Assessing Outcomes

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After the intellectual elegance and artistry of the last two speakers, I recognize a dilemma that I wish to share with you. As you phrase it, “I have a case.” I am expected to talk about assessing outcome in a decade of diminishing resources, where all of us must do more for less with less. Thus, I originally intended to discuss measuring productivity, efficiency, and effectiveness of Balint groups, which meant that I should describe what Alec said we can't do -- namely, randomized control trials of Balint groups and developing good clinical guidelines that will make Balint groups look good to that dominant culture out there. But, now, I have a dilemma.

I really love what Michèle Lachowsky said; she described how I feel. I am here three days, and I am bitten by the Balint group bug. I like all of you. I like what you do, and I feel grateful for your hospitality, for inviting me here inside this circle. And, thus, as a way of saying thank you, as a way of being honest to my experience, I insist -- don't measure productivity, efficiency and effectiveness. Don’t do those things! You don't need to do it. You can’t do it anyway. There is something better. It's called Balint research, and it’s already part of your tradition. My talk is about assessing outcomes the Balint way.

Two days ago Penny Williamson mentioned gathering at a campfire. I like our being in a circle this morning; this is our gathering (see Figure 1) (Larson, 1993). So let us come together and tell our sacred stories. Imagine that it is a dark, moonless night and we are under the stars. There is a slight chill around us, and we hear the sounds of owls and wolves. A fire is built ti keep warm and to cast light. We begin getting a little closer and some of us hold hands, because relationships matter when you’re out in a dark woods and wolves and owls lurk nearby. Soon we start telling stories to get warm, to get a little closer, to get the emotions flowing. We start paying more attention to ourselves, to each other in the circle, and to the surroundings, the context, the wolves, the stars, the fire. We also have fun and make some music together.

Relationships, stories, awareness, fun -- these are the outcomes I want to discuss. The campfire is our fantasy. In order to reach the real one, we must walk in the woods. Our wood’s walk will have three stops along the way. The first stop is for sharing a story about Michael Balint. This story points to which path we should take into the woods. The second stop is to explore which outcomes we can assess. And the third stop is to briefly look at two additional research tools for helping us in assessing those outcomes.

Which path do we take into the woods? Let's ask Michael Balint, because in 1970 he and his group showed us the way. I found this little monograph in a used bookstore (see Figure 2), and it’s a gem, Treatment or Diagnosis: A Study of Repeat Prescriptions in General Practice (1984). This is Balint research. Twenty-four years ago, they did what Rich Addison described yesterday. They didn't have the language; the word "hermeneutics" isn't in the book, but it could be. Balint and his colleagues used their training group to do research. They started by doing what Balint groups do -- looking for situations where you keep being surprised, where something is amiss but you don't know what it is. These are the researchable moments (see Figure 3) (Larson, 1993). They appear in Balint groups with every case. Look for these moments. They are what you need to research. In this case, it was something missing that got their attention. Their group never heard a case of repeat prescriptions. These are patients who keep coming back, month after month, for the same prescription and everyone has forgotten what the original diagnosis was. Balint and the training group recognized these repeat prescriptions were an outcome of something that had been going on in the doctor-patient relationship, and so they decided to research it. They simply did what they knew how to do; it was called Balint training. It actually followed a design similar to the ones presented yesterday by Rich Addison. If you recall, Balint training was originally referred to as training research. They started strategically, a word we'll come back to. They collected some numbers, and they made some tables as a means for convincing the dominant culture that there is such a thing as repeat prescriptions. The answered quantitative questions. What are the prescriptions that were prescribed? What are the characteristics of these people? That was the first part (see Figure 4) (Balint, et al, 1984). Then they did what they really wanted to do all along, which is study what mattered to them, the visionary stuff, and they did it their way.

They relooked at their stories, at their case studies, their campfire stories.

