

---

JOURNAL OF THE BALINT SOCIETY, VOLUME 50, 2025

## **Transcending Babel: A Balint Exploration of Medical Encounters**

Balint Society Essay Prize 2023 Winner – Student

Ariana Axiaq<sup>1</sup>

<sup>1</sup> Resident doctor, NHS Lothian, Edinburgh, UK: [ariana.axiaq@nhs.scot](mailto:ariana.axiaq@nhs.scot)

---

Every medical professional has experienced patient encounters that linger in their memory, leaving an indelible mark on their journey.<sup>1</sup> These encounters stand out not merely due to complex diagnoses or unique treatments but because they touch upon the essence of human personhood. They remind us that, amidst the intricate web of blood tests, scans, and procedures, the heart of medicine lies in understanding and relating to the person seeking care.

In this essay, I will reflect on my Balint experience, presenting a case with a patient called Ms Lennox.<sup>2</sup> Her case, reminiscent of the ancient parable of the Tower of Babel, has been salient in my appreciation of the paramount importance of effective communication and empathy in the doctor-patient relationships. Ms Lennox's consultation challenges the boundaries of understanding between patient and clinician, leading to a tangle of unspoken emotions. In this narrative I have recounted my Balint experience as a presenter sharing my perspective on the dynamics between consultant, nurse, patient, and presenter, and explore the importance of reflection in medical education.

### **The Tower of Babel: An Analogy for Communication Breakdown in Healthcare**

In the biblical narrative of the Tower of Babel,<sup>3</sup> shared by both Jewish and Christian literature, the people of the city of Babylon aimed to construct a tower, wanting to reach the sky. As a divine response to this hubris and excessive ambition, God dispensed discord, mistrust, and alienation among the people by making them speak in different tongues. This fateful punishment parallels the complex misunderstandings and the erosion of rapport frequently observed in medical

---

<sup>1</sup> At the time of writing this piece, the author was a medical student at Queen's University Belfast, Northern Ireland, UK.

<sup>2</sup> Names have been altered to protect the identity of individuals involved in this case.

<sup>3</sup> *Genesis* 11:1-9 (New International Version).

consultations. The case of Ms. Lennox, which I presented during a Balint group session, mirrors the Tower of Babel allegory, where diverse languages led to an acute communication impasse. Both the patient and the clinician were deeply committed to the patient's well-being, yet they grappled with divergent perspectives on the path to achieving this goal. Failure to decode the patient's emotional nuances resulted in mounting frustration, disappointment, anxiety, and anger, overshadowing trust and respect in the consultation room.

### **On Presenting the Case**

I have sought to experience Balint within different capacities, as a presenter and a participant, and both in groups focussing on medical students and others with more established clinicians. However, I always find myself grappling with the same question: am I more inclined towards being a case presenter, or do I experience a deeper sense of fulfilment when actively engaging in discussions around cases presented by others? For me, presenting evokes a sense of trepidation, characterized by lingering uncertainty about the significance of the cases I choose to present and a nagging curiosity about what compels me to select specific cases over others. Meanwhile, as a non-presenting participant, I enjoy contributing my perspective to the flow of discussion within the group. Like an orchestra co-producing a symphony of music, building on each other's thoughts and emotions with the opportunity of occasional challenge is highly satisfying to me. Nonetheless, when I do assume the role of a presenter, I find comfort in ceding control, allowing the rich tapestry of discussion to unfold. Therefore, during my first session in the National Medical Student Balint Group, to dispel the long silence had pervaded the group, I volunteered to present.

### **The Case: Meeting Ms Elizabeth Lennox**

I started by setting the scene. It was a sunny spring morning in the geriatric outpatient clinic at a small rural hospital. The consultant, Dr Peter Murphy, and I had navigated our way through a list of 'straightforward' patients, such as individuals with query TIAs, Alzheimer's dementia, or early signs of Parkinson's disease. The clock had ticked its way to 11:40 am, and, with just one patient left to see before the anticipated early lunch break, a palpable sense of eagerness permeated the geriatric team.

As the consultant glanced over his screen, with a mixture of excitement and trepidation in his voice, he looked over and uttered, 'You will want to watch this one.' Intrigued, I sought clarification, yearning for a better understanding of what lay ahead. His response, however, only added to my perplexity. 'She's a character,' he remarked.

