

Mutiny on the Balint: Balancing Resident Developmental Needs With the Balint Process

Marcia Smith, PhD; Gowri Anandarajah, MD

Background and Objectives: Many residency training programs offer Balint groups as a means of encouraging residents in reflective practice. Residency Balint groups around the country are variable with regard to format when compared to the recommended structure. This paper describes a resident Balint group in which the residents initially expressed strong dissatisfaction with the group, although they understood its purpose and expected format and were committed to the group process and goals. The seminar was modified to address their concerns, and the subsequent group process was studied to evaluate the effect of the changes. **Methods:** The subjects were 11 second-year residents in a 13-13-13 program in the northeastern United States. A needs assessment using a qualitative survey and focus group-style discussion was performed. The immersion-crystallization method was used at all stages. Field notes from subsequent sessions, combined with leader reflections, captured the group process. **Results:** The first sessions addressed requested professional development topics. The residents then spontaneously returned to a process more consistent with traditional Balint, although discussion of the patient perspective was infrequent. **Conclusions:** Our experience suggests that modification of Balint group structure and process may be necessary with some groups of learners to pave the way for a more meaningful Balint experience over the course of training.

(Fam Med 2007;39(7):495-7.)

A central goal of residency education is to teach self awareness, which in turn enhances patient care and professional relationships. However, finding effective teaching methods that residents will embrace can be challenging. There is consensus that reflection and discussion of core topics can promote personal awareness and lead to more-effective physicians.¹ A widely accepted method of promoting reflective practice is Balint group, with approximately half of all family medicine residencies providing such groups.² Residents who participate in Balint groups report enhanced skills,³ but not all residents appear to be motivated or able to benefit from such groups.⁴

Balint groups are based on the work of Michael Balint,⁵ who developed a method of facilitating group seminars for general practice physicians. Since Balint first described his method, it has been embraced on both

sides of the Atlantic and around the world.² There has been a great deal of work to develop the concept of an ideal Balint group process,⁶ which will be referred to as “traditional Balint” in this article. Characteristics of effective group leadership have been described,⁷ and it is possible to become certified as a Balint group leader.⁶

What began with Michael Balint is a specific method of using group process to facilitate in-depth understanding of the doctor-patient relationship. The method has roots in the psychoanalytic technique of free association, which is used, among other things, for the interpretation of dreams.⁸ The meaning and significance of dreams can be elucidated by stepping back from the obvious content of the dream and reporting everything that comes to mind. The practical application in a Balint group is that when a physician describes a patient, without efforts to edit or censor the content, thoughts and ideas that are previously suppressed can surface. At the core of Balint group process is a spontaneous case presentation, followed by a reflective group discussion.

From the Department of Family Medicine, Memorial Hospital of Rhode Island, Brown Medical School.

Balint developed his method with experienced general practice physicians. Such physicians would already have a strong professional identity and considerable experience with the day-to-day challenges of being a doctor. Resident physicians bring a different set of skills, attitudes, and needs to a Balint group, which may conflict with the structure and even the goals of a Balint group. In fact, there is evidence that the structure of the groups in training programs varies widely,⁹ an observation that may come in part from attempts of leaders to address the complex educational needs of resident physicians.

Many resident Balint groups deviate significantly from the usual agenda of examination of the doctor-patient relationship. In particular, group support, affirmation of identity as a family physician, and a haven of safety in the health care training environment are seen as important functions of Balint group.¹⁰ It has been proposed that what occurs in the group instead is an essential process for residents. These "side benefits" of Balint seminars may be more relevant to residents than the central goal of understanding the doctor-patient relationship. However, there is considerable consensus that there are significant advantages in terms of promoting professional development by maintaining the framework pioneered by Balint.¹¹

Methods

The setting for the study was a university-affiliated family medicine residency (13-13-13) at a community hospital in the Northeast. The research protocol was approved by the Institutional Review Board.

The program has been offering Balint group to second- and third-year residents for 10 years. At the time of this study, Balint groups were offered three times a month. Group attendance was encouraged but not required.

Subjects

The participants were 11 family medicine residents. The leaders were a family physician and a psychologist. Both leaders have more than 15 years of previous experience with different types of small-group educational formats, and the psychologist also has experience with therapeutic groups. Formal Balint training included an intensive program, preconference workshop, and periodic peer supervision with other faculty with Balint training.

Program Evaluation

Needs assessment consisted of a group discussion and a qualitative questionnaire of five open-ended questions, designed by the leaders. The questionnaires were transcribed by an assistant before we analyzed them to protect resident confidentiality. We then recorded the content and process of the group over the next year and

a half. In the session notes, we attempted to identify the themes and issues most prominent in the discussion. Finally, during the last session we asked residents to give us feedback on the program at the end of the third year. The leaders performed a qualitative analysis of the survey and session notes using an immersion-crystallization method.¹²

Results

Survey Results

The first survey question, "In your mind, what is the purpose of Balint Group?" assessed understanding of the expected process of the group. The themes that emerged from residents' answers were: reflect on the doctor-patient relationship, examine feelings and reactions toward patients, professional development, group process, and discussion. All of the residents referred to the doctor-patient relationship in their responses. One resident said, "Allows for reflections on patient-doctor interactions/experiences." Another commented, "To discuss vexing or confusing patient interactions to a group of colleagues in an open relatively nonjudgmental setting." We concluded that this group of residents had an adequate understanding of the purpose of Balint group.

