Rebalancing Attention

A Personal Charter for Balint Leadership

I want to begin with something that has changed for me.

I have been involved in Balint work for many years. I have led groups, taught about Balint, organised Balint events, and spent a considerable part of my professional life thinking about what happens when doctors are given a space in which they can think differently about their work.

And for much of that time, I think I had a fairly clear idea of what a good Balint leader did.

The leader listened carefully.

The leader protected the method.

The leader noticed what was happening in the group.

The leader intervened when necessary.

The leader helped the group to think.

I still believe all of those things.

But I am less certain now about the last one.

I used to think the leader was the person who ***helped the group to think.***

I now think the leader may be the person who ***protects the group from the many pressures that stop it thinking.***

That may sound like a small distinction.

For me, it has become quite a significant one.

Because increasingly I have become interested not simply in what we think about in Balint, but in the quality of **attention** that we bring to it.

And that has changed how I lead.

Attention

One of the people who has most influenced how I have come to think about this is Iain McGilchrist.

I don't want to attempt to summarise his work here, and certainly not to reduce it to the rather crude idea of a rational left hemisphere and an emotional right hemisphere. That is not his argument.

What interests me is his much more fundamental proposition: that the hemispheres offer us different ways of **attending to the world.**

One mode of attention tends towards what can be grasped, categorised, measured, made explicit and acted upon.

It is enormously useful.

Medicine could not function without it.

A doctor needs to identify pathology, interpret results, assess risk, make decisions and act.

But there is another quality of attention.

It is broader.

More receptive.

More relational.

More sensitive to context.

More able to remain with ambiguity.

And perhaps most importantly, more willing to encounter something before deciding what it is.

When I first encountered that distinction, I recognised something about medicine.

But, rather more uncomfortably, I also recognised something about myself as a Balint leader.

The temptation to get somewhere

I began to notice how easily I could reproduce, **inside** a Balint group, precisely the kind of attention I was concerned about **outside it.**

I could listen for the problem.

I could begin organising the material too quickly.

I could become interested in what the case meant before the group had really experienced it.

And, perhaps most seductively of all, I could feel that good leadership meant helping the group to get somewhere.

I don't think I was doing anything obviously wrong.

Indeed, some of those interventions probably looked like perfectly competent Balint leadership.

But I began to wonder whether competence itself could occasionally become intrusive.

Whether my wish to help the group think might sometimes interrupt the group's thinking.

McGilchrist gave me a language for questioning that.

Because Balint, at its best, asks for a rather different quality of attention.

We don't immediately grasp the case.

We don't rush to make the patient comprehensible.

We don't treat uncertainty as a defect that the leader must repair.

We allow ourselves to be affected by what we have heard.

And we wait.

That sounds remarkably simple.

In practice, I have found it one of the hardest disciplines of leadership.

Waiting

I intervene less than I once did.

That doesn't mean I have become passive.

In some ways I think I am working harder.

But more of that work is internal.

I notice the impulse to speak.

I notice my wish to clarify.

I notice when I have developed an idea about the case.

I notice when I want to rescue the presenter.

And increasingly I ask myself:

Why do I need to say this now?

Sometimes there is a good reason.

Sometimes the group needs protecting.

Sometimes somebody has moved too quickly into advice.

Sometimes the patient has disappeared and the discussion has become about clinical management.

Sometimes the presenter is being interrogated rather than listened to.

The leader has a responsibility to intervene.

But sometimes my wish to speak belongs to me.

I am uncomfortable.

I don't know where the group is going.

The silence has lasted longer than I expected.

And leadership can offer a very respectable way of escaping that discomfort.

You say something intelligent.

The group moves again.

And everybody, including the leader, feels relieved.

I have become more suspicious of that relief.

Silence

I think differently about silence now too.

There was a time when a prolonged silence could make me wonder whether the group needed something from me.

Increasingly, I wonder whether the silence is the group doing something that cannot yet be put into words.

McGilchrist has made me more interested in that distinction.

Not everything important announces itself immediately in explicit language.

Sometimes we know something before we can say what we know.

Sometimes the group has been affected by the case and has not yet found language for the experience.

If I intervene too quickly, I may give the group **my** words before it has discovered **its** own.

So sometimes the task of the leader is not to make something happen.

It is to protect the conditions in which something might emerge.

That has probably been one of the biggest changes in my own leadership.

I trust the group more.

And perhaps I trust myself slightly less.

I mean that positively.

The pressure surrounding medicine

There is also a wider reason why this matters to me.

The culture surrounding medicine increasingly rewards a particular kind of attention.

Problems must be identified.

Information recorded.

Risks categorised.

Guidelines followed.

Outcomes demonstrated.

Decisions documented.

And much of that is entirely necessary.

But the danger is that a mode of attention which is exceptionally good at dealing with parts begins to determine how we encounter the whole.

The patient becomes a collection of problems.

The consultation becomes a series of tasks.

The doctor becomes a provider of interventions.

And experience becomes data.

Something can be lost without anybody intending to lose it.

Context.

Relationship.

Contradiction.

Tone.

The thing that doesn't quite fit.

The feeling in the room.

The possibility that we do not yet understand what is happening.

These aren't decorative extras to medicine.

They are often where the human meaning of the consultation resides.

And this is one of the reasons I think Balint matters.

Balint creates a small interruption in the prevailing culture of attention.

