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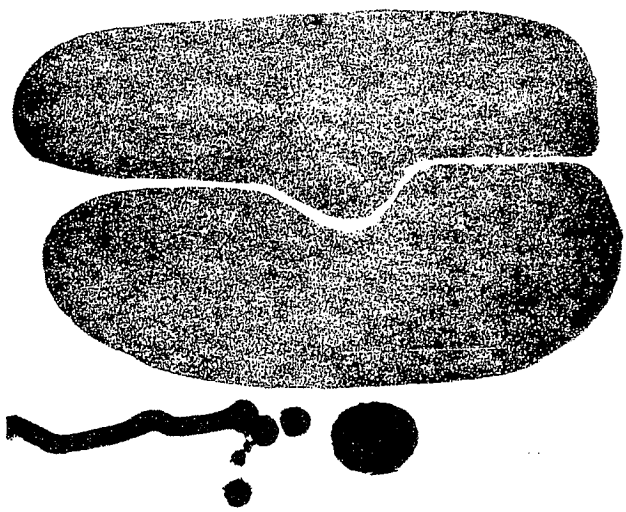

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Balint Seminars: A Method for Collaborative Care among Rural Family Physicians and Nurse Practitioners

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Abstract

This is a study of an eighteen-month Balint seminar experience with a group of family practice physicians and graduate nurse practitioners in a rural setting. Qualitative research methods were used to explore the potential benefits and challenges of Balint seminars within a rural multidisciplinary medical clinic. Two basic themes emerged: 1) enhanced collegiality among and between disciplines and 2) decreased isolation. Balint seminars, with special attention to leadership roles, should be considered for use among interdisciplinary teams, particularly within rural areas.

Balint Seminars

Michael and Enid Balint conducted small group sessions composed of British general practitioners that were engaged in active clinical practice while at the Tavistock Clinic in London in the 1950s.[1,2] Introduced into the United States in the 1970s, Balint seminars have remained true to the progenitor's focus on the doctor-patient relationship. However, in practice these seminars have primarily been employed to teach medical students and graduate physicians in residency training, not physicians engaged in independent clinical practice.[3-6] The utility of Balint seminars among U.S. practicing physicians, particularly rural physicians, has been little explored. Even less has been reported about Balint seminars with other health care providers or about combining physicians and nurses into a single Balint seminar.

Recently, the Balint group experience has been associated with the improvement of professional self-sufficiency and with the resolution of stressful situations between clients and community-based primary care nurses.[7] The Balint process also has application for stresses associated with profession identity and specialization changes as well as cultural adaptation.[8]

The primary purpose of this article is to describe the formation and development of a Balint seminar as a sustaining link between a rural area and an academic health center. A second purpose is to consider the benefit of this approach for promoting cross-professional development and collaboration in a group comprised of physicians and nurse practitioners. Key outcomes are measured using a qualitative approach.

Background

In 1991, the W. K. Kellogg Foundation funded a project designed to improve the supply and distribution of health care professionals through community/academic educational partnerships in rural areas. Primary health care sites included rural health clinics around which community members, health professionals, and health science students could develop collaborative working relationships. One of these sites is located in the Southern Appalachian area of northeast Tennessee, about a one-hour drive from the university medical campus. Medical faculties working at this site provide clinical experiences for students by collaborating with primary care agencies, teaching communication skills, health assessment and problem-based clinical reasoning, and precepting longitudinal clinical experiences.

The sustenance and maintenance of professionals who live in the rural sites would have a heavy impact on the success of the Kellogg program. Often somewhat isolated professionally, rural primary care providers are perhaps more vulnerable to the stresses common to medical practice. In addition to the many general changes in the medical care delivery system, these particular providers were experiencing consolidation of a family practice physician group and a nurse practitioner group. Nurse Practitioners are graduate level Registered Nurses (R.Ns.) who have achieved extra certification to function in an advanced practice role. This role includes management, diagnosis, and treatment of medical patients, under the protocol of a practicing physician. Thus, professional role identity and health care systems changes were considered to be additional potential stresses. A Balint seminar was proposed in this setting with this group of providers because its purpose is to promote collaboration among health providers, enhance professionals' self-awareness of their roles and responses to patients, and promote appreciation of the clinician-patient relationship. Clinical approaches that emphasize expansion of a medical-diagnostic focus to include an appreciation of a patient's psychosocial narrative are thought to enhance personal awareness, increase satisfaction with one's work and one's collaborators, and improve clinical care.[9,10] The stated goal of this Balint seminar was to enhance the provider-patient relationships. However, we anticipated that through this process there would also be an increased involvement of the parent institution along with increased development and maintenance of strong, positive interpersonal relationships across health care disciplines and perhaps reduction of caregiver burnout.