Confused and wanting to quell my curiosity and prepare myself for the impending consultation, I probed further. 'What do you mean by 'a character'?' I inquired. There was a tinge of irritation in his response, hinting at a certain level of exasperation as he repeated, 'She's strange, she's just strange.'

Our dialogue was curtailed as we prepared to welcome the patient. With the aid of a walking stick, Ms. Lennox slowly made her way to the consultation room, dressed in black head to toe.

The memory of Dr Murphy's words and his enigmatic grin haunted me. It brought to mind the image of a circus master, orchestrating the opening spectacle of a show. I was left to ponder not only the possible influence of knowing this information on my rapport with the patient but also how, if the patient had overhead us, it might affect her perception of the forthcoming consultation.

As Ms. Lennox settled between my consultant and me, she started to explain how, a few weeks prior, she had grappled with left-sided weakness, profound

fatigue, and numbness. These symptoms had propelled her into a hospital visit, marked by an exhaustive investigation for a suspected stroke. The thoroughness of these investigations and her night at the hospital had led her to firmly believe in the presence of a serious underlying cause.

The physician, charged with delivering the much-anticipated good news, sought to reassure her that the tests had yielded clear results, negating the suggestion of a stroke. However, each attempt to communicate this information was thwarted as Ms. Lennox fervently clung to her belief that a stroke remained the sole explanation for her symptoms.

The ensuing conversation spiralled into a self-perpetuating cycle, with both the patient and the geriatrician becoming increasingly entrenched in their disparate perspectives. Tensions mounted as Ms. Lennox castigated the doctor as rude, and he, in turn, pointed out her aggressive tone.

After a prolonged and increasingly heated deliberation, Dr Murphy reached a breaking point and decided to summon a nurse, Mary, to the scene. This intervention, however, initially exacerbated the situation.

As Ms. Lennox turned to Mary and me, her expression bore the weight of a plea for validation and understanding. Yet, in that moment, my ability to respond was limited to nodding and tending to the pieces of paper she wished to share as evidence of her stroke diagnosis. Ms. Lennox embarked on a final attempt to substantiate her concerns, focusing on a previous suspected myocardial infarction (MI) that had occurred months ago. However, the doctor swiftly pointed out the normal troponin levels on the electrocardiogram (ECG), bringing this thread of the discussion to a close.

Silence finally descended upon the room, and the doctor seized this opportune moment to convey the conclusive test results and the subsequent management plan. Given she was already on anti-coagulants, he explained that whether or not a stroke had occurred, her treatment regimen would remain

unaltered. As the doctor conveyed the news of her discharge, Ms. Lennox offered a brisk nod of acknowledgment and gruffly thanked everyone before making her way out of the clinic with the nurse. It was a moment that brought an unmistakable sense of relief to both the physician and the patient. I, on the other hand, was devastated by the consultation's abrupt and bitter ending.

### **On the Inquiry**

Upon concluding my presentation of this case, I was surprised by how exhausted I felt, reminiscent of the day when I had witnessed this protracted and seemingly fruitless encounter. Despite the length and depth of my presentation, I found myself harbouring an arsenal of unspoken thoughts and insights, parallel to how the patient must have felt during the consultation. Moving on to the inquiry phase of the session, I offered some clarification in response to my group members' questions before muting my microphone.

Prompted by one of the facilitators, the two other medical students initiated their line of inquiry. As I answered these questions, I wondered how my answers would influence the course of discussion; how knowledge or lack of knowledge of the circumstances around the patient's presentation could have affected our perception of her. (Soon afterwards, I wondered whether I was possibly thinking about these questions too much).

'Was she with someone?' 'No, she came alone.'

'Was she visibly ill?' 'No, but due to her frailty, she walked slowly.'

'Do you know anything of her previous encounters with the geriatrician?'

'No, I wish I did.'

I often find that, in Balint groups, it seems like there is not enough time for these factual questions. This limitation mirrors how time constraints and

psychological resistance from patients do not allow clinicians to obtain all their answers in a consultation. I have come to appreciate that the plot holes in the story are breeding ground for creative imagery, speculation, and free association. Questions brought up during discussion around the duration of the consultation, what happened after the consultation, and the geriatrician's usual demeanour, had to wait until the end.

