

**Albert Lichtenstein**

PhD, is Director of Behavioural Science and Senior Associate Director, Guthrie Family Medicine Residency, Guthrie/Robert Packer Hospital, Pennsylvania, United States. lichtenstein_albert@guthrie.org

Marion Lustig

MBBS, is a psychotherapist, Melbourne, President of the Balint Society of Australia, and Honorary Lecturer, Department of Psychological Medicine, Monash University, Victoria.

Integrating intuition and reasoning

How Balint groups can help medical decision making

Given the need to multitask and make rapid decisions, optimal medical practice requires a doctor to use intuitive, automatic cognitive processes. It is also imperative that a doctor knows when to override intuition and routine with deliberate reasoning. Knowing when to do this requires skills in self awareness, introspection, and empathy. This article describes how Balint groups help develop these skills through a unique peer consultation model. Informal case presentation followed by a skilfully facilitated group discussion leads to an increased empathic understanding of both the presenting doctor and the patient's experience.

Like most other people, doctors tend to be consciously aware of 'the tip of the iceberg' of their own thinking processes.¹ As a result, interactions with patients are guided mostly by automatic cognitive and emotional processes. Christensen et al² found that automatic functioning can be useful. Experienced general practitioners were able to respond automatically to common tasks, leaving more attention for noticing and utilising unexpected opportunities. They conclude that 'expert physicians, as do expert decision makers in other areas, rely heavily upon a rich set of flexible rules and automatic, unconscious processes that result in great speed and efficiency'.

The ability to function effectively using automatic processes helps tremendously with the complex, multitasking, demanding day of the average GP. It is essential however, that GPs self monitor this type of functioning to ensure accuracy. Novak et al³ cite several instances from the literature where treatment was impeded when doctors' personal attitudes, biases, fears, and emotional reflexes were not brought to the level of consciousness and automatic, habitual functioning proved ineffective.

A doctor's competence in any given situation depends on the ability to know when to avoid or abort routine and to thoughtfully redirect attention. Kahneman⁴ describes this process as monitoring – and, when necessary, overriding – intuition with reasoning. This article describes how participation in Balint groups helps doctors develop

the self awareness to know when to use a more deliberate reasoning style in order to maximise the accuracy of medical decision making.

Balint groups

Balint groups began through the work of psychoanalysts Michael and Enid Balint in the United Kingdom in the early 1950s, and have developed significantly since then.⁵ Samuel⁶ suggested that the three major goals for Balint work were to:

- encourage doctors to value their interpersonal skills and learn to understand their limits
- improve doctors' perception and understanding of their patients' communication
- allow doctors to become aware of blind spots in their interactions with patients.

A Balint group session consists of 8–12 participants and a group leader. One of the participants presents a case. The presentation may include some medical information, but mostly concentrates on the doctor-patient interaction and the nature of the dilemma that has led the presenter to bring the case to the group. The group discusses the case, exploring the situation from the point of view of both the doctor and the patient (see *Case example*).

Intuition, reasoning and self awareness

Kahneman⁴ describes two different information management systems for making any type of judgment or decision. The intuitive system is fast, automatic, and

relatively effortless. It is governed by habit, often beyond awareness, and is therefore difficult to modify. Klein⁷ describes intuitive functioning as depending on accurate pattern recognition. Data is perceived from multiple inputs in a holistic format which leads to the ability to make rapid judgments. However, a range of variables increase the salience of information used for intuitive judgments, not the least of which are 'hot' states of high emotional and motivational arousal.⁴ In our case example, if the doctor had recently been faced with difficult teenage patients he might have automatically responded to the situation by siding with the mother and pressing forward with the examination.

The other system Kahneman describes is the reasoning system. Reasoning is slow, serial, controlled, effortful, rule governed, flexible, and neutral.⁴ Ideally the function of the reasoning system is to monitor the use of intuition and deliberately override a quick, habitual but inaccurate response. The corrective operations of the 'reasoning system' may be impaired by such factors as time pressure, concurrent involvement in a different cognitive task, 'morning people' performing the task in the evening, 'evening people' performing the task in the morning, or even by being in a good mood.⁴

To function optimally, a doctor needs to be sufficiently self aware to monitor use of the intuitive system, have some sense when emotional reactions are playing a part in the situation, and know when to slow down and effectively bring the reasoning system into action. Novack et al³ call this 'reflection-in-action'.

How Balint groups promote reflection-in-action

Balint group work aims to stimulate participants' curiosity about the interaction between doctor and patient and the part this plays in providing optimum medical care.⁸ Group members are encouraged to bring up cases in which any aspect of the doctor-patient relationship did not proceed as expected. It is not unusual for a group member to say 'I'm not sure if this is really a good case' or 'This case should be short. I'll present if no one else has a case'. Cases almost invariably turn out to be fruitful and bear a great deal of meaning. This models the importance of valuing cues, no matter how

Case example

The presenter described walking into the consulting room to perform a regular prenatal visit. He was backing up a trainee, a usual part of the training process. The young patient, who was there that day with her mother, had been informed about the process and had consented to working in this way. However, when the patient heard that the doctor needed to do a pelvic examination, she became quite hesitant and upon questioning told the doctor that she had never been examined by a male doctor before. The patient's mother encouraged her to allow the doctor to do the examination.

