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The Elephant in the Room: The Balinteer in the Background

Balint Society Essay Prize 2021 Joint Winner - Student

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It has been a year, give or take, since I first came across the word 'Balint'. I was lucky enough to be offered a place in a Balint group happening near me, which was quite the surprise, considering that I live in a lower-middle income country in Asia. But work like Balint has a way to spread its roots, and quickly.

Ever since then, every month, on Sunday morning, I am transported into a world of transcendence. I've figured out that mesh of discomfort that comes from having unnamed feelings bundled up inside one's chest. I've gone from only being able to relate to others by sharing a similar experience to actually using thoughts and words to express myself. A lot of the time, this comes as a shock: was I really that... ignorant? Or maybe the word here is 'aloof'. I'm like the patient with a mild pain who has been ignoring it for years, only dropping in to see a doctor because they were in the area and had time to kill. If I was hearing this story, for example, from someone a year ago, I'd reciprocate by saying, 'I know! There was one patient I saw…', as though 'I know' took the place of all or any of the complex feelings brewing in me.

There is, however, something missing in the world of Balint, probably because not many 'of our kind' are here yet. See, there is never just a doctor-patient relationship, the dynamics of which must be explored from different aspects and angles; at least not in teaching institutions; at least not the way I see it. There is one more person, a wallflower if you will, the elephant in the room: the medical student.

We stand in doctors' clinics, we 'shadow' physicians, we 'do rounds with' surgeons. But we are very much physically present and, it wouldn't be a stretch to say, emotionally invested. Indeed, this is the age of 'firsts' for us. It's the first time we see blood and someone faints, the first time we see a very sick patient that makes us dizzy, the first time we watch a miraculous recovery and passion is revived, the

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first time we see death or its grief as we stand around a lecturing professor in the ward.

And it doesn't have to be the first experience of something that shakes us to our core. They say that in war zones, you feel all the feelings, but not always at the right time. Here at the hospital it could be the second patient, or the third, that one patient we will remember forever when we actually feel things for the first time. And it is these feelings that eventually settle in and unsettle us. It is the first time we process feeling that something great has possessed us and that this great event has really stirred in us a feeling.

But the first time we process our feelings is in no way the first time we actually acknowledge them. That comes down the line somewhere, at least if you are as taken by surprise as I was, or as emotionally naive. And that brings me to a word I have been using a lot now: feeling. Feeling what? Just like 'I know' and 'right!' it has become one of my go-to words to describe anything from a grumbling stomach to true love. What exactly the feeling is, part and parcel of which is what it does to us, is wholly ignored. You can go through your whole day by saying you feel things and not actually describing them and I was doing just that, until I found myself sitting in front of my laptop screen in a meeting with ten or so participants being nudged to finally do it: describe what I feel and how I feel.

The strongest feelings are not evoked only during the classic *quadrad* (as I call it) of birth, disease, recovery and death. Somehow, a lot of literature revolves around these delicate absolutes. The truth is that a lot of how we feel about a patient encounter has to do with how we feel, full stop. And that's where those special patients come in. There are stories we cannot separate ourselves from; even though we may have been scrubbed-in to that same procedure multiple times, somehow this child is different from all others. Why that is remains a mystery.

There are talks and workshops that we attend to deal with difficult patient encounters. Again, it would be a stretch to think that there are some difficult encounters and other easy ones. Any encounter, of any nature, be it a clinic visit or a pre-operative assessment, can become a challenge when things go wrong. I think it takes great observation to realize that. It can be the sudden change in expression, so mild it could only be a twitch, that escapes a watchful resident's gaze as they look down to take a note. It can be slightly unconventional wording that indicates to you that this patient might just prefer it if their spouse wasn't around. It might even be a new piece of information that the patient is given that makes their situation considerably more difficult, such as being informed of a hospital stay when they thought it would be a day-care procedure.

All of these situations have been described in the third person, because that is usually who I am. The third person in the room. I am the prequel who asks a whole bunch of 'unnecessary' boring questions while people wait for the real doctor. I am also the one who bugs patients a lot more in the ward, asking them the same thing a junior doctor might have already asked them half an hour ago. I am the clerk who fills out the investagram when clinics need to be sped up. And, many times, I am dead weight that patients do not have the headspace to care for, and doctors are too busy to engage with. But throughout this grunt work, I am alive and observing.