### **On Discussing the Case**

#### *The Patient*

As I muted my microphone, simulating the 'push-back', my fellow medical students immediately fixated on Ms. Lennox's striking all-black attire. To me, that choice of clothing symbolised mourning, suggesting the possibility of significant losses in her life. The group delved deeper into this imagery, contemplating how it might be a prelude to dealing with the grief that comes with a diagnosis.

Questions began to emerge about her family, her children, or grandchildren. Why did she come to the clinic alone, especially given her apparent frailty? Did she push people away, or was it a case of bravely facing her struggles independently? These were questions left unanswered by the consultation, leaving us with only speculation. As I watched Ms. Lennox slowly exit the clinic and vanish into the hospital corridor, she seemed almost mythical, like a fleeting apparition. We could only speculate about what happened when she left the hospital, what her life was outside of being a patient, and who was close to her.

Our discussion revolved around deciphering the patient's feelings and motivations. We pondered whether her diagnosis served as an explanation for the emotions she struggled to articulate. Despite her unwavering reluctance to allowing the geriatrician time to speak, we empathised with the patient's sense of

disempowerment, considering how the geriatrician's withdrawal of her diagnosis could be perceived as invalidation. We felt how helpless she was at the face of the consultant and then the nurse. As the presenter, I had shared some of this helplessness during the consultation but was too scared to speak up in front of the clinician, given his authority. As the group members wondered about how difficult it already was for the patient to come into hospital on her own, we also fantasised about how she might have felt embarrassed by her frailty and her slow stride. This led us back to her choice of black attire, a possible attempt to blend into the background and avoid drawing attention to herself, further explaining why perhaps she presented alone.

#### *The Presenter*

As the facilitator guided us to reflect on my role as the presenter during that consultation, a rush of emotions from that day flooded back. In memory, they had been overshadowed by the plot as I had remembered more of what happened but less of how I had felt. The group empathised with how constrained I felt during the consultation, however it was divided on how much I could have done to influence the patient's experience. While one member recognized the challenge of intervening due to the power dynamics and the heated nature of the consultation, another suggested that more questions about her background, perhaps during or after the session, might have provided insight into her family and life circumstances. This comment resonated with me the most, and I appreciated that the group members had felt safe enough to provide this constructive feedback.

Prior to this discussion, my sense of helplessness and my desire to stay on good terms with the clinical supervisor had hindered me from taking more initiative. I had believed there was little more I could do, and I couldn't afford to challenge the geriatrician's authority. Even after the consultation concluded, I failed to approach the patient when I saw her in the hospital reception hall. I needed time

to process the encounter. However, the guilt and slight embarrassment I felt due to my inaction during the session motivated me to strive for better next time.

As a medical student, I have the privilege of spending more time with patients and having fewer clinical work constraints. I can communicate with patients and rebuild their trust in the medical profession in a way that clinicians focused on ordering and interpreting lab results and x-rays cannot. This is why Balint is indispensable for medical students. Without the opportunity to reflect on our roles as medical students, we risk accepting a passive role within the clinical environment without realising the potential for more significant impact.

### *The Consultant*

Most of the discussion centred on the patient's feelings and then on those of the presenter. While the patient's anger seemed more justifiable, the members of the group, myself included, found it challenging to consider the consultant's perspective. This was an essential aspect raised by the facilitator, given that the group found it relatively easy to comment on the patient's viewpoint instead. By forcing ourselves to reflect more deeply about the consultant, the session proved to be a transformative experience of empathy, especially when a person's behaviour is harder to decipher.

The consultant's introduction of the patient, resembling a circus performance, was a perplexing image that lingered through the discussion. It contradicted the empathetic interactions I had previously witnessed when he dealt with upset families or spoke to patients on ward rounds and in clinics. This inconsistency left me bewildered.

We questioned the consultant's previous encounters with this patient and whether his preconceptions led to a self-fulfilling prophecy, where the boundaries he erected to shield himself from discomfort contributed to the session's discord. Through observing the discussion between the other medical students, I was able

to speculate on how his initial sarcastic remark about the patient might have served as a defence mechanism, concealing his anxiety.

Was the consultant threatened by the patient's unwillingness to heed his clinical judgment? We speculated about how the presence of a medical student might have exacerbated the situation, making the consultant reluctant to shed the persona of the 'all-knowing' clinician. In medicine, medical students not only acquire hard skills but also internalize the values, norms, and perceptions of the clinicians they work with. Dr. X's inability to connect with Ms. Lennox might have left him feeling embarrassed, as if he had failed as a teacher.

