Qualitative research

Balint seminars: the transatlantic experience through videoconference

Jumana Antoun, Maya Romani, Alan Johnson, Clive Brock and Ghassan Hamadeh*

*Correspondence to Ghassan Hamadeh, Family Medicine Department, American University of Beirut, PO Box 110236, Beirut, Lebanon; E-mail: ghamadeh@aub.edu.lb

Abstract

Introduction: The Balint seminar is used in many family medicine residencies to improve and strengthen the patient–doctor relationship: to make better doctors. Given the lack of Balint leaders in developing countries, the family medicine department at the American University of Beirut (AUB) decided to collaborate with the Medical University of South Carolina (MUSC)—with more than 30 years of experience—to start Balint seminars through videoconferencing.

Objective: Evaluate the feasibility and effectiveness of Balint seminars conducted through videoconference.

Methods: A qualitative research using focus group and leaders’ feedback to evaluate feasibility of delivery of Balint seminars through videoconference. A Polycom videoconference was set up between residents at AUB and two credentialed Balint leaders at MUSC. The videoconference was composed of two parts: (i) MUSC faculty facilitating Balint seminars; and (ii) MUSC and AUB faculty debriefing following each Balint session.

Results: Twenty-six videoconferences were conducted from 15 February 2013 to 31 March 2014. Four themes emerged: technology and connectivity issues, administrative issues, coordination among different time zones and cultural/contextual issues. The videoconferencing with family medicine residents at AUB seemed quite natural and very familiar to the Balint leaders at MUSC. The seminars encouraged the residents to see things from the patients’ perspective, inspiring new thoughts and ideas on how to deal with troubling patients.

Conclusion: Videoconference Balint seminars offer a promising way to extend the activity to health care providers in other disciplines, states and countries. Moreover, this format has the potential to increase the number of trained Balint leaders.

Keywords: Balint psychoanalytic therapy, family practice, physician–patient relations, videoconferencing.

Introduction

The Balint seminar is used in many family medicine residencies to improve and strengthen the patient–doctor relationship with the aim of making better doctors (1–3). With one or two leaders facilitating the Balint group, a patient encounter is studied focusing on the emotional and relational aspects of the case. These group discussions have improved job satisfaction and well-being among GPs (4–6). Balint group seminars with oncology residents have improved their communication skills and decreased their level of burnout (7).

Videoconferencing is defined as ‘synchronous audio and video communication through computer or telephone networks between two or more geographically dispersed sites’ (8). It has been used in various educational contexts (resident education, journal clubs,
seminars, ward rounds and clinical supervision) in different residency programmes and medical disciplines (9–12).

The family medicine programme at the American University of Beirut (AUB) is a 4-year residency programme. The curriculum includes communication skills training where the importance of the doctor–patient relationship and patient-centred approach are emphasized. The programme does not have support group meetings. Residents are asked to write reflective pieces and discuss them with their advisors every 3 months. In order to expand the patient–doctor relationship training and given the lack of credentialed Balint leaders in developing countries, the family medicine department at AUB decided to collaborate with credentialed Balint leaders at the Medical University of South Carolina (MUSC), known for their long association with Balint training, to start Balint seminars through videoconferencing.

This report evaluates the feasibility of using videoconferencing to conduct Balint seminars, and identifies the technical, organizational and social factors that might have impact on their success.

Methods

The Polycom videoconference setup was already present at AUB and is used in the oncology department. The Polycom setting allows for multi-person audio and video conferencing capabilities for large conference rooms within a Session Initiation Protocol internet telephony system. The meeting room allows the residents and faculty members to gather around a central rectangular table such that everyone has a clear view of the large LCD screen on the wall facing the shortest side on which the leaders appear (Fig. 1).

Session description

The meetings were scheduled every Friday based on the availability of the videoconference room. The seminars were offered to two sets of residents, 5 PGY3 (4 females) and 5 PGY4 (1 female). Each group of residents met biweekly. The session started with 1-hour Balint seminar led by the MUSC faculty members (CB, AJ) in the presence of two faculty members from AUB as observers. In few sessions, the AUB faculty joined the residents as group members. At the end of the Balint seminar, the residents would leave the conference room and the two faculty members from AUB would spend a half an hour with the MUSC faculty with the intent to debrief and develop Balint group leadership skills (JA, MR).

Evaluation

Evaluation of the seminars was based on two measurements. The first related to the technological aspects of the environment and the impact of cultural aspects. Accordingly, a focus group was conducted with the residents to explore their overall attitudes. The second related to the effectiveness of the Balint seminars. Measuring
the effectiveness of the sessions is not straight-forward because there are no standardized instruments measuring outcome, or the long term effects on the residents’ relational skills. The group’s effectiveness was derived from: (i) the residents responses, during the focus group, about how they thought the sessions affected them and their practice; and (ii) the credentialed leaders’ assessment of how comparable the sessions were to ‘offline’ ones they had previously facilitated. Here the faculty focused on the groups’ developmental time line (13). We were interested to see whether the group became cohesive: a reflection of trust and intimacy which is essential to the work.

Focus group
Focus groups are common methods used in programme development, improvement and evaluation (14). A focus group was deemed appropriate as the Balint seminars deal with content related to individual, personal emotions and relationships rather than patient diagnostic categories. We hypothesized that the introduction of technology and videoconferencing might affect the relationship between the members of the group and the Balint group leaders. Due to the novelty of the intervention, focus groups allow the expression of diverse individual perceptions and may uncover several ideas and feelings excluded by a set of questions to which each participant is expected to respond. All residents were asked by the department administrator to attend a one-hour meeting to evaluate the Balint seminars’ educational utility. The moderator was a faculty member in the Department of Public Health and was unknown to the residents, in order to create a safe environment. An assistant was present to take notes and assign random letters to the residents thus ensuring confidentiality. An interview guide was prepared that included 12 open ended questions (Box 1) to explore: (i) technical aspects of the videoconference; (ii) residents’ attitude towards the seminars; (iii) their perception of the effect of the seminars on their practices; and (iv) their roles as physicians. The notes were coded and synthesized into themes.

