BALINT GROUPS FOR MEDICAL STUDENTS
Understanding the Relational Impact of Illness

A HANDBOOK FOR CO-LEADERSHIP

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Foreword

There has been increasing emphasis on reflective practice throughout the NHS and in medical training, and this is cited as an essential skill by the GMC. There are many different models of reflective practice but that being used for groups of medical students across the UK is the Balint model. Balint groups employ a particular structured approach to reflective practice and focus on the emotional aspects of the practitioner or student – patient relationship.

In 2014, the Royal College of Psychiatrists set up a working group to promote the development of medical student psychotherapy and Balint group schemes across the country. At the time, only a few medical schools were running Balint groups, but today around 50% of all medical schools in the UK offer Balint groups to students. Most groups are offered to students in their first year of clinical training and are often located within psychiatry placements.

King's College London GKT (Guy's, King's and St Thomas') School of Medical Education is the largest medical school in Europe and runs mandatory Balint groups for all first year clinical students throughout their longitudinal placement in psychiatry. There are around 450 students in each year having placements either at South London and Maudsley (SLAM - around 350 students) or Oxleas NHS Trusts (around 100 students). At SLAM we provide 32 groups of 10 - 12 students in each group. Each group has 13 Balint sessions during the academic year. A similar scheme runs for medical students based at Oxleas Trust.

This handbook has developed from our experience of running groups for 3rd year students (first clinical year) as an SSC (Student Selected Component) in 2017/18 and as a component of academic days during longitudinal psychiatry placements from 2018. This academic year 2025 – 2026 is now the 8th year of this scheme for GKT medical students. Balint groups were disrupted during the Covid pandemic and were all undertaken online in 2020 / 21. As our groups have returned to face to face since 2021, this handbook does not cover the considerable amount learnt from leading Balint groups online.

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Introduction

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Training in medicine is very challenging, involving not only major academic and clinical skills components but also increasing exposure to the impact of illness and dying and to interpersonal encounters with patients which can evoke strong emotions in the student doctor. This all happens in parallel with students having to forge their own professional identity and during young adulthood which in itself poses significant internal and external developmental challenges.

Participation in a Balint group provides students with an opportunity to talk about and explore the emotional and interpersonal aspects of work with patients. Through engaging with this, students can increase their awareness of the significance of the relationship between the patient and student / doctor and the treating team as well as the emotional impact of illness on the patient and their wider relationships, particularly family members. Group members may be sympathetic to difficult clinical encounters and emotions evoked and may have been in similar situations themselves which can be very relieving for students.

The process of reflection encourages students to see patients as human beings who have a life and relationships outside the medical setting and so helps to develop a more holistic approach to medical practice. As students develop a better understanding of patients' communication, patients become more interesting to listen to and easier to help.

Group members may gradually reach a deeper level of understanding of their patients' feelings and their own. They may realise that certain patients or emotions resonate with what is going on in their own inner and outer lives and that this can cause problems which the student can learn to avoid or even turn to therapeutic advantage.

Increasing emotional awareness and attention to the psychological pressures of practicing medicine through participation in group reflection can reduce burn out and harmful coping mechanisms and increase resilience and enjoyment of the privilege as well as challenges of medical practice.

Finally, doctors do not work in isolation but in team environments and need to develop interpersonal proficiencies and some awareness of group dynamics to do so. Participating in Balint groups helps students develop crucial skills in listening to and respecting the views and feelings of others and in discussing situations where there are no clear cut answers which are common in all areas of medicine.

BALINT GROUPS

History
Balint groups are named after the medical doctor and psychoanalyst Michael Balint (1896-1970). In the 1950s Michael and his wife Enid developed groups for GPs in London, based on case presentation and discussion in a small group with a facilitator, focussing on the relationship between the doctor and patient. This work was first described in the book The Doctor, his Patient and the Illness (1957).
Balint groups have since spread internationally - there are now national Balint Societies in 22 countries around the world fostering and developing the Balint approach.

The Balint Model
Groups consists of around 10 participants and 1-2 facilitators and run for 60-90 minutes.
The general structure is as follows:

- The group starts with a reminder about confidentiality and an invitation for someone to present.
- The encounter presented is one that has made an impact on the presenter and stayed in their mind.
- The presentation is informal – no notes are used.
- The presentation includes:
  - a description of the encounter
  - feelings evoked
  - background history may be informative
- The group are invited to ask clarifying / factual questions for a few minutes.
- The presenter sits back and listens to the discussion, rejoining later 10 -15 minutes before the end of the group.
- Discussion is 'free floating' and focuses on relationships with patients, particularly the practitioner / patient relationship.
- Relationships between the patient and wider treating team and family dynamics are also considered.

Challenges in running Balint groups for medical students

There are important differences between running Balint groups for experienced clinicians compared with groups for medical students who will not have had experience of this type of work previously. This can call for modifications in technique including greater encouragement and more involvement in the discussion whilst also being mindful of the leadership role and of providing space for the group to develop.

1. Medical students are young and junior, they will not have had much exposure to clinical work and some may easily feel humiliated.
2. They are often very anxious to start with and may have concerns about being scrutinized psychologically by psychiatrist facilitators.
3. They may have the idea that this is some kind of group therapy.
4. Whilst the focus is on patient encounters, students often have other concerns that they want to explore which are of general relevance as they involve emotional topics and should be accommodated.

5. When groups are mandatory, some students may be less receptive to the experience and need more encouragement. Excessive resistance and negativity can affect and inhibit the group's functioning and needs to be addressed.