Balint seminars focus on the relationship between the care provider and the patient and not upon the practice of medicine per se. This was thought to be useful as it could afford prospective participants a 'common ground' upon which mutual altruistic values might be affirmed and through which group support might facilitate adjustment to the medico-cultural changes this group was undergoing.

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Participants and Procedures

In 1997, the Office of Rural and Community Health provided logistical support for the sixteen Balint seminar sessions that met for one hour once or twice a month over an eighteen-month period. On average, six participants met each session and each of the nine participants attended, on average, ten (10.4) sessions over the life of the Balint group. Two leaders facilitated the sessions – one a licensed psychologist, trained and certified by the American Balint Society, has led Balint groups with family practice residents for over ten years. The other leader was a doctoral-prepared RN with experience leading support groups for nurses recovering from substance abuse and returning to work. Both leaders have worked together from many years in clinical training experiences.

Data Collection and Analysis

Using a qualitative approach, three types of data were gathered throughout this project: 1) two short questions were completed by seminar participants at the end of each session. These questions were aimed toward understanding participant thoughts regarding patient care and the impact of the session on clinical practice. After six months of data collection, these questions were altered to explore ways the seminar might have affected attitudes toward patients and other professionals (Table 1), 2) leaders dictated a summary of the interaction process of the Balint groups and, 3) a focus group activity conducted at the conclusion of the eighteen months which elicited participant reactions to the Balint experience.

All responses were transcribed and entered into the QRS NUD*IST software package for purposes of analysis. Responses were coded independently by four raters: the two Balint group leaders, an anthropologist involved with the project as a research coordinator, and a research assistant. These independent coding decisions were then brought to group consensus as to meaning and categorization. Coded data were grouped into three major categories or index trees: 1) provider-patient relationships, 2) insights and self-learning and, 3) the Balint process. Text was then coded into multiple subcategories or nodes. A representation of the index tree, 'Balint Process,' can be seen in Figure 1.

Results

Two types of data are reported in this section: field notes describing leadership issues, and participant responses directed at rural and interdisciplinary experiences discovered through the responses to the post Balint seminar short questions.

Leadership Issues

Dornfest and Ransom[11] defined two primary roles for group leaders: task roles and maintenance roles. Task roles include setting the time frame and creating a friendly atmosphere that encourages experimentation and playful discovery. Maintenance roles include maintaining punctuality, confidentiality and protecting the presenter and group members' emotional well being. As facilitators, our leadership role was to provide an environment to encourage the exploration of multiple points of view. One leader issue involved the selection of a co-leader. It was thought that a nurse co-leader would provide nursing colleagues with a role model peer leader.

Group leaders encouraged both supportive acceptance and risk taking. Group members were encouraged to experience the tension of an unresolved dilemma or to speculate about the provider-patient interaction. This balance was important initially as group members bonded in the group. A parallel balance issue was that of superficiality in case discussions versus the depth that occurred with risk taking. Occasionally group members expounded on superficial details of a case. As leaders, we worked to help the group transition to a more in-depth analysis of the patient-provider relationship, thus intentionally creating some tension.

Vigilance was required to follow the Balint process and to not become simply a support group for these health care providers.[12] Initially, this necessitated interventions to re-focus the group on to the clinician-patient relationship through gentle reminders to consider how the patient might have felt or thought. Sometimes this required that leaders encourage members to discuss how they might have felt in the circumstances as described by the presenter.

Milberg[13] described a number of 'pitfalls' for leaders to avoid. One of the most common was that of providing a particular point of view. In our groups this meant that leaders needed to avoid giving advice on case management or psychological interventions. Since many of the cases were related to the leaders' areas of interest, substance abuse and chronic pain management, it was important to return questions back to the group rather than becoming engaged in an academic dialogue.

As mutual trust was established, the group often became enthusiastic and began 'problem-solving' a case rather than exploring the clinician-patient relationship. Another related 'pitfall' was a tendency of group members to shift into a teacher role. Occasionally members offered a discussion on how to manage the case or questioned the presenter excessively. This occurred several times between a physician and a nurse practitioner and required a redirection back to the client-provider relationship while keeping the emotional tension light and the group 'buoyant'.[14]

Another situation that necessitated re-direction was the serendipitous recognition that group members shared or had treated the same case being presented. During the focus group, several members commented on the benefits of

knowing the particular patient and being able to compare with and contrast their feelings and perceptions.

Seminar members tended to 'socialize' with non-case related discussions. This appeared related to group attendance. If a member had missed several meetings due to caseload or holiday, the tendency was to socialize more. We considered this, in part, to be related to clinician collegial isolation. Socialization was encouraged following the Balint seminar, after the participants had completed written responses to the research questions.