They discovered some marvelous insights. They elaborated an elegant, yet simple, model of what happens in a doctor-patient relationship over time to bring about repeat prescriptions. What they found was that, time and time again, in certain doctor-patient relationships, there comes some troubling diagnostic moment, either a serious illness requiring prolonged diagnostic testing or a confusing illness where neither patient nor doctor are sure what is the diagnosis. From these struggles is generated a whole set of disturbing polemics. These consist of bantering and battering back and forth, seeking some resolution. Lots of issues starting to rise that are uncomfortable for both doctor and patient. Peace, an uneasy peace most of the time, is achieved through a temporary truce -- a pill, a repeat prescription. And it works. They both feel better afterwards, and so the prescription continues on and on and on. Any time some conflict arises or some new challenge to that repeat prescription emerges, all kinds of sparks and flashes break out. These moments were named lightening conductors, and they were resolved by continuing the prescription. This model of repeat prescriptions is an outcome, a theoretical generalization about a common aspect of the primary care doctor-patient relationship.

So how can we do more such Balint research? Let's follow Michael Balint's path further into the woods. But, like Little Red Riding Hood, heed the warning not to be distracted by certain sheep and flowers or risk being eaten by wolves when you reach the end. Here is my list of warnings (see Figure 5). I would consider not measuring these things. Strategically, these outcomes are dangerous for you to measure. I'm not sure, in the short run, that Balint training is going to improve patient satisfaction, resident satisfaction, disease outcome, productivity, or adherence. I'm suspicious that it could, in the short run, make some of them worse. It could have devastating consequences for future funding if our first studies demonstrate that Balint training initially results in unhappier patients, unhappier residents, worse disease outcome, less efficiency, and less treatment adherence. I suspect these negative results are transient because the Balint process is a long-term one that helps us tolerate ambiguity. Balint training is not an opiate for life's arrows (see Figure 6) (Larson, 1993).

On the other hand, here are some outcomes we can risk our lives on -- relationships, stories, awareness, humor (see Figure 7). Let's start withe relationships. What do I mean by assessing relationships as an outcome? Relationships matter in Balint training. The central focus of Balint is the doctor-patient relationship. But there are also the relationships between co-leaders, between leaders and presenter, between different members of the group, between residents and attending, between doctor, patient, and family, between doctor, patient, and third-party payor. What are these relationships like? How do they change over time? How are these people related to each other? These are outcomes (questions) for Balint training.

Another visionary outcome is stories, your cases -- the ones about disasters, about awkwardness, about breakthroughs, about death and the fear of it, about sex. Each of these clusters of stories is representative (a research word) of some generalizable (another research word) truth or proposition (another research words) about the human condition and about doctors and patients and their living together. That's research. The propositions are outcomes.

A third visionary outcome is awareness. What are leaders aware of? What's the awareness of the presenters? What are the group participants aware of? Patients? How does self-awareness change in each of these as a result of Balint training? Finally, humor is a fourth visionary outcome because we all need it. Remember these four visionary outcomes. Cherish them, protect them, and assess them!

Practically speaking, we also need money to do this visionary work. Balint training is, as several of you mentioned earlier, part of a counter-culture. Let's say that and feel okay. We are a dissenting subculture which recognizes that life is deep. We promote uncomfortable knowledge, the kind of knowledge that challenges what others want to believe. Unfortunately, it is the others' money we want. Therefore, we have to know about the dominant culture (see Figure 8) (Larson, 1993). One helpful means for understanding the dominant culture is to think of them as a difficult

patient and use out Balint expertise and process to improve the relationship; we know how to do that.

Thus, we need strategic outcomes -- outcomes that cost less, taste great, and look good (see Figure 9). These are outcomes that matter to those with influence and money, but they are also consistent with and facilitate the visionary outcomes noted earlier. These are fundable outcomes. I believe there is a good chance that Balint training will lead to the prescription of fewer drugs and the utilization of fewer diagnostic tests. These reduced costs are important to governments and insurance companies who struggle with shrinking budgets.

Balint training also tastes great. As Dr. Lachowsky points out, there is a certain feeling better about making contact with peers, about seeing patients as wholes. I think the physician in a Balint group feels better over time. These is testable and worth it. Over the next ten years, we are going to see a continuing increase in the number of group practices and collaborative practices, including practices with social workers, family therapists, psychologists, nurse practitioners, and/or physicians assistants. Managed care is promoting the formation of these kinds of group and collaborative practices. In these settings, Balint training could potentially build teamwork and increase trust. In a similar way, Balint training may potentially facilitate information transfer, the dissemination of new knowledge. All of these issues are important to government agencies responsible for promoting guidelines and to large health systems developing the group and collaborative practices. Finally, Balint training may also look good by promoting and developing greater empathy and cultural sensitivity as all practices face an increasingly cultural diverse patient population.

