that feeling unsure was part of the process, and that helped me present my own case without fear of judgment or needing to justify my actions.

However, presenting this to the group was still difficult for me. I had felt powerless and conflicted at the time, and those feelings resurfaced as I shared the case. What helped me most was hearing how others perceived the situation. Some saw the nurse's action as self-protective, others wondered if the patient's rudeness was a manifestation of his illness. What struck me most was the idea that it wasn't about choosing sides but about acknowledging the emotional reality of everyone involved, including myself.

I had suppressed a lot of frustration and guilt about that situation. The Balint group helped me surface those feelings and examine them. I learned that emotional awareness is not just about patients; it's also about understanding myself. The group gave me permission to hold conflicting emotions without immediately resolving them.

I began to ask myself more difficult questions. Why did I feel so strongly about not letting the nurse down? Was it because I saw her as a colleague or because I felt responsible for maintaining harmony on the ward? These questions made me think about the emotional roles I take on in clinical settings, roles I might not even be aware of. The Balint group helped me begin to uncover those patterns.

One peer's interpretation of the nurse's actions as defensive, rather than justified, challenged my own assumptions; my instinct had been to support her unconditionally. That contrast showed me how my own emotions and alliances might cloud my interpretation of events. It challenged me to consider other angles and reflect more critically on my assumptions.

A comment that struck me during these sessions was, "Empathy without boundaries can be self-destructive." This resonated deeply with me. I realised that in trying to be everything to everyone – colleague, caregiver, peacemaker – I was ignoring my own limits. That insight has stayed with me, reminding me that compassion must be balanced with self-protection, and that boundaries are not barriers to empathy, but conditions that make it sustainable. As Balint (Balint, 1955) suggested, doctors often unconsciously take on their patients' emotional burdens. This moment helped me understand the emotional toll of such identification, and the need for reflective distance.

Becoming Comfortable with Discomfort

In medicine I am often expected to remain calm, composed, and clinical. But the truth is, patient care can be emotionally taxing, especially when you lack the experience or support to navigate it.

Several of the cases we discussed revealed this. In one, a presenter felt helpless when a psychiatric patient broke down during a long history-taking session. In another, the presenter was asked by a patient if they planned to stay in the UK to practise medicine. At the time, the presenter hadn't thought much of it but later reflected on whether there was an underlying discriminatory tone. These moments revealed how often we experience discomfort without fully acknowledging it.

I realised that part of professional development isn't about becoming emotionally detached but about learning how to manage and process those emotions in healthy ways. The Balint group offered a model for this, a space where discomfort wasn't avoided but examined. It also reminded me that emotional discomfort often signals something important, something worth exploring rather than suppressing. As I move forward, I hope to retain this awareness and to build emotional resilience by facing, rather than fleeing, these difficult feelings.

Evidence-Based Insight

Recent evidence reinforces what I experienced in the group. A systematic review and meta-analysis (Gong et al., 2024) evaluated the impact of Balint groups on empathy and professional development. Across 11 studies – including randomized controlled trials and qualitative analyses – they found that Balint group participation significantly improved empathy, emotional awareness, and reflective ability. Notably, attending ten or more sessions had a markedly greater effect on emotional processing and perspective-taking, particularly among medical students. These findings mirror my own experience: twelve sessions allowed time to deepen trust, emotional insight, and personal growth. The evidence gives me confidence that what felt transformative emotionally was also meaningful educationally.

Differences and Dialogue

As the sessions progressed, I began to appreciate the diversity within our group. We came from different backgrounds, held different beliefs, and had varying thresholds for what we found emotional or meaningful. At times, we disagreed. But what surprised me was how these differences enriched the discussion rather than hindered it. I learned that disagreement

doesn’t have to be divisive. Instead, it can be a form of dialogue. For instance, when a peer interpreted a seemingly benign comment as patronising, I was initially surprised, but their interpretation made me re-examine how tone and context shape meaning. An awareness that’s vital when treating patients from diverse backgrounds.

At times, someone’s interpretation was conflicting to hear – not because it was wrong, but because it revealed blind spots in my own assumptions. These moments reminded me that discomfort can also be interpersonal. The group became a microcosm of clinical teams, with all the implicit tensions, alliances, and misalignments. Learning to navigate this respectfully was just as valuable as anything I learned from the cases themselves.

In clinical practice, I know I will work with colleagues who see the world differently. This lesson feels especially important for clinical teamwork, where empathy must extend not only to patients but to colleagues who think differently from me. Rather than suppressing my views to conform, I want to hold onto the confidence I gained through the Balint group, the confidence to say "I" and to share my perspective while respecting others'. I believe this confidence will be invaluable not only in team dynamics but also in the care I provide to patients. Every patient comes with a unique story, shaped by culture, personality, and life experience. The more open I am to different viewpoints, the better I can understand and support them.

Conclusion: Carrying the Lessons Forward

The Balint group has taught me more than I expected. I learned to speak in the first person, to sit with discomfort, and to acknowledge emotions that I might otherwise push aside. I realised that reflection isn’t just a tick-box exercise, it’s a vital skill that helps us become more attuned, and empathetic doctors. This was, as our facilitators reminded us, not an

academic exercise but an experience. It challenged the conventional boundaries of professionalism and invited us to include ourselves, not just our patients, in the cases.

While the Balint group offered a powerful reflective container, I am aware that its structured nature may be difficult to replicate in everyday clinical settings. I wonder how I will retain this emotional openness under time pressure or within hierarchical environments. Reflection takes time and psychological safety, both of which are often in short supply. This tension between insight and institutional constraint is something I still grapple with. Yet perhaps naming it is the first step toward working through it.

In a profession where we are often expected to put others first, the Balint group reminded me that my own emotional wellbeing matters too. Being aware of my feelings doesn't make me less professional, it makes me more human. And ultimately, I believe that embracing this humanity is what will make me a better doctor.

What I have learnt will have a long-term impact on how I relate to patients, colleagues, and myself. By continuing to reflect on the emotional dimensions of clinical practice, I hope to bring more depth, compassion, and authenticity to my future in medicine. The Balint group planted the seeds for this growth, and I am very grateful for that. As I continue my journey in medicine, I carry forward not just clinical knowledge, but a deeper understanding of myself and others – something I now see as essential to becoming a better doctor.

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