When I revealed that the consultation had lasted for an hour and fifteen minutes, we realized that the duration was a crucial factor in understanding the consultant's behaviour. In hindsight, this prolonged consultation illustrated the futility of the consultant's approach. Like the people featured in the story of the Tower of Babel, the patient and the consultant seemed to be speaking entirely different languages, and no amount of time would bridge that gap. Was the consultant better off accepting this as a challenging consultation he just had to get through?

Understanding the constraints within an under-resourced healthcare system, with overbooked clinics and long waiting lists, made us more empathetic toward the consultant's position. Possibly, he felt constrained by his lack of the time and skill required to handle Ms. Lennox effectively.

### *The Nurse*

The introduction of the nurse, though mentioned late in our discussion, offered another opportunity to consider Dr X's perspective by considering his intentions for his decision to involve her. Beyond potential legal concerns, the consultant might have turned to the nurse to compensate for his communication

shortcomings. However, the patient might have misinterpreted this introduction as a collusion against her, further fuelling her anger.

As the nurse's body language began to mirror that of the patient, Ms. Lennox gradually relaxed in her presence, allowing the consultation to conclude. Being in her 50s, we considered whether the nurse represented a daughter-like figure for the patient. With the other two students, I explored how the nurse's presence might have bridged the power imbalance between the patient and the consultant. After the session, I pondered on the role medical students could assume in advocating for patients to address this gap.

The presence of the nurse was only discussed after I re-joined the group at the end. It struck me as ironic that, just as nurses are often overshadowed in ward rounds and multidisciplinary team discussions, our group had initially failed to recognise the nurse's significance in this interaction.

### **Post-session**

As the facilitator brought our meeting to a close, we bid our goodbyes, unsure if this would be a one-time encounter. Exiting the Zoom meeting, I felt relief. Knowing that other medical students shared my passion for delving into the intricacies of medical interactions was reassuring. In the days that followed, I held onto the knowledge that I wasn't alone, and I couldn't help but wonder if other medical students I knew had similar feelings and apprehensions about medicine's complexities.

Yet, alongside relief, a sense of confusion lingered. This consultation was just one isolated episode in Ms. Lennox's care. I never got to experience what came before or after. What had happened as Ms Lennox exited that hospital door? How did she get home and where did she live? Did she live alone? It left me without closure. Presenting the case had helped me come to terms with it, but I still had

unanswered questions. I became more appreciative of the enigmatic beauty of the relationships between patients and healthcare professionals—there's often no clear right or wrong, no clear hero or villain. Balint encourages me to embrace dialectical thinking, allowing for the critique of actions without assigning blame.

### **Medical Students and Reflective Practice**

Among the many facets of medical education, reflective practice often stands as an overlooked, ambiguous pursuit for medical students. Similar to patients receiving prescriptions from their doctors, we receive learning outcome lists for various clinical competencies, from history-taking to diagnostic procedures – but the role of reflective practice remains a nebulous entity (Gathu, 2022). Unlike the clear objectives of mastering clinical skills, reflection tends to be relegated to a checkbox exercise, lacking clear modelling and structured guidance from experienced mentors (Gathu, 2022). This absence of a framework can lead medical students to perceive reflective practice as peripheral and less important, a skill that appears detached from the immediate demands of the clinical environment.

In recent years, there has been a growing body of research highlighting the challenges medical students face, including declining mental well-being (Peng et al., 2023). However, without clear evidence and direction on how to teach reflection, few academic institutions have posited reflective practice as a solution for fostering sustained performance and self-care (Uygur et al., 2019).

## **Why Balint Is Important for Medical Students**

The case described in this essay underscores the persistent existence of complex and perplexing interactions for medical students. Our unique vantage point as passive observers rather than active participants in patient cases provides us with rich exposure to the emotional tapestry of healthcare. However, this role is often unstructured, leaving students without formal outlets to express the emotions we encounter. Moreover, as students continuously transition between various specialties, we often lack opportunities for involvement in the continuum of care, leaving us on the periphery of the patient's journey. Balint group discussions, however, offer a pathway to better closure and a forum for medical students to share challenging experiences with seasoned healthcare professionals. These conversations transcend the common practice of peer support, fostering an environment where personal narratives are examined critically, assumptions are challenged, and multiple perspectives are considered.