Typical Themes in Medical Students' Balint Groups

Attitudes of and towards doctors

- The absence of a holistic view. Concentration on medication with no consideration of psychosocial factors.
- Why do doctors sometimes appear cold and unempathic towards patients?
- Why do doctors not listen to the patient?
- Why do doctors avoid providing information to patients?
- Can situations be too distressing for doctors?
- *The view that as a doctor is it better not to be emotionally attuned to your patient or to your interaction with them.*

Managing and treating patients

- Difficulty in working with a patient when there is no existing effective doctor-patient relationship.
- Difficulty in providing clear and honest information for patients.
- Difficulty in assessing the patient's ability to make decisions, is it sometimes necessary to make decisions for the patient?
- How to manage a seriously ill patient when you don't know what they have been told?
- How would a doctor discuss a very poor prognosis with a "cheerful" patient?
- Difficulties in communicating with a patient who has an untreatable, terminal condition and responding to death; fear of being emotional.
- Coping with failures in and the limits of medical treatment.
- What is it like for close friends and relatives? Is the patient's social network helpful or problematic for the patient and doctor-patient relationship?
- Considering the interplay between physical and psychological aspects of medicine (including psychosomatic illness).
- Dealing with uncertainty.
- *Issues around managing diversity and bias e.g. around race, sexuality, gender and socio-economic differences both from and towards patients are increasingly apparent whether raised directly or avoided.*

Medical Student Role

- Can medical students be helpful in a consultation?
- How to establish and maintain professional boundaries, being friendly rather than a friend.
- Patients can remind one of oneself of one's own family or friends, what are the implications of this?
- Appreciating help from patients, guilt at 'using' patients for one's own learning.
- Labelling "difficult" patients, can you believe the patient?
- Fear of contact with mental health patients, will you make them worse? Fear of risk of suicide.
- Anxieties about professional guidelines in relation to themselves and other health professionals.
- Professional identity – what kind of doctor will they become?

Leading Medical Student Balint Groups

Getting Started

- **The aim is to create a relaxed, supportive environment**
  As a leader you are trying to help create a setting where the students feel able to speak freely. They will be unfamiliar with this work and many will find it new and daunting to think and talk about psychosocial aspects of medicine let alone their own emotional responses to patients. They will need encouragement especially in early sessions in order to help the students gain confidence. It helps to be enthusiastic, friendly and approachable (within limits).

- **Encourage presentation of a case**
  Students may be reticent, at least at the start. The case could be from previous voluntary work, from their longitudinal placement in general practice the previous year or from a current clinical placement. More historic encounters can be 'dead' emotionally and allowing them may collude with the students that they have no current encounters of note to present. While historic cases may be allowed in early groups, continuation of this can be countered with the proviso that at the next group a current encounter be presented – they will have 2 weeks to find a patient and this may provoke greater engagement with patients as individuals.

  Students may bring encounters in which they are observers of an encounter between another health professional and a patient rather than one in which they have an active personal interaction with the patient. Such cases can be interesting and evoke discussion but are often rather thin on detail and emotional response in the student. It can be useful to let students know from the start that the expectation is that they bring personal interactions with patients and that if they haven't had that opportunity then they should actively seek it out e.g. by finding a patient who could spend some time with to have a discussion about the psychosocial impact of their illness rather than biological / medical facts. As well as promoting a holistic appreciation of the patient, this generally evokes an emotional response in the student.

  Asking students to set up a WhatsApp group to decide in the couple of days before the group who will present that week can be helpful although may encourage the problem of students deciding a rota in advance which can also lead to deadened cases being presented. However, this may be outweighed by the advantages of promoting actual rather than observed interactions with patients, endorsing the expectation that all students take part in the process and have a responsibility to the group. It may be helpful to the students that everyone is expected to present a case during the course of the groups.

  Students often bring cases from psychiatry placements. This is understandable as the encounters can be disturbing and more foreign to their experience and they may know more about the patient's background. However it can be problematic as the students may feel that is what you are interested in as psychiatrists, they are often more pre-occupied with the psychiatric aspects of the case than with the nature of their interpersonal encounter, they are more likely to put pressure on group leaders to teach them and importantly it risks locating this type of learning and reflection within psychiatry rather than being seen as relevant to all medical practice.

  Encouraging cases from other medical placements can initially feel less comfortable for psychiatrists too but helps avoid being pulled into a more didactic teaching style. It also

stimulates students' interest in their patients' lives and relationships and promotes attention to their interactions with patients across all health care settings.

Let the students know that the case or encounter doesn't have to be anything dramatic e.g.:
"Has anyone had an encounter that surprised them"
"Has anyone had any contact with a patient yet that they could tell us about"
If no one offers a case – ask about current medical / surgical placements, "someone must have seen a patient in the last week that they remember?"
Continued reticence in providing a case would need to be addressed with the group and discussed in supervision.

- **Explain the presentation should not be from notes**
  This allows for a more fluid discussion and attention to what aspects are remembered or discovered as omitted (See Balint guidelines and what underlies them Page 10).
  If notes are produced then ask the student to put them aside and tell the encounter as a story or description. Why has that case stayed with them? What emotions were evoked? Any background history?

- **Invite factual questions** (not about clinical management and not personally intrusive). Do not let these go on too long, 5 minutes is plenty. Try not to let this stray into opinions which would be part of the discussion after the presenter sits back.

- **Ask the presenter to sit back**
  This helps with the tendency for students to address the presenter or the group leaders directly. Remind students at the introductory session that the presenter is listening to the discussion and not involved again until later. Focus on the leaders can usually be managed subtly and kindly by limiting eye contact and trying to involve other group members in the discussion.

- **Encourage discussion**
  Groups can be rather quiet at the beginning and find silences difficult (although this may change over time), so leaders may need to take a more active stance. Generally leaders will be able to intuit mounting anxiety and intervene to limit it.

  One way to deal with silence is to summarise what people have been saying and wait for further comments or invite comments through open questions e.g.:
  "We've just heard an interesting case, I wonder what reactions people have had to it"
  "Has anyone else got any thoughts on what X has just said"
  "Did anyone feel differently about what was described?"

- Bring the focus back to the relationship and feelings evoked in the encounter rather than academic or management discussion e.g.:
  "How do think the presenter was feeling about this situation"
  "Has anyone got any thoughts about how the patient might have experienced the situation"

- It may be helpful to encourage group members to reflect upon how a relative or other staff present might have felt e.g. "I wonder how I would have felt if I were ….."

- **Bring the presenter back** into the discussion 15 mins before the end, this allows them some digestion of the discussion. Invite them to comment if they want but let them know it is not necessarily expected.

