The Goldilocks of Social Justice Education: Balint Groups as a Curricular Intervention to Support Equitable Health Care

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Abstract
While there is consensus within the medical profession on the importance of ensuring future physicians are well versed in issues of social justice, there is little consensus on how to best achieve this. Traditional methods of didactic lectures or case-based learning, with an emphasis on the transmission of knowledge, run the risk of reinforcing the very inequities they are aiming to disrupt. The classroom experiences do not call on trainees to act on issues of social justice beyond discussing imagined actions in a carefully constructed case. Balint Groups offer an alternate pedagogy that align with a more interpretative style of teaching and offer an opportunity for meaningful engagement with issues of social justice. In Balint Groups, students are engaged in cases where the presenter has participated directly in the clinical encounter. While these cases tend to focus on relational dilemmas between the doctor and patient, the dilemma can also highlight an internal dilemma between competing professional identities – such as the biomedical expert and the socially conscious professional. Imagined agency is removed and the group is tasked with reflecting on the dissonance created by these two competing identities. While the use of Balint Groups as a curricular intervention offers exciting opportunities to promote social justice, there are cautions. First, Balint Groups operate within the dominant discourse of medical education and

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facilitators must be sensitive to how this may position the presenter; second, it cannot be forced – it must arise from the case presented.

**Keywords**
medical education, social justice, balint groups, interpretive teaching, professional identity, imagined agency

When we discuss clinical cases in medicine, we tend to focus on the pertinent details in the history and physical exam with the goal of arriving at an appropriate diagnosis and disposition plan. We emphasize the “facts” and the “evidence.” This is reinforced throughout medical education – both inside and outside the classroom. While dominant forms of medical education tend to focus on the acquisition of both the biomedical knowledge and the clinical skills of gathering history and conducting physical exams, there continues to be increasing attention to social determinants of health and the psychosocial factors that influence not only an individual patient’s presentation, but also their understanding of health and their engagement with healthcare practitioners and systems. As such, psychological, social, and environmental factors are powerful predictors of well-being and it is generally accepted that medical educators and training programs have a responsibility to equip future physicians with the knowledge and skills to deliver equitable, socially just healthcare to all citizens.¹⁻³

Driven largely by accreditation standards, the prevailing methods used to teach issues of equity, diversity and inclusivity in medical education tend to fall into two broad categories: didactic lectures and case-based discussion. Didactic lectures, are often:⁴

“…afforded a one-hour lecture block at the end of a long day of physiology and pathology or situated in the middle of rigorous hospital-based clinical responsibilities. This not only reinforces the perception of social justice issues as an add-on to the central curriculum but also fails to engage training in effective ways” (Das Gupta, 2006, p 247).

This is problematic for two reasons. The first, is that it positions social justice issues not only as an add-on but also as Othered to the real curriculum, that equips physicians to provide a one-size-fits-all biomedical approach to health care. The second is that it draws on transmission-based assumptions of learning where principles of social justice become distilled down to content knowledge for which students must demonstrate expertise, often by identifying the correct multiple-choice answer. It positions the learner as a passive recipient of the expert knowledge offered by the teacher and fails to engage medical trainees in ways that promote meaningful engagement in issues related to equity, diversity and inclusivity.

In contrast to the didactic lecture, case-based discussions offer the opportunity for the learner to be actively engaged in the learning encounter. These discussions have
become increasingly incorporated into medical education and invite students to consider principles of social justice as they relate to carefully crafted cases. These scenarios, while well-intentioned, tend to offer sanitized dilemmas, divorced from the learners’ personal experience, and offer engagement in the form of calling on the learner to identify the most politically correct answer. In doing so, they risk creating white-washed discussions of equity, diversity, and inclusivity. The participant is seldom asked to question their own assumptions or privilege and the discussion can become an arena of one-upmanship – of being the most woke.

In both didactic lectures and case-based discussions, the exploration is rarely tied directly to one’s professional practice or professional identity. The learner seldom has a stake in the case and can intellectualize explanations without the fear of having to implement the solutions they offer. Their agency is imagined and the gaze is outward. At best, it fails to create critically reflexive engagement. At worst, it may do the opposite of the intended educational objectives and perpetuate the inequities the session is aiming to disrupt.5

So, if one-hour lectures, added into the curriculum is not sufficient; and discussion of carefully crafted cases is not sufficient, what is? DasGupta (2006) suggests that “teaching social justice to support professionalism demands a new look at medical pedagogical styles” (p. 247).