For a period of time, the doctor is not required to solve the patient.

The group is not required to produce an answer.

The case is allowed to remain alive.

Different possibilities can coexist.

The doctor's feelings can become information rather than interference.

And uncertainty can be tolerated for longer than is usually possible elsewhere.

But Balint is not immune

There is a danger, though, in talking about Balint as if the method itself guarantees this quality of attention.

It doesn't.

A Balint group can become clever.

It can become interpretative.

It can become fascinated by explanation.

It can produce very sophisticated accounts of patients.

And it can still fail to encounter them.

The leader can contribute to that.

I certainly can.

That is why McGilchrist's work has become relevant to me not simply as a critique of medicine but as a challenge to my own practice.

What kind of attention am I bringing into the room?

Am I open to what is emerging?

Or am I searching for something?

Am I listening?

Or am I waiting for an opportunity to intervene?

Am I allowing complexity?

Or am I quietly trying to organise it?

Those questions have gradually changed how I understand leadership.

And over time they have become something like a personal charter.

Not rules.

Certainly not instructions for other Balint leaders.

More a set of reminders to myself about the kind of leader I want to be.

A Personal Charter for Balint Leadership

1. Attend before interpreting

My first responsibility is to encounter what is being brought before trying to understand it.

Interpretation has its place.

But attention comes first.

2. Protect uncertainty

Not knowing is not necessarily a failure of the group.

Sometimes it is the most truthful place the group can reach.

I don't need to rescue it from there.

3. Resist premature coherence

There is a powerful temptation to make the case make sense.

Sometimes it doesn't.

People are contradictory.

Relationships are contradictory.

Medicine is full of stories that do not resolve neatly.

The group should be allowed to experience that.

4. Trust silence

Silence is not empty.

Before filling it, I need to ask whether something is happening that I cannot yet see.

The less I speak, the more I hear.

5. Notice my own need to be useful

This may be the most personal one.

Leadership creates many opportunities to demonstrate usefulness.

Not every opportunity should be taken.

Sometimes the most useful thing I can do is refrain from being useful.

6. Keep the patient alive in the room

The patient can very easily become a case.

A diagnosis.

A difficult personality.

A problem to be explained.

Part of my task is to notice when the living person has disappeared from the conversation.

7. Protect the presenter without rescuing them

There is an important difference.

The presenter needs safety.

They don't necessarily need relief.

Sometimes the group needs to stay with something uncomfortable.

8. Prefer curiosity to certainty

Certainty closes.

Curiosity keeps the case open.

When I become certain about what is happening, I need to become particularly curious about my certainty.

9. Trust the group

I don't have to carry all of the intelligence in the room.

Indeed, one of the great pleasures of Balint leadership is repeatedly discovering that the group can go somewhere I could never have taken it.

My job is often simply not to get in its way.

10. Remember that attention is itself an intervention

We sometimes think of intervention as something we say.

But the quality with which we attend changes what becomes possible.

How we listen matters.

How we wait matters.

What we refuse to hurry matters.

The atmosphere created by the leader's attention may be one of the most important interventions we make.

Holding the method

None of this means abandoning leadership.

Balint requires structure.

The boundaries matter.

The presenter must be protected.

The group needs to be brought back when it moves into advice, diagnosis or interrogation.

There are moments when leadership needs to be clear and authoritative.

But I have come to distinguish authority from activity.

I don't demonstrate leadership by how frequently I intervene.

Sometimes leadership is visible.

Sometimes it consists of holding a boundary.

And sometimes it consists of tolerating the anxiety of not doing very much at all.

That last form may be the hardest.

What has changed for me

If I compare the way I lead now with the way I led years ago, I don't think the difference is that I know more about Balint.

Hopefully I do.

But that isn't the important difference.

I think I am less anxious about where the group is going.

Less impressed by my own formulations.

More interested in what I haven't understood.

More willing to allow something to remain unresolved.

And more aware that the quality of my attention influences the quality of attention available to everybody else.

Perhaps that is what experience has given me.

Not greater certainty.

A somewhat greater capacity to live without it.

Rebalancing attention

The title of this talk is Rebalancing Attention.

I chose it because I increasingly think that this is one of the things Balint offers medicine.

Not an alternative to scientific medicine.

Not a retreat from evidence.

Not an argument against measurement, diagnosis, guidelines or accountability.

Those things matter enormously.

It is a rebalancing.

A reminder that human beings cannot be fully encountered through a mode of attention designed primarily to grasp, categorise and control.

Michael Balint understood something about that long before we had the language of contemporary neuroscience.

The doctor is not simply applying knowledge to a patient.

Something happens between two people.

And what happens there matters.

McGilchrist has helped me understand why the quality of attention we bring to that encounter may be so important.

Balint has given me somewhere to practise it.

And leadership has forced me to confront how easily I can interfere with it.

So perhaps my personal charter can ultimately be reduced to something much simpler.

Pay attention.

Pay attention to the patient.

Pay attention to the doctor.

Pay attention to the group.

Pay attention to what is said.

Pay attention to what isn't said.

And pay particular attention to the part of yourself that wants to make everything clear too quickly.

Because perhaps one of the responsibilities of Balint leadership is to protect a form of attention that the culture around medicine increasingly struggles to sustain.

And perhaps, occasionally, the most important thing the leader can do is simply to make enough room for it to appear.