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A Role for Balint Groups in Medical Student Training

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Stress, burnout, and erosion of empathy are common in medical training. There is growing interest in efforts to buffer against these outcomes. Balint groups, which explore the doctor-patient relationship, may be of value in this regard. Medical students have reported that stressful clinical care-related experiences are common, that many of them go undiscussed, and that their effects are numerous. Ten medical students participated in a Balint group that met every other week for eight sessions. Participants responded positively to the groups, reporting several benefits including: improved empathy, greater acceptance of one's limitations, authentic shared experience, and improved tolerance to distress. We propose that Balint groups are beneficial to medical students by addressing an unmet need in their curriculum and fostering future physicians who are better prepared to meet personal and professional milestones.

Key words: *Balint groups, professional burnout, physician-patient relationships, empathy, medical education*

Introduction

The rates of stress, depressive symptoms, and burnout are high among medical students.[1] Common sources of stress include dealing with death and suffering.[2,3] With the increasing volume of scientific material students must learn, less curricular attention may be given to managing the stress associated with the emotional complexity that surrounds disease, suffering, and mortality.

Balint groups have been proposed to improve resilience and satisfaction among physicians.[4,5] These groups, named after the psychoanalyst, Michael Balint, facilitate exploration of the doctor-patient relationship in a nonjudgmental environment of colleagues. The meetings focus on a real-life case presented by a participant. The case presented often represents a particularly challenging doctor-patient interaction or relationship.[6,7] Case presentation differs in many ways from that of a typical medical case conference. Exam findings, diagnostic dilemmas, labs, imaging, and medical treatments are not foci of the discussion. Rather, what often brings a case to mind for a presenter is some distress or confusion in the relationship. After a case is presented, clarifying questions are asked. The presenter is then asked to "push-back" from the group (move his or her chair back and remain silent), as the group takes on the case. This push-back approach prevents further questioning of the presenter, and facilitates the group taking ownership of the case. Group members sit with what they have heard, and share their reactions. The facilitators' role throughout this process is multiple: maintain a sense of the group being a confidential and safe space, gently discourage interrogation or cross-examination of the presenter, and keep the discussion focused on the doctor-patient relationship. Towards the end of the session, the presenter rejoins the group. At that point, the presenter may share thoughts and feelings that emerged during the session. Physicians who participate regularly in Balint groups have reported several positive effects such as feelings of competence in the doctor-patient encounter, professional identity, sense of security, endurance, and work satisfaction.[5]

Balint groups have been widely used in family medicine training programs, with expansion into other specialties.[8] More recently, Balint approaches have been trialed in medical student populations in efforts to enhance students' appreciation for the relationship aspects of their patient encounters.[9,10] Common themes reported in medical student Balint groups include witnessing injustice, value conflicts, difficult human relationships, the incurable patient, and role confusion.[11]

In our medical school, we were interested in assessing the prevalence and perceived impact of challenging clinical

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experiences in third- and fourth-year students. We were also interested in recruiting a subset of students to then participate in an eight-session continuity experience with Balint groups. For several years, our medical school has offered monthly Balint group meetings, open to any student currently enrolled. These monthly group meetings occurred throughout the academic year, often taking place in the early evening on the main campus, or at a facilitator's house. Attendance at the first one or two meetings of the year would be relatively high (8+ students), but would quickly drop off as students became busy with other academic obligations and off-site rotations with late hours. We felt that growth of the group process was limited by variable turnout, wide range in degree of clinical exposure, and inconsistency in the specific members comprising a group. Therefore, we sought to improve upon this format, with the hypothesis that more frequent participation in Balint groups, with a consistent group of colleagues, would benefit personal and professional growth. Such a continuity group experience is consistent with traditional Balint formats for physicians.

Methods

Participants

Participants included third- and fourth-year medical students at the University of Pittsburgh School of Medicine, during the 2013-2014 academic year.

Project Approval

The project was reviewed and approved by the Institutional Review Board and designated as "exempt" under section 45 CFR 46.101(b)(1) Educational strategies, curricula, or classroom management methods.

Survey, Measures, Intervention

The primary author developed the surveys, adapting several questions from a Balint evaluation form used at the Santa Rosa Family Medicine Residency, with permission from Richard B. Addison, PhD, Director of Behavioral Medicine. Additionally some questions were adapted, with permission, from another study.[12] We sent the anonymous survey electronically to all students in the third- and fourth-year medical student classes. Students had six weeks to respond, during which time two reminder emails were sent.

Ten students volunteered to participate in a series of eight Balint sessions, held every other week from January to May 2014. The primary author facilitated all sessions, which were each one hour in duration. After the eighth Balint session, students who had participated in these groups were invited to complete a follow-up survey.

Statistics

Data from surveys were analyzed using the Pearson correlation coefficient, where appropriate.

