Tailoring The Balint Group Seminar For First Year Family Medicine Residents

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BALINT GROUPS FOR PGY-1

Over the course of several years we have gathered some experience with running Balint groups with first-year Family Medicine residents. This paper addresses the question of the unique opportunities and challenges presented by a Balint group experience for first year Family Medicine residents.

One way to approach the question of Balint groups with first-year residents is to look at the special needs of this group. First-year residents must respond quickly to emergencies, carry a demanding case load of sick hospitalized patients, work long hours, and learn to present their patients in a "factual" way with a minimum of non-medical material. In contrast, in the Balint group the residents are encouraged to explore the circumstances of their patients' lives, to examine their interactions with them, and to weave a psychosocial perspective into their "diagnosis." For first-year residents the Balint group comes at the time of their own professional identity formation. They have to not only develop medical competence, but also confidence in these new skills. First-year residents are commonly unduly critical of their performance, an attitude often encouraged by a system with high expectations and scant rewards. To add the requirement that they be sensitive to the emotional needs of patients and their families is a significant challenge.

BALINT GROUP CONTENT

Institutional Issues

Though all Balint groups are structured around a patient case, it is not uncommon for material in first year groups to focus on institutional relationships such as difficulties the residents have in dealing with nursing staff, senior residents or attendings. In our experience these issues can be profitably addressed. We were careful not to allow the group to become a general complaint session, but since relationships with other professionals are a part of establishing their identity as physicians, we extended the scope of the group. The "case" could therefore be a triangular situation between resident, attending and patient. Discussion in the group centered on the impact of the situation on the resident, and subsequently on patient care. An excellent example of this is conveyed through the following case example.

> *The resident initially told the group that he was feeling guilty because of the way he had handled a woman whom he had examined on the labor suite. He felt badly that he had been less than sympathetic with this woman, had treated her abruptly, and after the encounter had felt ashamed of himself. He began to wonder whether family medicine was indeed the right type of work for him since he had failed so miserably in his effort to deal with this particular patient.*

Rather than accepting the story at face value, the resident was encouraged to delve more deeply into the circumstances that night. The attending had asked him to do the evaluation even though this patient was not on the resident's service. Furthermore, the nursing staff had warned the resident that the patient was extremely demanding. Consequently, he entered the patient's room feeling angry and apprehensive. Not surprisingly, the interview had a poor result. When the case was discussed with the group, it became clear, first to the group and then to the resident involved, that his issue was not with the patient but with the attending who had put additional work on his shoulders. When he was able to talk about his anger in the situation, he was able to understand the impact of his feelings towards the attending on the subsequent interview with the patient. We discussed the defense mechanism of displacement, in which unacceptable feelings towards one person (anger at the attending) were displaced onto an "easier" target (the patient).

The issue of powerlessness in the fact of a large system came up often. By having the group explore these issues in relation to specific cases, they were able to develop ideas and strategies for "treatment" of the problem. This led to a different understanding of their role in the system.

Psychological Considerations

First year groups often focus on cases at the extremes of suffering and medical difficulty. We found it useful to focus on the impact of the case on the presenting resident and to explore areas where the resident was making a contribution. For example, a resident presented a case of a patient in the terminal phase of a long illness.

> *The patient was for most of the time semi-conscious and the resident spoke of her frustration. She mentioned in passing that the patient had several close relatives who visited frequently and that she would stop to talk with them. She mentioned almost apologetically that since the patient was so difficult to deal with, she spoke to the relatives as an easier alternative. In the course of these discussions she learned about the dying man's life and formed an understanding of who he had been before his terminal illness. This gave a human face to someone who had been seen only as a medical nightmare. The resident initially saw her contact with the relatives as trivial, and thought that the "real work" - saving the patient - was beyond her reach.*

The group saw the resident's work with the family as the appropriate level of intervention. The family members greatly appreciated her interest and benefitted from the opportunity to share their memories and feelings. The group process allowed the resident to feel that her intervention, although not "traditionally" medical, was valuable and contributed to the overall care of the patient.

The care of acutely ill hospitalized patients demands biomedical expertise, but the psychosocial dimension is easily lost. By working through the material presented in the group, the residents were able to conceptualize their role in a broader sense. Balint talks of the drug "doctor" and it is this powerful drug that they were beginning to use in a more sophisticated way.

Professional Identity Formation

Even though the residents frequently felt that their skills were not up to the tasks they faced, they were able to help each other differentiate reasonable from unreasonable expectations of themselves and others. Issues of competence came up in many ways. Residents often spoke about feeling inadequate. They even felt incompetent in choosing appropriate cases for the Balint group. The issue was usually not so much competence as confidence. A case vignette will illustrate the point.

> *A resident presented a middle-aged, married man with young children. He was recently diagnosed with a pancreatic abscess. Alcoholism was not a factor. The abscess was too extensive for surgical treatment and death was certain. The resident felt very badly for the patient as well as his family. She believed more discussion of the prognosis with the patient and his family was needed. Despite the fact that she had identified some of the key issues in taking care of this terminally ill patient and his family, she ended her presentation by saying, "I don't think I'm describing the problem very well. It probably is the wrong kind of case."*

The resident had put her finger on the essential dilemma of treating a terminally ill patient. She was able to articulate the difficulty she and the attending had in discussing the bleak prognosis with the patient and his family. She was able to express the frustration at facing an incurable illness in a young person. Finally she was struggling with her own uncertainty about her role on the management team. None of these questions has easy answers. However, she asked the right questions. In spite of this, she ended her discussion with an expression of her own incompetence.

By discussing the case in the group, she and others gained an increasing confidence in their own perceptions and in their ability to articulate problems.

CONCLUSIONS

In summary, this paper supports the value of Balint group training for first-year Family Medicine residents. There are differences from standard Balint groups, especially due to the unique and vulnerable position of the group members. The focus of the group was extended to allow other members of the health care team to be a part of the "case." We did not let the Balint group become a support group or a complaint session. The group stayed centered around a case discussion with problem-solving. The group was supportive to the residents as they developed in their roles as physicians, and was experienced as helpful with the difficulties they encountered during the year. Institutional support is crucial if the Balint group is to be successful in meeting training needs of first-year Family Medicine residents. Support from the residency director and other attendings gives the process validity, and back-up from senior residents makes it possible to provide coverage for an hour a week. This in itself is greatly appreciated by the residents and our experience is that the majority take advantage of it. Within the group, the leaders must foster an atmosphere that promotes open discussion and helps the residents to develop their own understandings of the material presented. Given this type of support, we found that first year residents are capable of looking at their work, at their interactions with their co-workers, and at their relationships with their patients.