The question of pedagogical style has a long and contentious history in education. This is usually discussed in the form of contrasting teaching styles and the epistemological assumptions of how one learns. For example, Barnes (1976) contrasts transmission teaching, where the goal of teaching is to transmit information into the mind of the learner, to interpretive teaching, where the goal of teaching is to help the learner interpret new information by relating it to their prior knowledge.6 Some feminist scholars have also characterised two models of teaching: the banking model, where the teacher deposits knowledge into the mind of the learner, and the mid-wife model, where the teacher assists the learner in the birth of new knowledge.7 Perhaps the most notable, especially in terms of social justice, is Freire’s (1970) distinction between teaching to read the word and teaching to read the world – to critically examine how we are positioned in the world by the multiple discourses that inscribe our lives, including our own privileges.8 We can conceptualize all teaching encounters as occurring on a continuum, with transmission-based teaching on one end and interpretive-based teaching on the other end. Within the culture of medicine and medical education, teaching encounters tend to fall towards the transmission end of the continuum and as discussed above, the teaching of social justice is no exception to this. DasGupta’s (2006) call for a new look at medical education pedagogy suggests a shift toward a more interpretive approach to teaching and Balint Groups offer just this opportunity.

Balint Groups are closed groups of physicians that meet regularly to discuss challenging cases. The groups are facilitated by co-leaders who guide the group through a process of examining perspectives the patient and doctor may bring to the presented scenario and to consider relational factors impacting treatment. The pedagogical assumptions that underlie Balint Groups align with the interpretative style of teaching.
One way this is evident is in the way it calls on learners to draw on their past experiences to make sense of the current dilemma, as they create new understandings. Another way this is evident is in the positioning of teachers as problem-posers, rather than experts. They are tasked with guiding the conversation. In fact, teachers are specifically tasked with not teaching, and I would argue here that it’s not so much that they are tasked with not teaching as it is they are tasked with not moving the group towards the transmission-style end of the continuum.

Balint Groups continue to gain in popularity in North America and have increasingly been incorporated into post-graduate medical education training programs. As such, they have established themselves as an acceptable and feasible curricular intervention. Various benefits of Balint Groups in this setting have been reported — such as professional development, developing clinical skills, fostering empathy, mitigating burnout and promoting a sense of wellbeing and cohesiveness among participants.

One area that has received little attention is their role in promoting social justice. Given both the recognized importance of social accountability and the current challenges in teaching it effectively, the opportunity for Balint Groups to serve as a vehicle to teach social justice is an important consideration. These groups not only offer an alternate pedagogy, but they also ground the teaching encounter in a personally meaningful way, that is directly tied to participants’ professional practice. The case is presented spontaneously from a clinical encounter that the presenter has directly experienced. The spontaneity of the case presentation means that the case is not distilled, polished or sanitized. The presenter is not distanced from the case — they have participated in it. The group members, who are often colleagues in the same training program, are more likely to imagine themselves as having agency in the case — given they rotate through similar clinical training experiences. As such, the discussion becomes a case-based exploration of an authentic clinical dilemma, rooted in a clinical case that has been identified as important (by a student present in the learning environment), where the presenter has had to act. It is these differences that set up the opportunity to engage trainees in meaningful and relevant discussions related to what it means to be a socially just and competent physician. Furthermore, because it is neither distanced nor sanitized, it invites students to critically examine their own position(s) within the case, including their privilege.

The focus of the Balint Group is always on the presented case, with the goal of exploring relational factors affecting patient care. Often the focus of this discussion is the relationship between the doctor and the patient. However, at times, this may include other relationships felt to be important to the case, such as a family member or, as is not uncommon in the case of medical education, a clinical preceptor. Sometimes the presented case will emphasize issues of equity, diversity and inclusivity. When these characteristics are highlighted in the presented case, it signals the possibility of another relational dilemma — an internal dilemma for the presenter between two competing professional identities: the Medical Expert and the Social Justice Warrior.