Rotating through different wards has one important implication from the Balint perspective. It means we see a snapshot of a patient's life and are likely to never see them again. If there is anything I have learnt from my Balint groups so far, it is that incomplete stories are the hardest to tell and often take a huge toll on you. We immerse ourselves in the patient's story (just one of many). We focus all our energy on 'this case': we read about it, we write about it, we give it undivided attention – and then, just like that, we move on to the next bed. So we'll never know

what happened to them, if they got better, if they had a relapse, or if their multiple sclerosis is resulting in more contractures.

We are just expected to move on, and these multiple one-offs are incomplete, like a diary entry that is started but never signed off. The Balint case becomes not an exploration of the patient's life and our perspective of it, but a fragment of a story that has so many missing chapters that it is difficult to make out the present. If a student, like myself, is presenting a case in a Balint group with no other students, one might have to explain the glaring reality that not being able to follow this story is one of the reasons it is so taxing. I learnt this when, in the first few groups, the presenter reflected that this case was emotionally taxing because the client never came back after a few visits. This was a common theme in many case presentations. If it is such an emotionally fatiguing experience for healthcare professionals that it comes up routinely in Balint groups, I can only imagine the impact it must have on students, who invariably see a patient just once. The thoughts of what could have happened keep coming to our minds because it is so hard to keep track of a patient once your rotation has changed and you have to give undivided attention and focused energy to someone else's story. When I am considering presenting a case to my Balint group, I struggle because each one has its own element of emotional significance, but each one is emotionally taxing because it is left incomplete. My Balint group, in which I am the only student, often presents a case where the doctor's great fear and guilt is about whether they did everything they possibly – and humanely – could for that patient. Another realm of the medical student-patient relationship is how there is only so much that we can do. Being assigned barely any responsibility compared to the rest of the team does not mean that we have it easy. I feel this, too, is similar to the helplessness that envelops any war zone. It isn't just the active role, but also the passive role that suffers; there is too much out of your control. It is just as frustrating at times to be on the sidelines, watching. As the team work their way through the treatment you,

the one who took so much of the patient's time, or who shook them awake for 7am rounds, just stand there, taking notes, making a learning opportunity of it. The great fear for us and our guilt is about whether we would be able to do anything at all and play our part. But we are assigned, specifically, to stand and observe.

This observation becomes much harder when a complex doctor-patient dynamic is unravelling. Of course we don't always get assigned to the more emotionally aware, verbally sophisticated or even politically correct physicians. When there is a clash, and I mean a clash, there isn't a good manual that tells us where to look. Learning so much about Balint, trying to be more cognisant, and making that daily effort, seems out of place when you walk into a consultation that is doomed. It may be a clinic visit where the doctor is too harsh, a counselling session where the information is too fragmented, or a post-operative follow-up where the pain is shrugged off. All those lectures and workshops come back to you, and the mnemonics play in your mind, telling you when to sign-post bad news and when to listen actively, like muscle memory for times when your brain freezes. But you cannot use any of it until it comes up in your exam. Because you may be able to be more tender, give fuller information, and re-evaluate pain management, but you are not authorized to do so. In fact, at times like these, most of us find comfort in blending with the walls.

Even opportunities for one-on-one discussions with the patient are limited. And when they do arise, most patients save details for the consultant. And so, when major revelations are made, from the Balint perspective, it is not so much the medical student-patient dynamic that needs to be explored but the doctor-patient-medical student dynamic. Others in the healthcare team, and those who accompany the patient, add to this list, making the scenario much more complex.

As more Balint groups that cater to students – particularly medical students – evolve, a major issue that I imagine will need addressing in nearly every group is the effect of student-doctor dynamics on how we relate to the case. Do strict

consultants make us bolt up our feelings? Do approachable consultants make us face our vulnerabilities more? And then I think of all those consultations where I have seen poor examples of communication skills, impatience and a lack of empathy from physicians. I wonder if we, without regular reflection, absorb these small acts throughout the day, and gradually lose the knowledge of our talks and workshops. At the same time, empathetic doctors have a lasting impression on us and we strive to be like them. How does this affect the way we perceive the dynamics of patient care? I have yet to explore this in detail, but I gather that it is often the doctor who discusses the emotional intricacies of the case with me outside the clinic room that I learn the most from. Indeed, there are many doctors who, like me, will reciprocate a story about an onerous encounter with another.