Hints for some particular difficulties

- A student saying at the introduction that they think the group will be a waste of time. Try not to just tell the student they are wrong – you can validate their opinion whilst maintaining that feedback and research shows that many students do find it useful. You can emphasise that it helps to have a variety of opinions in a group and you hope the student will be able to contribute to discussions and come to enjoy the experience.
- If more than one case is offered at the start of a group, encourage the students to work out who will present the case in that session. Don't suggest dividing the time to accommodate both cases.
- Students may bring in other similar cases or experiences during the discussion – whilst this may be reassuring there is a risk that a series of anecdotes undermines more in-depth consideration of the case presented and of the experience of the presenting student, so think about steering it back e.g.:
  "Yes, I can see the connection between the cases but let's stick with the presenter's case as there are bound to be differences as well which we might miss if we take our eyes off that case"
- Some students may say a lot and others very little, to an extent this is fine as some will naturally be less vocal. However gentle encouragement of quiet students could be helpful and occasionally it might be necessary to manage the group to protect quieter members to allow them to finish speaking before someone else takes over.
- Sometimes a student may disclose some personal difficulties in the group that seem too revealing or may need attention outside the session. You might thank the student for entrusting the group with difficult personal material but also try to say kindly that the focus of the group is on patients' relationships with us as health professionals but not on personal difficulties and then try to steer the discussion away. At the end of the session, you could discretely ask the student if they would like to talk further or arrange a time to meet separately. These situations should be brought to supervision.

Ground Rules- to be discussed in the introductory group

- Confidentiality – This is paramount if the Balint Group is to become a space where students feel safe to share their experiences and emotional responses. Students are requested not to talk about or refer to any content from group sessions outside of the group, including to the group members themselves.

  Likewise, the group leaders will only be discussing content from the groups within supervision. It is important for the students to know that the leaders / supervisors do not share information with medical school staff other than attendance. In the unlikely event that there is a significant concern that requires discussion beyond the boundary of supervision, the leaders will first discuss this with the student.

- Respect – group leaders should encourage students to think about the nature of respect for one another's participation and views in group sessions.

- Time keeping – Group members are expected to attend on time and stay for the whole session.

- Notification of absences – Students are asked to email the co-leaders if they cannot attend a session. Leaders will let the group know if they are not able to attend for any reason.

- Use of mobiles/ laptops/ tablets – group members are expected to refrain from using these during the session but may need to be asked to turn them off and put them aside.

Balint guidelines and what underlies them

Guidelines are to make the group safer and more secure - a forum in which to have more freedom to think, play with ideas and learn. They are inevitably going to be bent or broken; but attention and thought about why and how they are can be helpful. For example, is this being done reasonably and mindfully under the circumstances or is the group trying, perhaps unwittingly, to avoid focusing on working together.

1. Starting on time – excluding late comers

- Not intended punitively but latecomers will miss the presentation and not be in a place to join in the discussion. 10 mins is often used as the maximum time after which a student would not be able to join.
- Everyone's presence and views are important and all have a responsibility to attend and contribute.
- Important to develop skills in teaching and learning in and from peer groups.
- Promotes development of respect and trust between group members so allowing for better functioning of the group.

2. Use of the term 'presenter '

- Reminds the group that this is about their professional development *not* the *personal* development of the student presenting. This reduces the risk of moving into 'therapy' for the presenter and so disrupting the focus of the group.
- Provides some protection to the person presenting who can easily expose themselves more than they wish.

3. Presenting without notes

- The story comes out spontaneously with unexpected emphases and surprising omissions.
- Helps the presenter and the group think differently about a case and discuss it more fluidly.
- It produces a different atmosphere in a group discussion where not knowing something is not reprehensible but a point of interest to be explored.
- What is not reported may be significant to the case.

4. Presenter sitting back

- The aim is to protect the presenter from continued questioning by the group and to help the group focus on and think about the information already given.
- It offers the presenter an opportunity to think about their case in the light of the discussion.
- The group may be reluctant to let the presenter sit out and to face the work and anxieties of discussing the case.
- It may not be appropriate if there are few students present – it can be difficult to have a productive discussion with a group of less than 5 students (including the presenter).

5. Questions of clarification

- These are about matters of fact and clarification, not of process.
- They are best limited (to around 5 minutes) as otherwise the group can continue to interrogate the presenter rather than work on the material given. This is more likely if the presenter does not sit back.
- The issue of importance for the presenter is often revealed in the first few minutes of the story and more questions and information can obscure rather than enlighten.

6. Finishing on time

- People need to meet other commitments.
- Extending to wrap up etc. doesn't necessarily help as group members often delay contributions anyway until just before the end in case their input is not taken seriously.
- If the group overruns, it is worth asking why - it may relate to the case.

Leadership of Groups - What Balint Leaders Do

General
Keep to time
Remind everyone about confidentiality
Monitor how everyone is feeling
Make space for quieter people when they want to speak
Tolerate uncertainty and silence (within limits)
Allow the group to follow preferred lines of thought (within limits)
Help the group manage distress

Bring the Discussion Back to Relational aspects of the case – particularly the Student (Doctor/Team) – Patient Relationship
Remind the group to ask themselves 'what is going on here?' rather than 'what should be done'
Encourage students to put themselves in the patient's shoes
Encourage reflection on how the patient makes us feel
Represent the patient if he / she is in danger of being lost

Encourage students to put themselves in the position of the patient in relation to important others (eg friends, family, work colleagues etc) and vice versa

Particularly initially it can be hard for students to think in much depth or speak openly about interactions with patients. It may be easier for them to engage with relationships in the patient's wider social networks which is also very valuable and may be a steppingstone to thinking more about student - patient relationships in later groups.

More Specific Techniques / Problems
Intervene to protect group members from unwanted personal questioning
Manage excessive personal disclosure
Reflect questions
Observe and draw attention to metaphors
Comment occasionally on parallel process (that what is happening in the group discussion may reflect what was happening in the encounter presented).

Co-leadership Model

Benefits

- Co-leadership offers the group a 'reflective pair' and the value of mutual de-briefing after a session.
- The co-leadership pair can provide the group with the feeling of containment (co-leaders will at some level be experienced as a parental couple).
- Different professional interests, gender, racial and cultural identity and perceived or actual seniority relationships in the co-leadership pair can benefit the group through respectful and creative ways of relating to one another and by offering students different role models with whom to identify.
- By modelling a difference in opinion which engenders curiosity rather than conflict.
- Sharing of the leaders' responsibilities e.g. keep the structure / timing, attend to the emotional tone of the group, ensure both student and patient are represented in the discussion.
- The group being able to meet if one leader is absent.

