

# Section 1. Introduction

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The influence of the work of Michael Balint on vocational training for general practice has been profound.<sup>1</sup> Many argue (Horder J, personal communication) that the Balint essence has been adequately absorbed into the culture of small-group discussions on day release courses. Those holding this view might argue that there is therefore no longer any need for the formal structure of a traditional Balint group.

Balint-oriented course organisers hold a different view. They argue that the traditional Balint approach offers something of great importance and different from anything else. How might one define what this 'something' is and is it really there anyway? Do Balint groups really offer an added value that vocational training schemes (VTS) should not afford to be without?

The Balint Society decided to investigate the possibility of mounting a research project to explore these issues. Our initial idea was to use qualitative methods to compare some VTS Balint groups with other small groups. We planned to start with a pilot project in which we would select perhaps three Balint groups and three non-Balint groups for study. We restricted our work to the London area, as we knew that there were several Balint groups there.

In this Section we set the scene for our research. We then describe briefly how our project developed from the original proposal, as our team expanded to include RP, an experienced ethnographic researcher, and AM, who also has a background in ethnographic research, as our advisers. We then give an overview of the other Sections in this paper.

### Background

Michael Balint was a practising psychoanalyst who made a seminal contribution to general practice as a result of his 'research-cum-training' seminars held at the Tavistock Clinic in the 1950s and 1960s. These resulted in the classic book *The Doctor, His Patient and the Illness*.<sup>2</sup> (For a brief summary of Balint's life and work, see Appendix 1.) This book laid the foundations for future Balint training. This has always emphasised the importance of the doctor-patient relationship and the need for the doctor to understand his or her role as an instrument of care. Many Balint-oriented doctors found that it was this focus that has helped them to avoid burnout and to continue to engage enthusiastically in practice.<sup>3</sup>

Balint provides a process within which doctors can bring their current and immediate concerns and examine the difficult areas of their practice. The presentation of difficulty might be no more than a feeling of unease or an uncomfortable response to a patient. This approach is entirely in tune with the current ethos of professionals identifying and fulfilling their own learning needs, but personal growth only takes place slowly and deeper insight can never be either measured or defined in

advance. So, by its nature, Balint training is not tailored to making these needs, and the resulting accountability, public. Balint fosters self-regulation within the individual and among his or her peers. There could even be a growing need, if not appetite, for this kind of scrutiny of practice. If so, there will also be a need to understand how to make the most of that contribution in the contemporary contexts of practice.

Balint's teaching has had a profound influence on medical education, lending its support to ideas such as patient-centred medicine, mentoring and narrative work, which are popular today.<sup>4</sup> Many of the prime movers in developing GP vocational training were members of the early Balint seminar groups, and Balint-trained GPs also contributed substantially to the seminal work on training, *The Future General Practitioner: Learning and Teaching*.<sup>1</sup> The influence has extended elsewhere. Balint training is practised today in many parts of the world.<sup>5</sup>

Despite this, understanding the links between patients' emotional difficulties and physical illness is still seen as marginal to the real business of medicine.<sup>3</sup> Both Sinclair<sup>6</sup> and West<sup>7</sup> have pointed to the lack of an acceptable conceptual vocabulary within which to understand psychosocial issues in medicine, and Burton and Launer<sup>8</sup> suggest that 'unreflectiveness has become institutionalised'. A series of papers in the *British Medical Journal*<sup>9</sup> indicate that difficulties balancing the 'science/art' dilemma – perhaps at the heart of quandaries in postgraduate medical education – are alive and well.

Further, while some GPs still follow the style of Balint's approach, there are now decreasing numbers of GPs and group leaders who have personal experience of traditional Balint group membership. Although most vocational training schemes for GP registrars in the UK today involve small-group work and all, to some degree, seek to improve understanding of the doctor's consultations, improve communication skills and provide support for the trainee doctor, vocational training for general practice is continuously evolving and, perhaps, becoming transformed by other imperatives.

There is evidence that some GPs believe that their vocational training does not prepare them for the responsibilities of independent practice and partnership.<sup>10</sup> Some have also raised critical questions about the promise of experiential learning itself, and the ways in which learning outside conventional bounds is limited, particularly in its ability to question its own foundations.<sup>11,12</sup> For example, Usher, Bryant and Johnston<sup>13</sup> argue that:

*There is discipline through self-discipline, a process which is pleasurable and empowering but only within a matrix . . . of understood and unchallenged contexts and systems. . . . Experiential learning is opened and closed at the same moment. . . . It is inherently ambiguous.*

Crucially, the context in which GPs practise today is different and still undergoing rapid changes.<sup>14</sup> GPs face new demands arising, not least, from the varying composition of the workforce, the introduction of professional revalidation, evidence-based medicine, the rise of performance indicators as measures of efficacy, the interdisciplinary organisation of health care in community-based health centres and the recruitment crisis within the profession itself. Thus the nature of the doctor-patient relationship, which Balint sought to illuminate, seems compromised. Broader structural processes are also at stake, such as the imperatives of medical technology, consumerism and global migration.