While such an exchange is also a great form of reflection – and is certainly cathartic in its own right – it seems less useful in learning how to process one's feelings. It would be like a Balint group where everyone shares a case, but the presenter is never sitting back. Giving it a word just helps us know it's real and lets us talk about it, which is essential if we are to properly process it. Before Balint, I don't think I would have figured out just how different my situation is as a student, compared to some of the other members of the healthcare team. Now, listening to the perspectives of healthcare professionals in my Balint group, I realize that their situation has shaped their perspectives very differently from mine.

Even though we do not just share cases in Balint groups, the idea of 'a story for a story' is not so far off from the Balint mission, it seems. During our Balint group retreat, when participating in a group of strangers after the comfort of being in the same group every Sunday, I realized that the cases presented here are not altogether that different from those presented in my regular group. I guess we all feel the same way at some level, and are intrigued and that the same things that might bring one of us pain tend to bring all of us pain. I gather that Balint groups do not just help us process a case after the fact, when we hear our group members

discuss it while we observe silence. Balint does, in fact, prepare us for similar situations that we might encounter ourselves, not just by making us more emotionally responsive, but also by widening our view of the human experience. We do not merely discuss a case – we try to put ourselves in the presenter's shoes (consciously or unconsciously) and then build resilience that we may need later on when similar feelings are evoked in us.

An old question for an old problem is: do students really need all this resilience? I have been asked this on multiple occasions when I share my experience with physicians not involved in Balint group work. My simple answer is, yes. My complete answer is, yes! Balint is not an exercise in 'digging out' vulnerabilities where there are none or conducting a pseudointellectual discussion with one's peers. It is a means of catharsis for all the built up emotions that healthcare professionals have been carrying around since the start of time or, more specifically, since they were medical students. If students are given so much practice before the first time they step in front of a patient, they really must be given the psychological support of the strains of such an encounter. Not just because it is my first, but such encounters have left a lasting impact on me because I have to, by design, adopt a passive role. Anything practice or guideline that suggests otherwise for a medical student is too vague, with little safeguards for our protection when speaking up. Even offering the simple flavour of empathy is not easy when patients do not realize they can, and that you are actively trying to connect with them on a personal level. Coupled with that is how this point-in-time memory has no start and no end. When combined, all of this leads to simply too many 'what ifs'. Yet, people think students really do move on, just like the physical transition from one ward to the next, or one patient bed to the other. But elephants can remember. The fact that we have memory – and good memory at that – of all these precious first experiences bottled up inside us is never registered, let alone the fact that we may actually find it hard, very hard, to move on.

The picture is not, however, that bleak. There are fleeting moments where our textbooks are right when they say that we may, by strange coincidence, be the very person the patient feels comfortable speaking to and confides in. While this is nothing short of the most rewarding ethereal experience, it brings with it a barrage of difficult tasks and handovers that make this experience wholly difficult for the student and the patient. I haven't experienced any Balint groups with other students so it is unclear whether these perks also make their way into Balint group discussions. I gather they do, like so many enigmatic cases, end with the whole group's unspoken consensus that it may well be a happy ending for the patient.

It fascinates me how a group, together, can manage to draw such optimistic conclusions from a case and, most of all, think in harmony. If Balint groups have so unifying a power to herd people together, I gather that the interpersonal dynamics of such groups has the power to translate into solid action in the future. Consider this: twelve students meet every month and discuss similar core issues. They process how the lack of continuity of care, the shift in our rotations and the difficulties of solely observing add to the already hefty psychological strain patient care has on us. Surely, in this case, one would start to think towards ways to correct some of these problems. I don't think I could ever reach this stage of intervention-oriented thinking if, like most, I never actively processed under guidance of a facilitator, to consider the complex dynamics operating in patient consultations.