All of these fundable studies will provide money for research assistants, secretarial support, travel funds, interviewers, transcriptionists, and computer time. These resources can then also be used for studying the visionary outcomes. This brings us to the last stop on our way to the campfire.

Medical students often fantasize about how wonderful being a doctor will be, much like the mythical American cowboys who sang, "Home on the Range." "Home, home on the range, where the deer and the antelope play, where seldom is heard a discouraging word. . . .." Well, Balint training sings a different kind of song (see Figure 10) (Larson, 1993). Balint stories do utter discouraging words. So, too, do patients and doctors. These stories are a distinguishing outcome for Balint groups. How can we assess or analyze a case as story? We can use the technique of narrative analysis (Cortazzi, 1993 and Riessman, 1992).

Let’s start with some transcripts that emerge from a Balint credentialing process. How do we begin to approach it? What do we look for? We can use a structure common to all stories worldwide (see Figure 11) (Longacre, 1976). This is a model of story that comes out of anthropology. It seems to represent how most humans tell stories. You will see each of these elements in the Balint cases. A story begins with an opening, the aperture, which is the opening of a lens to a camera. There is always a formula for notifying us that a story is starting. You know the Balint formula. "I have a case." We know, upon hearing that, to sit down and listen. Then the stage is set. A dilemma is named and we learn about the time, place, participants, and overall mood which form the background and context for the case. The presenter is setting the stage, getting ready for the episodes, the heart of the case. Each episode or dilemma will have its inciting moment, some developing conflict and sense of dilemma, associated complications, intrigue, mystery, suspense, and clarifications. During the telling of the episode, the narrator (leader or group member) will also highlight select points or peaks. Then, usually after about an hour, there is a denouement, some improvement of the dilemma, some step past the impasse, some resolution of the tension. That is, in turn, followed by a narrator or leader’s concluding comments and then the familiar finis, the “thank you for participating in this group.” The story begins and ends with a recognized formula.

This is what is in every story. This is a structure that all of you can use to analyze those Balint transcripts. All of these structural features of any story are readily discernable in all Balint

cases. What might we learn if we compared the cases presented by students with those presented by residents or those by experienced Balint groups? How would each of these structural features manifest themselves? How would they be the same? How would they be different? We could compare cases which are hospital-based with those that are office-based or home-based. We could also compare the stories of acutely ill patients, or patients with chronic biomedical illness such as hypertension or diabetes, or those with the chronic "functional illness" such as irritable bowel or chronic pain.

Stories also have shared content features (Perrine, 1966). These were first described -- and now I'm going to get very continental -- by Aristotle in Poetics. We have not gotten better at it (see Figure 12). For narrative content analysis, you first look at a story and anchor it on a continuum from an escape, fantasy story, like television dramas, on one end to a deep, rich interpretive story, such as Brothers Karamazov by Dostoevski, on the other end. The anchoring is determined by examining plot and character. What's the plot? What's the action going on here, the sequence of action? Who are the characters? Then, which of those predominates? Is this a story that's mostly about plot, just sort of one quick action or image after another? That is an escape story. Or, is the plot really there to serve as a vehicle for showcasing the multiplicity and complexity of human characters, of the patient and the doctor as they try to work out a relationship together? Do these characterizations draw us in as the listener or reader and induce a sense of compassion? This is that deep, interpretative, rich stuff of an exemplary Balint group. We can evaluate Balint cases on this continuum. One of the big differences I observed when comparing resident fishbowl groups and the experienced groups is that resident ones were focusing more on plot with less character description. In the more experienced groups, I heard much more character development; the plot was just a vehicle for taking us there. In addition, for each story, it is important to examine how themes, symbols, irony, and imagination are used to open our hearts and minds to the central insights that reveal us to ourselves. That is why we all like a good story, like hearing a good case.