Participant responses

Analysis of the post seminar questionnaire using QRS NUD*IST revealed the highest proportion of responses was in the area of provider/patient relationships (40%). This was followed by insights/self-learning (35%) and the Balint process (25%). Since the focus of this study is the use of Balint in rural and interdisciplinary groups, data will be drawn from the coded category of the 'Balint Process.' Throughout the coding process, the working definition of this category was responses in which participants specifically referred to outcomes which were linked to the experience of having been part of a Balint group. (See Figure 1).

Content elicited through responses resulted in the four subcategories listed under the Balint process index tree. The first was ***insights gained in respect to other group members***. It was of interest that no negative insights were listed in the coded responses. Responses addressed two specific outcomes: a developing awareness of 'oneness' with other providers (nodes: shared reality, mutual understanding, empathy, personality values) and specific clinical suggestions (practice standards). Participants appreciated knowing that others faced the same challenges stating, 'We are not alone,' 'I feel more hopeful because we seem to have similar attitudes, similar problems,' and 'I am very happy to know that other feel similarly about patients and that they have similar reactions'.

Responses coded in ***peer support*** also reflected the dual outcomes of personal affirmation and vicarious learning that could be applied to clinical situations. Comments included: 'This helped support me and give me ideas for energizing emotionally with patients,' 'It is comforting to know that others share my sense of helplessness and I will remember these comments the next time I deal with this,' and 'I feel that other providers are concerned about similar issues and that they will give me support for doing what I think is right and ethical'.

Responses coded in ***evoke emotions*** were of interest since many comments acknowledged the negative emotions evoked through provider-patient encounters, while simultaneously stating the positive outcomes of the Balint seminar. Examples of these comments include: 'Other health care professionals can't always be cool and objective in all situations – I guess you think that you are the only one who has trouble staying objective,' and 'This helped me look at the failing issues of myself and other professionals helping patients dealing with these problems. I felt empathy toward other health professionals dealing with this problem'.

In the examination of Balint process in ***rural and interdisciplinary*** sites, several patterns emerged. The first was identified as problematic for health care professionals who live in rural areas, and centered on the small town dilemma of having friends as clients. Indeed, some participants acknowledged a reluctance to act as physician rather than as friend because of the fact that one may be 'less likely to tell the friends what he does not want to hear'. Despite this dilemma, practitioners initiated solutions by establishing clear boundaries and separating professional and personal roles.

Discussion

An overall pattern that was revealed in the content analysis was an expression of respect and collegiality among members. As one practitioner aptly stated, 'We are all dealing with the same issues personally and with our patients ... this has increased my ease and sense of collegiality'. While other viewpoints were appreciated, sense of one-ness was evident through statements such as, 'there were fewer differences than I originally thought' and the Balint seminar provided a 'sense of a mass community in terms of feelings/ attitudes, where MDs feel/think/act the same way as nurses do'.

Data indicate that participants were concerned about being isolated or alienated, reporting that the Balint process provided a welcomed opportunity to develop closer working relationships, 'to be a team with dignity' and 'take you out of your own limits and remove you from isolating encounters'. These finding support Brock and Stock's (1990) objective of enhancing professional self-worth by increasing the respect and collegiality among members. These participants also reported a desire to include other community health care providers in the Balint process.

Conclusions

Professional role identity and health care system changes are considered to be significant stresses for rural health professionals. Shifting from an emphasis on individual fee-for-service to a community-based managed care environment, the health care delivery system in the United States has undergone major changes over the past decade. Concomitant changes in academic health science systems have motivated formation of community and academic educational partnerships. These ventures have increased the distribution of health care professionals in rural areas. However, they also point to the need for viable links to sustain these providers.[15]

Although many of these systemic developments have enhanced health care within rural areas, they also have altered the roles of clinicians within these systems. Often isolated professionally, rural primary care providers may be more vulnerable to the stresses common to clinical practice. Because of this, rural providers have adapted in less traditional ways than their urban and suburban counterparts. The provision of care in rural settings often has required a sharing or blending of duties, as is the case with nurse practitioners. These changes have radically altered the landscape for both rural nurses and physicians, contributing additional stresses to these groups. Two overall themes emerged from the data elicited from participants in this rural interdisciplinary Balint group. These themes of enhanced collegiality and decreased isolation indicate that such an exercise can have positive outcomes which may lead to increased provider satisfaction and more positive provider relationships.

Based on the data collected through this project, we believe the Balint seminar is a method: 1) to sustain links between rural practices and academic health centers, 2) to promote collaborative, cross professional development, and 3) to enhance provider-patient relationships.

The Balint seminar can be a powerful tool for addressing the particular needs of rural health care providers and often the concomitant issue of interdisciplinary practices. Balint seminars should be revisited as a cost-effective method for professional development with special attention being paid to leadership roles.

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