Challenges

- Finding time for leaders to get to know one another.
- Difficulties in working harmoniously together.
- Differences in approach to the role of leader e.g. one person being very active and the other significantly more silent.
- Leaders remaining mindful of the dynamics between them including differences in gender, age, professional seniority, race and culture – differences can create difficulties as well as be potentially beneficial.
- Avoiding lengthy exchanges between co-leaders which may inhibit students from participating.
- Feeling scrutinised by your co-leader or that they are a more experienced or naturally proficient leader which can make you more inhibited in your role in the group.

Responsibilities of Co-leaders

- Communication with students
- Attendance records / policy
- During groups it is helpful for one co-leader to take responsibility for timekeeping allowing the other to have more space to focus on the students' discussion. This should be alternated so co-leaders are experienced as pair who work together and not experienced as a hierarchy.
- Record of sessions

Leadership Training and Supervision

These are necessary as part of an educational governance structure and will vary between different schemes around the UK. Arrangements for training and supervision at GKT are described on p17. Our training emphasises early sessions particularly aimed at student understanding of the purpose of Balint groups and engagement with the process. Our supervision groups mirror the Balint structure of the student groups. The focus is more on student participation, group and leadership dynamics rather than consideration of the case presented by the student. The aim is to enable co-leaders to reflect on their relationship with the student group and with one another and help them to ensure the group adheres to its task.
(***Appendices 2 – 3***, ***p25-28*** - information on training and recording student groups).

BALINT GROUPS AT GKT SCHOOL OF MEDICINE

OVERVIEW OF MEDICAL TRAINING AT GKT

Balint Groups in the Curriculum

GKT is the largest medical school in Europe with an intake of around 450 students each year. The course runs over 5 years. Clinical experience begins in Year 2 with a Longitudinal Placement in General Practice alongside academic study. In Year 3 students undertake the Longitudinal Placement in Psychiatry whilst also having clinical blocks in other areas of medicine. Balint groups are a component of the longitudinal placement and run from September to May providing around 13 groups over the academic year with 10-12 students in each group.

Year 3 is busy and a somewhat fragmented experience for students. In addition to adjusting to clinical medicine, during the first term they are completing a scholarly project and a course on 'student as teacher'. In the second term they also have written exams in January as well as written exams and OSCEs in May.

The new ***Medical Licensing Assessment (MLA)*** has been introduced nationally for the 2024 / 25 academic year. Although our third-year students will not be sitting this until their final year, there is considerable anxiety in the student community about it. We can reassure them that the psychiatry curriculum is fully mapped to this exam and that Balint Groups are an essential part of this.

Medical Students

The student body at GKT is particularly diverse. Most students come straight from school into medicine or after some other experiences including as Health Care Assistants so are in their early twenties during their 3rd year when they start their Longitudinal Placements in Psychiatry. Other groups include Postgraduate students, a few years older who train over 4 years and those on an Extended Medical Degree Programme (EMDP - specifically designed for students from non-selective state schools or participants of Realising Opportunities across England) which takes 6 years. In addition, there are some International Students.
Around 60% of the student intake are female.
Most of the students are from Asian including South East Asian backgrounds (most 2nd or 3rd generation British), many are actively practising the Muslim faith.
Students come from a wide range of socio-economic backgrounds. Many of the students are under significant financial constraints, often live with family some distance away and may have caring responsibilities and / or jobs outside of their studies. Travel from accommodation to placements can be expensive and time consuming and they may face student debts up to £100,000 by qualification.

Whilst there are obvious benefits to the experience of diversity, it can also add to perceived feelings of difference and superiority or inferiority between students. External responsibilities add to difficulties in integrating into a student body and feeling supported in training. Many live at home rather than in student accommodation, often do not know each other and feel anonymous within the medical school which makes forming smoothly functioning groups more difficult. It is exacerbated by the demise of the containing 'Firm' structure in which students are more included and known within health care teams.

Impact of the Covid Pandemic
Covid has caused considerable disruption to the education and social development of several cohorts of medical students. For example, the 2025/26 Year 3 cohort were in their final GCSE year during initial lockdowns and did not sit exams - receiving teacher assessed grades instead. In addition, many will have experienced bereavement and ill health in their relatives. Exam results have been inflated compared with pre-pandemic levels so some students may be more stressed academically taking a medical degree and be more anxious about failure. There have been more issues with failing exams and need to access support at GKT. There has been significantly poorer attendance, this being a national issue across Universities and courses post Covid. More students are contacting student supports including charities such as Student Minds.

Student support at GKT
We need to be mindful that students may be under considerable pressure, struggling in several ways and feeling dissatisfied with their education especially in the aftermath of the Covid pandemic and due to the impact of strike actions.
Supportive structures include personal tutors, educational supervisors and the student counselling service run through KCL. Other services accessible by medical students include counselling and peer support services via the BMA, as well as more generic supports via the NHS (GPs, IAPT etc) and the 3rd party sector.

The Longitudinal Placement in Psychiatry

This was initiated for medical students at GKT School of Medicine in 2018.

Structure
Students attend the longitudinal placement in psychiatry one day a week (Tuesday or Friday) throughout Year 3 from September to May. This runs alongside clinical placements in other areas of physical medicine.
Clinical attachments to mental health teams one week alternate with an academic programme the next. Students experience two clinical placements in psychiatry – usually one in-patient and one community mental health placement – attending in 'clinical pairs' and changing placement after Christmas.
The academic programme consists of small group teaching for 10 -12 students with their 'Firm Head', a Balint group for the same group of students and e-learning. Attendance at placements, including the academic day is mandatory and attendance is recorded.

Firm Heads
Firm heads provide small group teaching sessions for their 'firm', lasting 90 minutes and on a range of topics over the year. They also co-lead a Balint group (for a different set of students), are educational supervisors for 3-4 students and often also provide placements in their clinical teams for up to 8 students. As such a firm head may be relating to around 36 students a year and face a real challenge in remembering them as individuals including their names and in monitoring their attendance. This is important as many students feel anonymous and a burden in such a large medical school.