Having analyzed the story structure and content, we can, finally, compare our cases to the criteria for a good story. What do the people who do narrative analysis say is a good story? What do the literature professors say is a good story? Their criteria are noted in Figure 13 (Perrine, 1966). Good stories include an appropriate blend of subject and predicate where characters are the subject and the plot is the predicate. In a good interpretive story, the emphasis is on characters with the plot or predicate serving as a vehicle for the character development. A good story also provides some fundamental generalizations about life. In other words, the story must reveal something of importance about the human condition, about doctor-patient relationships.

The next three criterion refer to these generalizations. The insights must account for all of the known details of the case. There can be no contradictions between the insights and our own life experiences, although paradox is acceptable. Finally, the insights must be consistent with the characters and their relationships as we know them. These criteria are all things that we can evaluate in a Balint transcript.

This is narrative analysis, an analysis strategy which assesses stories and permits comparison of stories. This tool could be used in the credentialing process that was discussed yesterday. Imagine if every 20th case from every Balint group in the world were evaluated as part of some on-going, open-ended educative process using the methods described by Dr. Addison and narrative analysis. How many of the questions we have asked would have more clarity after about five or six years such evaluation? How many exciting new questions would have emerged? How many other primary care researchers would have been stimulated by the results? How much new funding would have been generated?

There is one other research tool I wish to briefly share that comes from the work of Schon and Argyris on reflective practice, also referred to as action science (Schön, 1983 and Argyris & Schön, 1978). The particular technique, called the left-hand column, is based on the ladder of inference, which I find remarkably consistent with Balint beliefs (see Figure 14) (Argyris, 1990). Starting at the bottom of the ladder, we witness a story or case being presented. It's observable,

but, as we climb the ladder, we each select certain data to hear and see about that case. We each add our own meanings to the selected data. We make assumptions, often unconscious until they are exposed, about those meanings and then draw conclusions based on the meanings. These conclusions become beliefs which guide out action. In a Balint group, this action takes the form of sharing our fantasy which is the end product of climbing the ladder in the group process. Sharing our fantasy, in turn, changes the observable data. This reflexive process is iterative; it keeps repeating; it's a reflexive loop. Balint training seeks to make more of this reflexive ladder consciously available to us, especially as it relates to doctors and patients. As Frank Dornfest put it earlier, Balint is successful if we "move from saying what I think to thinking about what I say." That is what this ladder of inference is about. This can be assessed, even measured, by using the left-hand column tool. Basically, you take a sheet of paper, draw a line down the middle, and have two columns (see Figure 15) (Argyris & Schön, 1974). For example, a Balint participant could be shown a videotape of one of their doctor-patient encounters. In the right hand column would be transcribed the interactional content -- everything the doctor said in that encounter. And then a facilitator/researcher and the doctor sit down, look at each thing said, and the videotape, and the doctor writes down in the left-hand column what she/he was thinking prior to each uttered statement. The facilitator/researcher slowly keeps probing and prodding the doctor until what gets revealed in the left-hand column is the data selected, the meanings, the assumptions, the conclusions, and the beliefs that led to the statements in the right-hand column. I hypothesize that someone who had done Balint training for two years will need less facilitator intervention, less time, and will have more depth in what is written in that left-hand column than before they joined a Balint group.. That is measurable. That is a way to assess how much more of that ladder has become conscious to the physician.

So, where are we as we finally near the campfire? I propose that Balint training's outcomes don't have to do with the measurable illusion of making things better, but they have everything to do with creating, recreating, and co-creating the sharing of our lives as doctors with our patients and with each other. That, by doing so, we can show ourselves and the dominant culture (see Figure 16) how we are more prepared to pay attention, to expand imagination, and to sustain healing space. To get there, we must occasionally be strategic in securing funding but always stay visionary.

Let us gather at our campfires (see Figure 17) (Larson, 1993). Let us share our sacred stories and study them. They are our outcomes. Think big. Get together. Relationships matter. Hear our stories into truth and become more aware with fun. Let's assess our outcomes such that we, together, can celebrate the wonder and mystery of being human, of being with each other, of all of life, of, as Lee Scheingold said, "being there." Thank you.

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