Results

Survey of third- and fourth-year medical students

Of the 290 students invited to complete the survey, 46 students (15.9%) responded (Table 1). Table 2 displays responses to survey questions about the prevalence of stressful clinical encounters, proportion discussed, reasons for not discussing, and perceived negative effects. Female sex was positively correlated with identification of potential negative effects of experiences ($r = 0.31$, $p = .05$). Identification of multiple reasons for not discussing experiences was negatively correlated with the proportion of experiences discussed ($r = -0.40$, $p < .02$). Additionally, the proportion of experiences discussed was positively correlated with the number of identified negative effects of experiences ($r = 0.37$, $p < .02$).

Table 1
Demographics of survey respondents (n = 46)

Year in school	
Third	**20**
Fourth	**23**
Not listed	**3**
Sex	
Male	**9**
Female	**34**
Not listed	**3**
Age	
21 – 25	**24**
26 – 30	**19**
31 – 35	**2**
> 35	**1**

Balint group and participant survey

Ten students participated in the Balint group; every student attended at least one session. Median attendance per session was four students, with a range of two to seven. Six students each attended at least four sessions and completed the follow-up survey. Therefore, the survey response rate for the Balint group was 60%. This group included five females and one male, three in their third year and three in their fourth year. Students responded on a four-point Likert scale to several statements about the Balint group and its relevance to training and their future career (Table 3). Overall, students responded to these statements with consistent agreement. Students also provided open-ended responses to several questions about the experience. All responses were reviewed. A summary of the themes presented, along with example responses, is shown in Table 4.

Table 2
Responses to survey questions

How many clinically-related experiences in the past year caused you significant frustration, stress, or anxiety?	Number who responded	Percent of respondents
1 – 4	22	48%
5 – 8	14	30%
>8	10	22%
What proportion of these did you discuss with friends or trusted colleagues?	**Number who responded**	**Percent of respondents**
0	2	4%
<50%	17	37%
>50%	27	59%
For experiences not discussed, what were reasons for not discussing them?	**Number of responses**	**Percent of respondents**
Issue not significant	23	50%
No one available	14	30%
Afraid it would negatively affect my grade	13	28%
Embarrassment	12	26%
Fear of ridicule or negative reaction	10	22%
Lack of time	1	2%
Patient confidentiality	1	2%
What are potential effects of frustrating interpersonal interactions in the work environment?	**Number of responses**	**Percent of respondents**
Cynicism about health care	44	96%
Burnout	40	87%
Decreased motivation	39	85%
Depression	27	59%
Change in sleep	26	57%
Use of unhealthy coping strategies	17	37%

Table 3
Responses of Balint group participants to quantitative questions (n = 6, out of 10 total participants)

Statement	Mean*
The group helped me explore my feelings and perceptions about patients.	**4.0**
The group helped me better understand and empathize with patients.	**3.8**
The group helped me feel that I am not the only one who has difficulties with patients.	**3.8**
Participating in this group will help me take better care of patients in the future.	**3.5**
I have felt differently about patients after presenting them in the group.	**3.3**
Participating in a Balint group is an important part of my training as a future physician.	**3.5**
Balint groups provide an aspect of training that is not currently addressed elsewhere in the medical school curriculum.	**3.5**
Having a space to regularly meet with fellow colleagues to discuss difficult doctor-patient experiences will be an important part of my career as a physician.	**3.7**

** Likert Scale. 1 = Strongly Disagree; 2 = Disagree; 3 = Agree; 4 = Strongly Agree*

Table 4
Responses of Balint group participants to open-ended questions (n = 6, out of 10 total participants)

Question	Response Themes	Examples
List ways you will change how you interpret, process, or react to challenging interactions in patient care	Attending to the process of the encounter Inviting patient's / colleague's perspectives Recognizing one's own emotions in encounters	"If I am having a strong emotional reaction, I hope to try to analyze what in my experience is contributing to [it]..." "Try to think about the situation from the point of view of each involved party..."
List the most helpful aspects of participating in these sessions	Normalization of difficult experiences Feeling of shared experience Authenticity in sharing Improved empathy	"Safe environment to speak frankly about certain emotions; learning that other trainees find certain patient encounters emotionally challenging." "Developing an appreciation for the patients' perspectives...The experience gave a lot more depth and substance to the meaning of empathy"
List the most challenging aspects of participating in these sessions	Sitting with discomfort Listening patiently Considering multiple points of view	"Trying to not immediately make judgments about a case but to try to think about it from all aspects." "Engaging in painful and challenging patient encounters (my own or those of peers) is a vulnerable and difficult activity..."
List ways in which the relationship you have with a patient can affect the patient's care	The doctor-patient relationship improves clinical outcome Advocating for patients Improved trust Improved understanding of patient goals/values	"A good relationship with the patient facilitates gathering a more complete medical history..." "I can serve as an advocate or voice for a patient who is inadequately heard by the busy medical team."
List ways you might be affected by your relationship with a patient	Enhanced self-understanding Improved empathy Recognition of factors beyond one's control	"I become a better doctor by really learning the details of my patient through a closer relationship..." "I grow as a person by continuing to improve my empathy skills and amassing experience with people who touch me in positive and negative ways."