These two identities, the Medical Expert (who holds the biomedical knowledge, how to prescribe, how to walk and talk like ‘the doctor’) and the Social Justice Warrior
(who knows how to be sensitive to, and advocate for, marginalized individuals and communities), are introduced and developed in the medical education classroom. In the classroom, these two identities can exist comfortably together because the engagement is characterized by imagined clinical agency - agentic ideals that will not need to be acted on. In the clinic, these two identities can be in conflict because the agency is no longer imagined. The imagined agency has little capital outside of the classroom, and trainees are forced to navigate the different socio-political positions of the two identities within the context of the clinical environment. The dissonance, created by the removal of imagined agency, sets up the relational dilemma between competing identities. Crucially, one of the differing features of case-based discussions in the Balint Group is that the presenter has already acted. The remaining students are then tasked with examining power, competing ideals and their own agency (or lack thereof) within the context of healthcare, the patient-doctor relationship and their role as ‘the doctor.’

It is these factors that makes the group an ideal vehicle to teach social justice and the power relationships that govern patient care. First, the Balint Group is grounded in a constructivist-interpretative style of teaching. Second, the imaged agency is removed because the case has been directly experienced by a group member. Third, the process calls on participants to reflect on their own position – and agency. This opens the possibility to engage trainees in conversations related to privilege, equity, social accountability and what it means to be the Other.

When facilitating case-based discussions that raise issues of social justice within program-mandated Balint Groups, we need to consider that these groups do not exist in isolation. They are a subset within the dominant culture of medical education, where transmission-based assumptions dominate and are often reinforced through teaching encounters. As medical educators, we not only have to be aware of and ready to engage in issues related to social justice but also must be aware of our responsibility to consider how using Balint Groups in this way may position the student within the overall dominant culture. Within medical education training programs, the Balint Group is counterculture. As such, cases that raise issues related to equity, diversity and inclusivity carry with them the risk of participants (and facilitators) falling back into dominant expectations of engaging – to demonstrate one’s wokeness, from a distant position characterized by imagined agency. This is an important consideration because it prevents critical reflection within the case-based discussion. This is not merely a point of academic interest. If the discussion reverts to imagined agency, it risks Othering the presenter who, having already acted in the case, is silenced by the Balint intervention of ‘push back’. The presenter is left in a position where their professional identity may feel unjustly attacked and result in humiliation rather than humility. This can serve to reinforce, rather than disrupt, systems that perpetuate inequities. Skilled facilitation, in keeping with the central tenants of Balint, is required to mitigate against this.

As a curricular intervention to support the delivery of more equitable healthcare, Balint Groups offer exciting opportunities. The central tenants of Balint naturally lend themselves to the exploration of issues related to social justice. As medical educators, we must resist the temptation to co-opt Balint to ‘fit’ within the accreditation standards.
Balint is just right – a Goldilocks of curricular interventions in equity, diversity, and inclusivity. It offers the pedagogical shift to engage trainees in a different way. It is grounded in an interpretive teaching style. The relationship between teacher and student is reconceptualized, where the teacher becomes a guide to students interpreting new understandings. The case material is presented spontaneously by a group member who has directly acted in the clinical encounter and so the dilemma is neither polished nor is it distanced. Co-participants are in similar stages of training and rotate through similar training experiences. Therefore, they are closer to the imagined agency they are invited to explore. The focus is not only on what I might do, but also what I might think and how I might feel. These features call on participants to reflect on their own assumptions and privilege within both the discourse of health and the patient-doctor relationship in a way that more directly confronts their identity as ‘the doctor’. The process of engagement in Balint helps to illuminate new ways of knowing. It supports examining the biases we inevitably bring to our work.12

As medical educators, as soon as we intervene in a way that alters these tenets in an effort to teach principles of social justice in the Balint Group, the essence of what makes the Balint Group just right is lost. If we chose the case, if we explicitly steer the discussion to explore relational dilemmas of professional identities that we want to talk about it no longer fits. This does not mean that we should ignore the opportunities that Balint brings to our responsibility to teach social justice. As medical educators we need to reconceptualize the teaching session as an opportunity for the ‘teachable moment,’ to explore issues of social justice as they naturally arise in the presented case material.

**Author’s Note**
American Balint Society National Meeting. Virtual. Jan 26-28, 2022.

**Declaration of Conflicting Interests**
The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

**Funding**
The author(s) received no financial support for the research, authorship, and/or publication of this article.

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