Responsibilities of Firm Heads and Co-leaders for Balint Groups

The co-leadership pairs consist of a firm head and a co-leader who is only facilitating the Balint groups. The firm head is usually a Consultant Psychiatrist and the co-leader a senior trainee (ST). We aim to have co-leaders of different genders working together – most commonly, and unintentionally, this will be a male Consultant firm head with a female ST which can raise difficulties for students and in co-leadership due to real or perceived hierarchical attitudes. Firm heads usually continue in the role whilst their trainee co-leaders tend to only do one year, generally as their ST mandatory psychotherapy experience. Most firm heads have little or no experience of participating in Balint groups but have gained experience of leading them over several years. Conversely STs have all participated in groups for 18-24 months during their psychiatry training but have had much less leadership experience.

Firm heads

- Take up issues about Balint group **attendance** and other areas of concern with their own students. These students will not be those in the Balint group that they are co-leading but those to whom they provide small group teaching. They will be informed by the Balint leader for the students. If concerns are serious, they will be elevated to Lead for Year 3 and potentially to the Medical School. It is helpful not to see this as a punitive response but as an opportunity to identify and support students experiencing difficulty with their studies.

- Discuss Balint groups with their own students at mid- and end- of placement **individual feedback sessions** and report anything of significance back to the co-leaders who facilitate the group for their students.

There will be only one **group feedback** for the Balint groups during the last Balint group. During the mid-placement feedback the Balint group will run as usual.

Balint co-leaders

- Keep Balint group **attendance registers** and make note of any concerning individual patterns of non-attendance, raising this in supervision and in line with the attendance policy. This is particularly important as it can lead to additional support being offered for such students who are usually struggling with attendance at other teaching and placements and can easily fall through the net in such a large cohort of students.

- Manage email **correspondence with students**, for example receiving apologies and contacting students who have not attended. It is best to 'sign' any emails from both co-leaders and copy your co-leader in. We have found that a friendly email to the group in the week before a Balint session has helped attendance – groups are at least 2 weeks apart, sometimes more, and this serves to show the students that you have them in mind. Feedback has been positive with students generally feeling they are more known and appreciated in this setting than is their experience in other placements.

- Take responsibility for **leaders' records** and sending these to their FH co-facilitator for agreement. These do not have to be extensive – a possible template is included in ***Appendix 3, p27.***

Leadership Training and Supervision

Leadership training is provided as a half-day session in early September before the groups start ***(Appendix 2a, p 25).***

The focus of the training is on promoting student engagement with the work, getting groups started, establishing ground rules and developing a group culture. We consider managing challenges presented by students, group dynamics and other group leadership issues, although these areas are mainly addressed in supervision.

The training includes two Balint groups, one to role play the introductory session and the other running as a standard group giving co-leaders opportunities to participate, co-lead or observe a group ***(Appendix 2b, p 26–27).*** It is important that as far as possible co-leader pairs attend the same training sessions together, and preferably with the other co-leader pairs who will be in the same supervision groups.

Supervision

- Arrangements vary between different schemes across the UK. At GKT we have been fortunate to have 2 supervisors for each supervision group. We have 4 supervisors in all – 2 are members of the Undergraduate Psychiatry Department at GKT and 2 are external. All are medical doctors with experience in psychiatry and accredited by The Balint Society UK.

- Supervision groups meet immediately before or after the student Balint groups are held. They run for 50 minutes (as do the student Balint groups).
  There is a 20 minute gap between the group and supervision allowing for leaders to discuss their group and make some notes. A possible template is included at ***(Appendix 3, p 27).***

- Supervision groups consist of 4 co-leader pairs and 2 supervisors and mirror the Balint structure of the student groups. After time for trouble shooting, a co-leadership pair present their most recent student group (mirroring a student presenting their case) and this is considered in line with the Balint model. After the presentation there is a brief time for questions then the co-leaders sit back during a group discussion before re-joining the group.

  Whilst the student case is described briefly to provide an anchor to the presentation this is not the focus of discussion. The focus of the supervision group is on student participation and on group and leadership dynamics rather than consideration of the case presented. The aim is to enable co-leaders to reflect on their relationship with the student group and with one another and help them to ensure the group adheres to its task.

  Supervisors keep their own records of each supervision group which will be confidential to them and help them to hold each supervision group in mind. A possible template which mirrors that for recording student sessions is included at ***(Appendix4, p 28).***

- Each supervision group creates its own WhatsApp group to facilitate easy communication between participants and let everyone know if they are unable to attend supervision.

Feedback and lessons learnt (2018 – 2025)

Despite the disruption to Balint groups including suspension of groups in the 2019/2020 cohort and online groups for much of the 2020/2021 cohort, leadership proficiency and student participation has steadily increased over time. We believe this has involved a number of factors. Many Firm Heads have now run groups for 5 or 6 years - their increased confidence and experience is very supportive of new co-leaders and students and helpful in forming and settling the groups. Balint groups have become a more established part of the student and medical school culture. As supervisors we have adapted our training and supervision sessions in line with our increased appreciation of the challenges of the scheme.

Feedback has been obtained from students in individual meetings with firm heads and in the final Balint group session at the end of the placement. Co-facilitators have provided feedback during supervisions.

Student feedback

1. Students have struggled with the concept of 'reflective practice' which is used in many aspects of their medical training to refer to differing activities, for example writing their own reflections on learning experiences but without any discussion of emotional or relational considerations for their patients or themselves. Use of the term 'Balint Groups' and descriptor 'Understanding the Relational Impact of Illness' to distinguish from such activities and greater emphasis on discussing the purpose of groups in the introductory session with students and their co-leaders appears to have helped significantly. It has also been helpful to show students a video made by Sheffield University of students discussing their experience of Balint groups. The link to this is https://balint.co.uk/medical-students/
   Despite this with some groups it has been necessary to revisit the discussion especially following the long Christmas break.

2. Students saying that they have no cases to bring for discussion. Among other reasons for this, seems to be lack of a coherent firm culture in their clinical placements in which students can feel that they belong to a team and are encouraged to have their own interactions with patients. Often students present observed rather than personal contacts with patients or only brief interactions focussed on clinical signs with almost no on-going contact with any individual patient. This focus may be understandable as the students are trying to acquire clinical skills which they will be examined on later in the year, however, as part of learning broader medical skills it should be challenged. Management of this has been addressed earlier ***(p8).***

3. Students' perceptions of uncomfortable silences during group discussions are common although some students do come to appreciate some space to think. Greater experience of leadership has facilitated more fluid discussions and increased awareness of reflective rather than uncomfortable silences.