When residents were asked to indicate whether the seminar was meeting their educational and professional development needs and to give suggestions for how to use the small-group meeting times, themes that emerged included a need for concrete strategies for coping with specific patient behaviors, such as narcotic overuse, issues of physician well-being, and skills for handling the new responsibilities of the second year of residency. Sample comments include: "Need lessons in how to balance clinic/professional obligations." "I would rather learn how to deal with specific patients, ie, bipolar, borderline, chronic pain." "We have a significant amount of new responsibility and no forum to learn how to deal with it."

Residents indicated that the particular way the group was structured, such as not allowing latecomers to participate, was sometimes a problem. One resident asked: "Are there less-restrictive formats, and, if possible, ones that would be more accommodating of schedules that don't always allow for prompt arrivals?" Another stated, "We can discuss how to deal with tough patients, but I don't like the strict structure of Balint."

Frustration was expressed over being discouraged from problem solving. Sample comments included: "It's OK for hearing about other people's experiences but it is very frustrating not to be able to problem solve" and "There is a lack of problem solving, which is probably what most of us want as second years and beyond." In addition, residents stated that structural elements of the overall training program, such as clinics running late, were obstacles to their attendance.

Modifications

With information from the survey, we modified the group by allowing residents to choose the focus of the discussion for the session. They were asked to choose a professional development topic or a case discussion. During case discussion, we encouraged residents to follow the format of a Balint group but allowed strategizing and problem solving. Latecomers were allowed but were asked to sit and listen.

After the modifications, the next few groups focused exclusively on professional development, specifically issues regarding the challenges of supervising interns. Then the group moved spontaneously back into patient case discussions. Recurrent themes around cases included the issue of responsibility for the patient, coping with noncompliance, and negotiation in the doctor-patient relationship. These discussions included both practical strategies, such as narcotic contracts, and more-reflective discussions, which are a key element in Balint groups.

We classified the themes extracted from the case notes into common professional development and practical patient care themes and themes more consistent with Balint process. Professional development themes included supervision, feedback, and difficult interactions with staff. Typical Balint themes included trust, responsibility, and residents' emotional experience. We observed within the typical Balint themes that more often the focus was on the resident's emotional experience of the patient, rather than reflection on the experience of the patient. The content of the sessions evolved, and by the end of the third year, difficult topics such as sexual attraction were beginning to emerge. Attendance was consistent through the end of the third year.

Discussion

The residents in this study appeared to understand the purpose of Balint group, and they expressed a strong desire to improve their doctor-patient relationship skills. But, they rejected the method of the Balint process.

As a result of a group of residents advocating for additional educational goals to be addressed during Balint seminar time, we altered our leadership strategy. We discovered that a flexible approach to the classic Balint style worked well for us and this group of residents. By making modifications, we were able to preserve an important group process and ultimately to be successful in encouraging the residents to become more reflective practitioners. Allowing residents to have input into how the group was structured paved the way for them to begin to explore a reflective approach to the doctor-patient relationship.

Corresponding Author: Address correspondence to Dr Smith, Memorial Hospital of Rhode Island, Department of Family Medicine, 111 Brewster Street, Pawtucket, RI 02860. 401-729-2332. Fax: 401-729-2923. marcia_smith@mhri.org.

REFERENCES

1. Novack R, Suchman AL, Clark W, Epstein RM, Najberg E, Kaplan C. Calibrating the physician: personal awareness and effective patient care. Working Group on Promoting Physician Personal Awareness. American Academy on Physician and Patient. *JAMA* 1997;278(6):502-9.
2. Johnson A. The Balint movement in America. *Fam Med* 2001;33(3):174-7.
3. Turner AL, Malm RL. A preliminary investigation of Balint and non-Balint behavioral medicine training. *Fam Med* 2004;36(2):114-7.
4. Musham C, Brock CD. Family practice residents' perspectives on Balint group training: in-depth interviews with frequent and infrequent attenders. *Fam Med* 1994;26(6):382-6.
5. Balint M. The doctor, his patient, and the illness, revised edition. New York: International Universities Press, 1964.
6. American Balint Society. www.familymed.musc.edu/balint/index.html. Accessed October 9, 2006.
7. Johnson A, Nease D, Milberg L, Addison R. Essential characteristics of effective Balint group leadership. *Fam Med* 2004;36(4):253-9.
8. Freud S. XXIX: Revision of the theory of dreams (1933). In: Strachey J, ed. *New introductory lectures on psychoanalysis*. New York: Norton, 1965:10-4.
9. Merenstein J, Chillag K. Balint seminar leaders: what do they do? *Fam Med* 1999;31(3):182-8.
10. Stein H. Reframing Balint: thoughts on family medicine departmental Balint groups. *Fam Med* 2003;34(4):289-90.
11. Addison R. Getting the frame straight. *Fam Med* 2003;35(9):615.
12. Borkan J. Immersion-crystallization. In: Crabtree B, Miller W, eds. *Doing qualitative research*, second edition. Thousand Oaks, Calif: Sage Publications, 1999:179-94.