The situation didn't feel right to the presenting doctor. When he articulated his concern in the Balint group, the doctor related that he felt as though he would have committed 'battery' had he chosen to proceed with the examination. He was puzzled about where this feeling came from and what he should do about it. Although the patient's mother was apparently trying to be helpful, the doctor felt in some way caught up in a triangle, which also felt 'not right'.

subtle, that lead to self reflection.

For group members to bring up cases that could expose struggles or blind spots, Balint group leaders work to cultivate a climate of trust through maintaining clear rules, ensuring confidentiality for both patients and doctors, and discouraging criticism or cross examination of group members.⁹

Borrell-Carrio et al¹ describe the process of diagnosis and treatment as creating a clinical tension which is heightened by uncertainty and relieved with the acceptance of a diagnosis and plan. This tension can be difficult and lead to premature closure or over reliance on intuitive automatic processes. In our clinical example, the tension in the room rose when the doctor told the patient he was going to perform a pelvic examination. This was a surprise to the doctor. The surprise the doctor felt led to feelings of confusion and tension. Balint et al⁹ describe this type of surprise as an indication to become more curious and explore. In other words, it is exactly the cue the doctor needs to switch from intuitive automaticity to a more exploratory reasoning process. However, in order to open up areas of exploration rather than close them down, the doctor has to be willing to tolerate tension and ambiguity. The Balint group leader helps group members learn to do this. When a case is presented to a new or inexperienced group, the initial response is to offer advice about how to handle the particular problem, thereby moving to premature closure. It is the group leader's responsibility to help the group tolerate uncertainty and encourage a deeper

understanding of the situation before moving to offer advice.⁹

The main strength of the method is that it requires an understanding of the feelings and thoughts of both the doctor and the patient, with a belief that this will broaden possible alternative behaviours the presenter can use with the patient. This process encourages both self reflection and empathy. The question is often asked of the group: 'If we were the doctor in this case, how might we have been affected by this patient?' The leader might also ask the group to speculate on what was motivating the patient. In our clinical case, the leader might have asked the group to speculate on how the patient felt when her mother encouraged her to go ahead with the pelvic examination, or the reason for her concerns about being examined by a male doctor. These questions encourage empathy with the patient's emotional state and the objective use of such information to inform the doctor's clinical impressions of the situation (both of which are elements of the integrative understanding model of empathy described by Stewart et al¹⁰).

Borrell-Carrio et al¹ propose that excellent doctors use insight to detect when they are at risk of cognitive distortion and premature closure, and to detect moments when they need to 'reframe'. In order to incorporate the process into practice, doctors must be able to learn from experience and conscientiously revisit tacit or intuitive knowledge. In essence, lifelong learning must occur on a level that reaches intuitive or automatic functioning. In our case example, the doctor who presented was able

to detect a 'surprise' in the interview and move from intuitive functioning to recognising the need for a rational consideration of the process. The group's discussion of how a doctor might experience a feeling of committing battery, the complexity of dealing with the patient and her mother, and how some patients can associate pelvic exams with having sex, helped to clarify and validate the presenter's perceptions. The group's speculation about the absence and prior role of men in the patient's life further helped arouse the presenter's curiosity about his patient's situation.

As an experienced, sensitive doctor, the presenter in this situation already related well to his patients and had an intellectual understanding of the effects of prior experiences on a patient's discomfort with pelvic examinations. However, this situation caught him by surprise. When a doctor encounters a set of inconclusive or conflicting set of physical symptoms, it makes sense to delay resolution (diagnosis) and do what is necessary in terms of laboratory tests, consulting the literature, or consulting colleagues in order to correctly treat the patient.¹ When the same thing happens in the doctor-patient relationship, as in our case example, a Balint group can help the doctor bear uncertainty and explore possible understandings.

In contrast to didactics or reading, the Balint process reaches past the rational system to influence intuitive functioning. It does so by engaging the intuitive system through encouraging nonjudgmental speculation, while at the same time monitoring rationally by juxtaposing the doctor and patient's views. Kern et al,¹¹ in a qualitative study of personal growth in medical faculty, found that powerful experiences and/or helping relationships led to personal growth outcomes when mediated by introspection. Personal growth outcomes included healthier behaviours, improved connectedness, improved sense of self, and increased productivity, energy and creativity.¹¹ One of the strengths of Balint work is that the group can take a problem and introspect out loud with the presenter, who is free to incorporate or reject new understandings. This may not only lead to situation specific learning, but may also increase satisfaction with the work of being a doctor.¹²

Conclusion

Intuitive, automatic judgments are affected by salience of information, framing of the problem, emotional state and a range of other variables.⁴ Yet medical practice requires that doctors quickly recognise patterns, multitask, detect subtle emotional cues, and intervene in a therapeutic, medically accurate, evidence based fashion. In this environment it is imperative for patient and doctor wellbeing for the doctor to know when to override intuition with reasoning through reflection-in-action. Balint groups help doctors acquire these skills. They provide a unique place in the medical world in which a doctor can consult with peers on doctor-patient relationship issues which affect quality of care and satisfaction with practice.

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