4. Students expressed resentment towards their peers who contributed little in groups. We try to address this in the introductory session by explaining that all students have a role in building a group culture and it is respectful to their colleagues to participate and encourage others. In training we practice an exercise for the students to promote discussion on forming a well-functioning group ***(Appendix 2b, p 26)***
   It may be that some students are naturally quiet, shy or unsure of themselves or struggling with this type of reflective practice or it may be an expression of hostility towards the experience. There could also be a group dynamic contributing. Such difficulties need to be brought to

supervision. Students who do not participate for any reason may be asked by the co-leaders to discuss this individually.
Student WhatsApp groups to agree before group sessions who will present a case that week, with an understanding that all students are expected to present during the course of the year can also be helpful in encouraging participation.

Co-leader feedback

1. Student anonymity. The medical student body at GKT is very large and the structure of the training such that most students do not know each other. This adds to the challenge of creating a group culture and a safe space for the expression of emotional responses to patient interactions. In parallel, most co-leader pairs have not known each other previously. Many co-leaders struggle to remember the names of their students - this is understandable given the large number of students they relate to, particularly the firm heads, but risks reinforcing the experience of anonymity for students. On the other hand, the structure of the longitudinal placement is a rare opportunity for students to bond and get to know each other as a group which is much appreciated.
   Running the initial group session with a more informal atmosphere and icebreakers has allowed students and facilitators to get to know each other and learn each other's names. ***(Appendix 2b, p26).***

2. Students' understanding of the relevance of Balint groups to their medical training. We have tried to address this by putting greater emphasis on explaining the purpose of groups and the Balint model – particularly of teamwork and learning to communicate in groups as well as the benefits of having a more emotionally open and empathic stance in the practice of medicine.

3. Structure of the programme. Fortnightly as opposed to weekly Balint sessions and greater gaps between sessions at times (particularly over Christmas when groups may not meet for 6-7 weeks), makes it a challenge to help students settle into the group experience and develop a group culture. Unfortunately, we have no influence over this as it is set by the Medical School.

4. The idea that groups are mandatory and that there is a clear policy around non-attendance at Balint groups is not always followed for various reasons. Students generally became aware that there are no serious consequences which will likely have contributed to poorer attendance from some however this has lessened over time with accurate record of attendance and a formal attendance policy ***(Appendix 6, p 32).*** The very few students with extremely poor attendance are generally struggling with other components of their training and already known to the Medical School.

5. There were a variety of ways in which students interact in the groups that can be difficult for co-leaders but which tend to improve with students' familiarity with the process and with consideration in supervision. A common example is of students being unwilling to express opinions or alternative views or disagree with each other, instead tending to be supportive of the presenter in a way that could close down freer discussion.

6. Rarely there are difficulties in the relationship between co-leaders which may only become apparent in later supervisions, this seems to be more to do with personal styles and may not been discussed between the co-leaders. Greater leadership experience and more attention in supervisions on how the groups and the co-leaders are working together (with less emphasis on details of cases brought by students) has helped address such difficulties earlier.

APPENDIX 1
(p20 - 23)
INFORMATION FOR STUDENTS ON KEATS:

BALINT GROUPS FOR MEDICAL STUDENTS

Aims And Learning Outcomes

Aims of the Group Sessions:

1. To provide the students with an opportunity to explore and reflect on the emotional aspects of their work in a safe environment

2. To increase the students understanding of their patients' communications

3. To learn to work in a group setting - all medical specialities involve team work

Learning Outcomes:

1. **Develop an 'emotional skill set'**

   - Be able to consider their clinical encounters in a new light

   - Become aware of the significance of the relationship between the doctor/student and the patient

   - Recognise feelings evoked by the interaction with the patient and to use these for the benefit of the patient

   - Value one's own humanity and personality and the effects on the patient

   - Recognise the inherent value and the therapeutic potential of the consultation itself including between student and patient.

   - Become aware of one's own limitations

2. **Develop the ability for team working**

   - Learn to better communicate in groups including speaking up, resisting dominating, listening and encouraging others.

   - Appreciate there are often no 'right' answers in medicine, learn to tolerate uncertainty, develop the ability to disagree whilst respecting the views of others.

   - Using the group to express and process anxieties and frustrations about their work.

-

BALINT GROUPS – UNDERSTANDING THE RELATIONAL IMPACT OF ILLNESS

Balint Groups are a component of the fortnightly academic day of longitudinal placements in psychiatry. There will be 12 clinical discussions during the longitudinal placement.
Each group will comprise of around 12 students and will be co-facilitated by two senior trainees or consultants in psychiatry who work at the South London and Maudsley or Oxleas Mental Health Trusts.

The Balint Group Experience

Balint groups are a form of reflective practice initially developed for GPs to reflect on encounters with their patients, particularly those that evoked overly negative or positive feelings in the doctor. They are available to students in many medical schools in the UK and are a formal component of training in psychiatry.

Balint Groups have a particular structure and an emphasis on the emotional aspects of the student or doctor / patient relationship. They are used to consider the emotional impact of illness on the patient and on their relationships not only with the professionals treating them but also with their wider family and social networks. They also address reactions of the wider multidisciplinary staff team to patients and team dynamics. They allow space to think about how the patients' background developmental experiences may affect the way the patient relates to others including those providing health care.

It is important to bear in mind that the focus of these Balint Groups is to try to think about the emotional and relational aspects of illness, not to prioritise or solve a clinical problem which is always a temptation (and a more prominent feature of other types of 'case based discussion groups').

The time, place and membership of the group is constant to allow for a protected reflective space. Members of the group present patient interactions that have made a particular impression on them in some way especially that evoked emotions that were hard to think about, manage or understand. Presentations are not formally prepared and do not involve any notes which allows for a more fluid and open discussion. Once a student has spoken about their case, and perhaps answered a few clarifying questions, they are invited to withdraw a little from the group and to listen to the responses of the other group participants who are encouraged to think and speculate about the scenario themselves. The presenting student will be invited back into the discussion towards the end, when they have the opportunity to respond or add to the group's contributions, if they wish.