Discussion

We found that medical students frequently encounter stressful clinical experiences, have difficulty discussing them, and readily identify multiple negative effects of such experiences. When engaged in Balint groups, which provide a confidential, nonjudgmental space in which to share, students develop a deepening experience over subsequent sessions and report positive effects in multiple aspects of personal and professional growth (Table 4).

Research examining the medical student experience with Balint groups is rare. Many attempts to bring Balint groups to medical students have included methods in which the actual group process deviated from the traditional format, often incorporating didactic elements and decreasing emphasis on individual student-patient interactions. Such modifications may limit the opportunity for the personal and group development experienced in a traditional Balint approach.[9]

Our findings are consistent with other reports of Balint experiences facilitating trust among peers,[10] improving knowledge of the doctor-patient relationship,[12] and improving the empathic abilities of medical students.[13] Our study builds research about the Balint approach with medical students by providing quantitative measures as well as open-ended self-assessments in a continuity experience.

In our class-wide survey, the predominant reasons students did not discuss challenging experiences involved perceptions of experience severity, unavailability of others, and concerns about negative reactions. Concern about negative reactions by others was a dissuading factor more than 10 times as often as lack of time (22% to 28% vs 2%). These findings underscore a need to better understand and address such deterrents.

Students who attended at least half of the Balint group sessions responded to the follow-up survey, and reported generally positive experiences. Several participants had expressed initial anxiety around the less structured nature of a Balint presentation (compared to a clinical case conference), potential feelings of vulnerability, and the lack of a concretely defined problem with a clear solution. However, many of these participants later reported that the personal growth they experienced far outweighed any initial anxiety.

The findings of this study can be placed into the larger contexts of medical student health and the importance of early interventions. Stress, burnout, and depression are common in medical school, and continue into subsequent training and practice. In a large US survey, medical students, residents/fellows and early-career physicians were more burned out and more likely to be depressed than age-matched population samples.[14] Other studies have shown that physicians are at higher risk for burnout[15] and even suicide.[16] Burnout is negatively correlated with empathy and positively correlated with level of personal distress.[17] The clinical years of medical school are a particularly crucial window during which self-reported empathy for patients declines.[18,19] The interrelationship between empathy, burnout, and mental health underscores the importance of attending to these factors sooner, rather than later, in training. We propose that it is critical to take a medicine approach to our own health care provider well-being. Future research should focus on longitudinal measures of how Balint groups may modify the risk of empathy erosion and burnout.

Limitations

The class-wide survey response rate was low, putting our data at risk for sampling bias. The nature of the survey may have contributed to the selection of students who more readily identify as having stress in training, and are more willing to disclose their experiences. In addition, given the prominence of concern for negative reactions by others, participation in a survey asking the respondent to provide information about stressful experiences (even anonymously) may have been perceived as too risky.

A second limitation may have involved the wording in our survey. Students were asked generally about stressful interpersonal experiences in the clinical environment, not necessarily limited to just those with patients. This was intentionally left general, in light of research that has shown that medical students, in particular, may have some of their most frustrating interactions with other health care providers.[11] Of note, however, all eight case experiences that were discussed in our Balint group did involve the provider-patient interaction as the core concern.

A third limitation was the variable Balint group attendance and the lack of survey responses from group members who attended less than half of the sessions. Group attendance varied greatly between sessions, despite attempts to coordinate schedules using online polling. Ideal Balint group size is 8 to 12 participants. Low median attendance, and high variability in attendance, may have limited the depth of group process and cohesiveness. Students identified other extracurricular commitments and time-intensive clinical rotations as the main barriers to attendance. At the same time, discomfort with self-disclosure, as has been noted by other authors, may have played at least some role.[20] Despite these attendance issues, participants stated the continuity format, with a core group, cultivated a sense of safe sharing and appreciation for the Balint process. They stated that having this structure was an improvement over the previous format of monthly school-wide meetings. Based upon this feedback, we plan that future Balint groups at our program will have a similar structure from the outset. Developing a Balint group elective available during the fourth year, which may satisfy additional curriculum requirements as well as protect time, would be a next step.

Conclusions

Medical educators, clinicians, and researchers continue to examine the interrelationships between medical training, empathy, and burnout and their effects on the doctor-patient relationship, physician well-being, and clinical care. At the same time,

approaches to identifying and cultivating the Core Competencies of residents and fellows (e.g., the Accreditation Council for Graduate Medical Education Milestones of Professionalism and Communication) are being implemented. Balint groups hold potential to facilitate progress among these multiple endeavors. Early involvement in opportunities to examine doctor-patient relationships, within a respectful group of colleagues, may aid in fostering a career of life-long learning, self-reflection, collaboration, and excellent patient care. Addressing the significant barriers to such opportunities, at interpersonal as well as organizational levels, is essential.

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Make decisions from the heart and use your head to make it work out.

- Sir Girad