Furthermore, the Balint approach introduces medical students to a world that extends beyond binary thinking and problem solving, which can become ingrained during our training. In the clinical realm, we are frequently presented with scenarios that demand definitive, right-or-wrong answers. Balint encourages a more nuanced consideration of multiple viewpoints, recognizing that a host of variables and complexities shape doctor-patient relationships. This perspective equips students with tools to grapple with uncertainty skilfully, promoting self-compassion in difficult clinical situations and enhancing our ability to empathize with both patients and colleagues. It serves as a profound reminder that doctors, regardless of their experience, share common insecurities, fears, joys, and the full spectrum of complex emotions.

The unique environment fostered by Balint transcends the traditional hierarchies of medicine, welcoming professionals from various disciplines and

career stages to convene as equals. In this counter-cultural setting, medical students find the confidence to express their thoughts and emotions more openly with non-peers. While Balint may still be relatively unknown among medical students, its potential to encourage emotional vulnerability is crucial for open, effective communication with patients and colleagues. It opens the door to more meaningful and genuine connections, ultimately shaping the next generation of doctors into practitioners who are at ease with their own emotions, adept at engaging with patients and peers, and well-prepared for the intricacies of medical practice.

### **Medical Student Balint Groups or Balint Groups with Medical Students?**

The depth and richness of the case presented in this essay underscores the value of Balint group discussions that involve medical students exclusively. In the described case, a Balint group consisting of three medical students and two facilitators provided a platform for vibrant and insightful discussions. Despite our relative unfamiliarity with one another, as participants, we found common ground in our shared concerns, fears, and contemplations. Our interpretations varied, creating an atmosphere of constructive challenge, broadening each participant's perspective.

By focusing on experiences common to medical students, these specialised Balint groups foster camaraderie that may not be as pronounced in groups with a minority of medical students. However, the contributions of more senior professionals offer a blend of clinical expertise and Balint experience that enriches the discussions. Hearing experienced practitioners openly share their own challenging experiences serves as a wellspring of inspiration for medical students, who are at the beginning of our journeys in healthcare. Furthermore, when Balint group members have backgrounds in psychotherapy, they bring a valuable

knowledge base that bolsters the depth of reflection and enriches the learning experience for medical students.

## **Conclusion**

Drawing on the poignant allegory of the Tower of Babel, miscommunication can lead to erosion of trust and a sense of alienation between people. In much the same way, the breakdown of effective communication between a doctor and patient can lead to a breakdown of patient rapport and poorer quality of care.

In revisiting Ms. Lennox's consultation, I find myself immersed in the profound intricacies of doctor-patient relationships. This narrative underscores the indispensable role of Balint groups in my medical education. With Balint, I strive to become more self-aware, empathetic towards colleagues and patients, and considerate of other perspectives.

In a healthcare landscape fraught with resource constraints and overburdened staff, I have come to realise that reflection plays an important role, enriching communication and nurturing compassion, while simultaneously guarding against burnout and compassion fatigue. These experiences in Balint have granted me profound insights into the human side of medicine, reaffirming the notion that doctors are not just purveyors of clinical knowledge but, in fact, serve as integral proponents of the healing process, akin to a drug itself.

## References

- The Holy Bible.** Genesis. 11:1-9, New International Version (1979), London: Hodder & Stoughton.
- Gathu, C.** (2022). Facilitators and Barriers of Reflective Learning in Postgraduate Medical Education: A Narrative Review. *J Med Educ Curric Dev*, 3(9): 23821205221096106. doi: 10.1177/23821205221096106
- Peng, P; Hao, Y; Liu, Y; Chen, S; Wang, Y et al.** (2023). The prevalence and risk factors of mental problems in medical students during COVID-19 pandemic: A systematic review and meta-analysis. *J Affect Disord*, 321: 167-181. doi: 10.1016/j.jad.2022.10.040
- Uygur, J; Stuart, E; De Paor, M; Wallace, E; Duffy, S; et al.** (2019). A Best Evidence in Medical Education systematic review to determine the most effective teaching methods that develop reflection in medical students: BEME Guide No. 51. *Med Teach*, 41(1): 3-16. doi: 10.1080/0142159X.2018.1505037