Vocational training today reflects these realities. Competency and skill-based approaches predominate.<sup>15</sup> In assessment there is an emphasis on the demonstration and measurement of performance.<sup>16</sup> These changes have, however, created concerns that something essential may be lost.<sup>17</sup> This therefore seemed to be the time to review the place of the Balint approach and its legacy.

### Our research

Our initial research question asked whether there were key and distinctive characteristics of Balint groups that need to be held on to. If so, what might these be? To start with, before AM and RP joined our group, we envisaged that a comparative approach would be the best way forward. We would use qualitative methods to investigate some Balint and some non-Balint groups, and then we should be able to decide if these key characteristics were present in the Balint groups but not in the other groups.

Our colleagues advised us that this traditional experimental approach to evaluation, promising firm information about outcomes, effects and efficiency, may be neglecting another way of looking at things. Rather than enquire whether 'Balint' was more effective than 'non-Balint', we started one step back. Our task was to understand the value of Balint approaches to small-group work in the particular context of vocational training for general practice. We began by asking what Balint training was, is and might be, documenting its evolving theoretical base and actual practice. We discuss this in Section 2. We then tried to define the broad questions we were attempting to answer in our observations of Balint groups. We eventually arrived at the following:

- What was the learning climate in small groups in GP vocational training? How was it being put to work and understood?
- What were the dynamics of learning in a small group and how might the Balint approach affect them?
- What might be an appropriate methodology for evaluating small-group work on the VTS?
- What else was happening in the small groups under study and with what possible effects?
- How was the Balint approach variously understood? What were the differences that make a difference?

### This Occasional Paper

Having explored something of the theory and practice of Balint work, we go on in Section 3 to discuss the

methodology of our research. We describe in some detail why and how we finally decided to use an ethnographic approach to the work. This initially caused some tension between the team members with a research background and the GP members. This tension was not a personal issue but a normal consequence of researchers from different disciplines coming together. Moving between different paradigms was particularly taxing, given the sensitivity of this particular project. We hope that Section 3 will show how the tension between the team members became a creative one, allowing an important role for the GP authors as 'insider' researchers. We will leave it to readers to judge if our openness about our relationship, unusual as it is in published work, represents integrity or foolhardiness.<sup>18</sup> We like to think that it was in the spirit of Michael Balint giving us the 'courage of our own stupidity'.<sup>2</sup>

The second part of Section 3 goes into some detail about the place of an ethnographic approach and the philosophical issues it raises. We hope that readers will find this of interest but those of a more practical bent may wish to move straight on to Section 4, which is the core of the paper. In this Section the observations of the groups and the interviews with participants are described in a series of seven case studies. Some of the questions raised by each case study are highlighted in the Section.

The following two Sections discuss some wider lessons from the doctors' narratives as described in the case studies. In Section 5 we explore the strengths and limitations of a Balint group in facilitating learning about the complexity of practice and the contexts that help to shape it. Section 6 discusses and summarises the research in relation to the questions we were attempting to explore. It ends by asking, 'where next?' In what ways might our research be applied to the development of small-group work in GP vocational training? What issues might merit further research? Finally there are two appendices. The first is a brief biography of Michael Balint. The second is a personal view from John Salinsky about the place of Balint groups in GP vocational training. John Salinsky was trained in a traditional Balint group for established doctors and has been a VTS course organiser for many years. In the appendix he reflects on the differences between the original groups and those developed for registrars in training schemes.

Liberal minded as we thought we were, the GP researchers at times found the concepts and language of ethnographic research to be difficult to follow. Ethnography thrives on complexity. It tries to get the whole picture of a culture. Everything that is observed is relevant and repays further exploration. This is very different from the scientific approach, where only one or two specific variables are studied. The language of ethnography, which mirrors the complexity of the approach, pervades a great deal of this paper. We have tried to make it as comprehensible as possible to readers who, like the GP authors, are not used to it. Working with colleagues espousing this approach to research eventually became immensely rewarding for us. We hope that reading about it will similarly repay the effort for you.