Educational Benefits

The groups aim to help students enhance reflective practice skills, deepen their understanding of doctor–patient relationships including psychodynamic perspectives and learn to consider and understand wider team and group dynamics. They allow for a more holistic view of the patient as influenced by and influencing family and wider social relationships.
Increased confidence in reflective skills and understanding of psychological factors in doctor-patient relationships allows for safer and more consistent professional practice and greater empathy and compassion particularly with those patients who experience inter-personal difficulties or with whom the doctor feels in some way thwarted in their therapeutic endeavours. The recognition of strong feelings towards patients, if not consciously realised and processed, are liable to be expressed unhelpfully for example in prioritising certain patients, avoidance of

engagement with others, prolonging or prematurely terminating consultations, over-zealous use of investigations or prescribing etc.
The ability to reflect on our day-to-day work helps with our own well-being and resilience as well as our team and patients' welfare.
Learning to reflect on patients and experiences in clinical medicine builds essential skills for students and doctors working in demanding and pressurised situations and trying to maintain patient-centred care. In addition, students will develop the skill to reflect on broader dynamics of their work environment. It is crucial to learn how to communicate and work effectively in a group setting given that all medicine involves working in teams.

BALINT GUIDELINES AND WHAT UNDERLIES THEM

Guidelines are to make the group safer and more secure…a forum in which to have more freedom to think, play with ideas and learn. They are inevitably going to be bent or broken; but attention and thought about why and how they are can be helpful. For example, is this being done reasonably and mindfully under the circumstances or is the group trying, perhaps unwittingly, to avoid focusing on working together

Starting on time – excluding late comers

- Not intended punitively but latecomers will miss the presentation and not be in a place to join in the discussion. Generally, a student would be unable to join the group if more than 10 minutes late.
- Everyone's presence and view is important and all have a responsibility to attend.
- Important to develop skills in teaching and learning in and from peer groups.

Use of the term 'presenter '

- Reminds the group that this is about their professional development *not* the *personal* development of the student presenting. This reduces the risk of moving into 'therapy' for the presenter and so disrupting the focus of the group.
- Provides some protection to the person presenting who can easily expose themselves more than they wish.

Presenting without notes

- The story comes out spontaneously with unexpected emphases and surprising omissions.
- Helps the presenter and the group think differently about a case and discuss it more fluidly.
- It produces a different atmosphere in a group discussion where not knowing something is not reprehensible but a point of interest to be explored.
- What is not reported may be significant to the case.

Presenter sitting back

- The aim is to protect the presenter from continued questioning by the group and to help the group focus on and think about the information already given.
- It offers the presenter an opportunity to think about their case in the light of the discussion.
- The group may be reluctant to let the presenter sit out and to face the work and anxieties of discussing the case.
- It may not be appropriate if there are few students present – it can be difficult to have a productive discussion with a group of less than 4 or 5 students.

Questions of clarification

- These are about matters of fact and clarification, not of process.
- They are best limited (to around 5 minutes) as otherwise the group can continue to interrogate the presenter rather than work on the material given. This is more likely if the presenter does not sit back.
- The issue of importance for the presenter is often revealed in the first few minutes of the story and more questions and information can obscure rather than enlighten.

Finishing on time

- People need to meet other commitments.
- Extending to wrap up etc. doesn't necessarily help as group members often delay contributions anyway until just before the end in case their input is not taken seriously.
- If the group over runs it is worth asking why - It may relate to the case.

Link to Video by medical students at Sheffield University discussing Balint Groups
https://balint.co.uk/medical-students/

APPENDIX 2a

STRUCTURE OF TRAINING

Medical Student Reflective Practice - Balint Leadership Training

Date: **……..**

Time: AM session 09:00 – 12:30 (Lunch 12:30-13:30)

PM session 13:30 – 17:00

Location: WEC classroom 3

Leaders: **…….**

Preparatory work

- Come with a *physical health case* that still sticks in your mind from Medical School or your early House Officer/Foundation years
- Be prepared to co-lead a group discussion

Ground rules

- Please arrive on time
- Please protect the time from interruptions from your day job
- Please be open, respectful, maintain confidentiality, and ready to participate

Outline of the day

09:00 – 09:35	Introduction to the scheme / The Balint Model / working with students
09:35 – 10:20	Session 1: the introductory session (icebreakers and explanations)
10:20 – 10:35	Q&A
10:35 – 11:00	Break
11:00 – 11:50	Session 2: a Balint Group
11:50 – 12:10	Discussion of Balint Group
12:10 – 12:30	Q&A

13:30 – 17:00 Above repeated for afternoon groups

APPENDIX 2b

DESCRIPTION OF TRAINING DAY

Balint Reflective Practice Leadership Training Day 2025

Welcome to the Medical Student Balint Programme. You may be familiar with the Balint model (see table below). The students are new to the experience and will almost certainly need your encouragement and help in engaging with discussions, which may require you to be more flexible than in a traditional Balint group. The focus should be on the psychosocial elements of the case and the student-patient interaction (although be careful not to lapse into formal teaching!).

Standard 50min Balint Group	
Up to 10min	Invite a member to present a case.
5 minutes	Factual questions.
Approx 20min	Presenter 'sits back'. Group discusses interaction between presenter & patient.
10-15min before end	Presenter invited to rejoin the group. Advise no new information. End of group.

Phased Introduction to Balint Groups
On the next page is a flow chart depicting how you could phase your students into the Balint Model; this isn't proscriptive, and many groups don't require as phased an introduction and get the gist quickly. You will need to meet with your co-leader beforehand to think about how best to start with your group.

Problem areas that the students may need more support with:

1. Forming a group – students may feel shy or fear being judged; they may not know eachother.
2. Grasping the value/learning potential of the groups – many students will be preoccupied with exams; some will have travelled far to attend and may question its value.
3. Lack of cases – this is more likely at the beginning, when students lack confidence and may not have spent quality time with patients. Modelling and reassurance can help.
4. Balint-specific issues – use of 'sitting back' and the term 'presenter'.
5. Silences – pauses can be experienced as lengthy and awkward, rather than a space to think.

Structure of the year
There are ~ 13 groups running from September to May, with a lengthy break over the Christmas period. The break can be quite disruptive and so we recommend that you email them after Christmas to prompt/encourage them, and revisit the introduction to the programme when you reconvene.