I have used the words conclusion and intervention with great care, as I know for a fact that Balint groups do not intend to, and should not provide solutions. However, it is not the active proposition of a solution, but the discussion of shared issues that keeps one thinking long after the case is over. It fascinates me how we learn so much from a group when there is no conventional inlet of knowledge. We only share cases, something healthcare professionals do routinely, but somehow this time because we do not reciprocate the case with another as we so often do in

our conversations, we manage to nurture our minds from within. It is as if we become self-sustaining, and that's just a stone's throw from one form of resilience.

Would I like a group with fellow students? Yes, I certainly would. But being in a diverse group, with different disciplines and various training levels has its own pros. It somehow soothes my feeling of not being an active part of the healthcare team when I see how universal our struggles are. At the same time, it gives me some leeway to reflect independently as my own perspective is so different from the rest. I wouldn't go so far as to say that a group with professionals helps me mature intellectually. Maturity of this kind has nothing to do with the hierarchy of the team and everything to do with one's introspection, understanding of the self, and how much we try to exercise this muscle, like being in a Balint group. I can say that, compared to the start of the year, I have matured just as much as the others, and my difference in clinical experience has not caused any hindrance. As I said before, I do think that many healthcare workers do not perceive the dynamics of patient care as well as Balinteers do, and in that regard, I think it is the active application of all the lessons we learn in workshops and lectures that can make that final impact and translate into action. In many ways, Balint does just that.

I have a long way to go along the Balint path. I still use so many day-to-day examples to describe my feelings. But I guess that can only improve with practice. I have even started using the name to mean more than just Balint groups. I now use it as a verb too. I gather this semantics will continue to evolve as I find more and more use for Balint. As Balint expands to other populations, including other professions, the landscape, and perhaps the structure of the groups may change significantly. If, even within the healthcare profession, when comparing physicians and their student counterparts, the degree of complexity has greatly changed, as has the focus of the group, it will certainly evolve when it crosses over to other fields.

Suffice to say, Balint for students has a long way to go, too. It is a pressing need that is not being met as enthusiastically as it should, but, once such groups are up and running, I am certain that the most preoccupied of students will make time to attend these groups. If they face as many challenges routinely as I do, I imagine they would make the most of these groups regardless of other commitments. It should be, in my opinion, part and parcel of patient care experiences. Perhaps one day it will be. Until then, and to make it happen, we need to inculcate a sense of Balint into emerging healthcare professionals. The key to do that is by engaging more students. If given a flavour now, I'm certain there will be more uptake than can be expected by seasoned doctors with busy schedules and other priorities.

The case for Balint for undergraduate students is much worse off here in my home country. With just a handful of Balint groups operating throughout the country, the chances of regular groups for students remains slim. However, students should not naturally come after professionals when expanding Balint groups. They should be considered just as important a population that can benefit from reflection, and if any, a more vulnerable one too. Here, resilience is not routinely taught to medical students, and they find themselves moving from the lecture hall to the bedside overnight. There is little opportunity to learn and be proficient in healthy coping strategies ourselves. And while this may indicate a pressing need for Balint for medical students, most of them do not know what Balint is – having opportunities to participate in groups is a long way off. If the elephant in the room is not addressed soon, its effect on the wellbeing of students and their mental health will continually deteriorate, and the prospect of a healthy career will diminish even further.

But this is not a debate; it is an established fact that I have merely reemphasized. No matter how fast Balint grows globally and here at home, if students do not have adequate access to groups, at least those with other students,

Balint may not be as well established in healthcare workers as we would hope. This was, in fact, a more reflective exercise of my experience, and I would like to end on this note: has Balint changed me? In many ways, I am still camouflaged in the background of clinical experience, doomed to vigilant observation and lesser practice than I would hope. But without Balint, I would have accepted this fate and would have really moved on to the next patient bed. It was only when I paused to think amongst the chaos of healthcare that I realized the strange discomfort harboured in my being. Through the groups, I verbalized those feelings – a feat for me! I believe that, for me, this is the greatest milestone, as though I have learnt a new language to put words to feelings. And indeed I have. It is the language of Balint and the language of human experience.