Engaging the students
Focus is less on maintaining the strict Balint model and more on engagement, getting the students to know each other and work together, at least at first. It is helpful for your students to set up a Whatsapp group so there is a sense of them being a part of a group and messages can be communicated. Due to the difficulty in bringing cases it is helpful to clarify the expectation that each student will bring at least one case of a patient they have had a personal interaction with, particularly non-psychiatric cases.

Roles of co-leaders
Most pairs are made of one firm head (with experience of running groups) and one co-leader (usually ST with more experience of being in Balint Groups). Communication with the students is normally led by the co-leader but signed by both. Sending gentle reminder emails and asking for apologies before each group is advised. The firm head of the group (not their Balint co-leader but the person providing

Small Group Teaching) may need to be copied in at times. Please ensure you keep an attendance register as this is required by the medical school and monitors student engagement.

There is a template for making brief notes on your groups which helps debrief with your co-leader and is an aide memoire before presenting in supervision. In supervision the emphasis is not on the student case but on the group dynamics and co-leadership.

Training Session
We will roleplay two groups to practise:

- The introductory session with icebreaker and discussion of the purpose of these groups.
- An early session where group members are encouraged to bring a case, and if not forthcoming, one co-leader presents a case from their personal experience of physical medicine.

For the introductory session we suggest a particular icebreaker that seems to have worked best in engaging the students and helping everyone learn each other's names. We also suggest splitting into small groups to generate discussion around the purposes of Balint. Groups. You and your co-leader might want to use your own icebreakers.

Suggestions for early groups

Session 1

- Icebreaker: e.g. "Tell us where your name comes from – why were you given your name?"
- Split into small groups: ask each group to reflect on groups they have been in before (sports teams, book club, etc) and answer the following (each group considers one Q and feeds back to the whole group after):
    - What makes a group work well?
    - What gets in the way of a group working well?
    - What's it like to be in a group?
- Large group discussion – "What is reflective practice and is it important?"
- Explanation of Balint Groups (Ground rules, Housekeeping, Timings, 'Presenter' and 'Sit back')
- Expectations – each student to present a case over the year, type / sort of case (prefer physical medicine), student WhatsApp group
- If more time, co-leaders give examples of the kind of cases you might bring to a Balint Group (emphasising that it doesn't need to be too dramatic, or necessarily a psychiatric case).

↓

Subsequent groups

- Expectation that students bring a patient they have had a significant and personal interaction with.
- Initially co-leaders may need to participate and encourage actively.
- As students become more active the co-leaders can take more of a facilitative role.
-

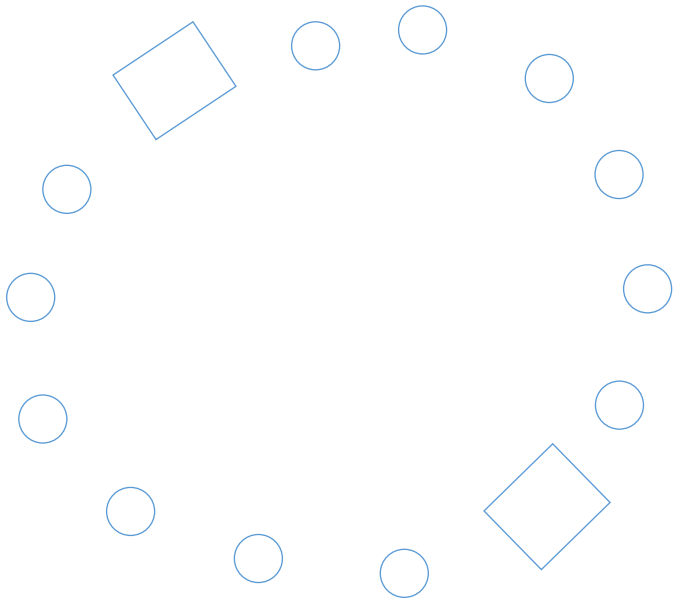
APPENDIX 3

Balint Session Recording Template

Date: Session number:

Present:
Apologies:

Seating plan:



Case presented by:
Case Summary:

Student-Patient relationship:

Individual students' reactions:

How reactions were received:

Pressures for leaders – reflections in relation to case

Tensions between leaders:

Important moments

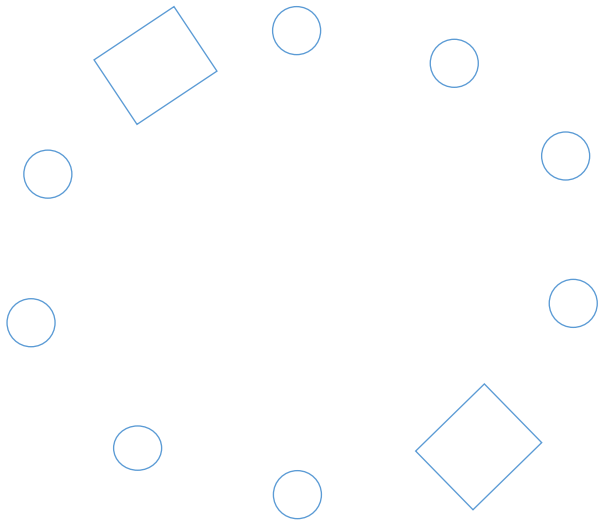
APPENDIX 4

Balint Supervision Recording Template

Date: Session number:

Present:
Apologies:

Seating plan:



Co-leaders presenting :

Student attendance:
Student presenter and Case Summary:

Students' involvement / relationships:

Themes:

Individual students' reactions:

Important moments:

Leaders' perceptions of the group / presentation

Pressures for leaders – reflections in relation to case

Relationship between leaders:

Important moments:

APPENDIX 5

STUDENT ABSENCE POLICY

Balint Groups: actions for co-leaders

Student action	Response
Student misses 1 session	Speak to student informally/email, check if they attended small group teaching with their firm head and if they have informed anyone
Student misses 2 sessions without explanation	Inform firm head who is then to have discussion with student about absences
Student continues to miss sessions	Escalate to Undergraduate team
Student continues to miss sessions or insufficient engagement	Psychiatry Lead for Stage to discuss with firm head and may arrange 3-way meeting with student and/or liaise with medical school Education Support Department.