Results
Twenty-six videoconferences were conducted from 15 February 2013 to 31 March 2014. All the residents attended the focus group. In the following discussion, AUBMC would be considered the host and MUSC as guests.

Four themes were noticed peculiar to the use of videoconference between different countries: (i) technology and connectivity issues; (ii) administrative issues; (iii) coordination among different time zones; and (iv) cultural/contextual issues.

Technology and connectivity issues
The host’s limited internet connection speed occasionally lead to a freeze of the guests video feed. Notwithstanding, the audio functioned properly causing no interruption of the session. Some comparative studies have shown that meetings with combined video and audio, and meetings with audio alone were both efficient; though some participants found it difficult to follow up in a meeting with audio only (15).

Also due to the video and audio time delay, there was frustration when people from the two sites spoke simultaneously. Each speaker would then be silent and wait for the other to speak, making for an awkward silence; this would sometimes happen repeatedly.

The microphone’s position at the centre of the table made the participants uncomfortable as they would need to talk more loudly.

**Box 1. Focus group interview guide for the Balint activity evaluation**

Main questions are in bold; probing questions are in italic.

1. Did the audio/video streaming affect your interpersonal communication? Were you bothered by the time delay, occasional freezing of the video, and adjustment of the voice?
2. Was the timing of the sessions acceptable? Day of the week, time of the day and frequency of meetings. What are your preferred days and times?
3. Did you have difficulty in expressing your thoughts and feelings using the English Language? Did it affect your participation in certain occasions? Would you have been involved more if it was conducted in Arabic?
4. Do you think the physical presence of the leaders is important in building the relationship between the group and the leaders? Effects on group cohesion, trusting the leaders.
5. Did you think leaders should be from the same department/same country in order for the Balint sessions to be effective? Having the leaders residing in the USA affected negatively/positively my trust in the content of the Balint sessions. Do you think the leaders will not understand your feelings if they reside in a far country?
6. How did you feel about the presence of your faculty members in the Balint session? Was their presence assuring to you especially in the presence of International leaders conducting the Balint? Was their presence intimidating to you and affecting your participation? Do you think it is an important factor for success for others who are starting a program of Balint through videoconference?
7. Do you think leaders should be well known to residents? Was it encouraging versus intimidating.
8. What were your expectations from the Balint sessions? Did the sessions meet your expectations? What new discoveries do you think you might uncover in future Balint seminars?
9. Has participating in the Balint seminar caused you to rethink in some way your role as family doctor?
10. Has participating in the Balint seminar led you to reflect in greater depth on the patient’s presentation?
11. Has participating in the Balint seminar led you to reflect on the complementary roles that you and your patient might be playing? Examples: more than his or her doctor, who may you have become for your patient and who has the patient become for you?
12. How do you evaluate the Balint seminar videoconference experience as a whole?
than they would in a normal conversation. This is especially so in the case of softly spoken female participants. When not properly heard or understood they would have to repeat themselves.

All in all, the streaming was acceptable to almost all of the residents, with some reporting that they were accustomed to online communication with technologies like Skype.

**Administrative issues with booking the rooms**

A few Fridays were cancelled due to the unavailability of the room at either site (United States and Lebanon) so the continuity of the biweekly meetings for each group of residents was interrupted. At one point, one of the groups met less than once a month. In November 2013, we decided to combine the PGY3 and PGY4 groups. The residents appreciated the merged sessions stating that these brought more diverse ideas and more interactions among themselves. The residents considered the weekly meetings to be tiring. They also worried that they would not have a case to present.

**Coordination between different time zones**

The seminars were being held at 10:30 a.m. EST (the guests’ location), corresponding to 5:30 p.m. in Lebanon. Accordingly, the residents were meeting on Friday evenings, when their energy was lowest. One resident mentioned that s/he was too tired to concentrate and wondered about the importance or significance of a question posed by the facilitator.

Moreover, the residents were not conversing in their native language. Speaking in a second language affected the way they expressed their thoughts which might have led some to remain silent. Most residents, however, were at ease in expressing themselves in English. On a scale of 1–10 (low-high difficulty), the average level of ease was 3.8 (maximum 6).

**Cultural/contextual issues**

A prominent factor hindering smooth communication was that the guests were unfamiliar with the ambient culture. This was considered a distraction, forcing participants to expand on a known local context before returning to the case under discussion. For example, the mention of a certain hospital or patient’s citizenship would trigger contextual associations for the group. These givens would need to be explained. Sometimes, participants needed to explain the current Lebanese thinking or culture, particularly with regards to sexuality and family dynamics.

All the residents agreed that the physical presence of leaders was not needed to build a relationship between them and the leaders, because they felt the interactions were to be mostly among themselves. The leaders were thought of as facilitators only, allowing different members to participate and talk, where otherwise one or two residents might dominate and there would be chaos. However, they argued that the issue at stake is not the physical presence of the leaders but the presence of someone from the Lebanese society.

Residents who supported the need for cultural similarity between the leader and group members based their argument on: (i) the need for the residents to explain the setting of the patient or the situation in the country or local policies; and (ii) occasional culturally unfit or unacceptable solutions proposed by the facilitators/leaders. In one Balint session, the whole case discussion was around the importance of virginity and reaction of family members towards the issue in the conservative Lebanese/Arab culture. The residents felt that this issue might not be of relevance to the facilitators and one resident asked the facilitator whether such a case would have been presented in the USA. The facilitator assured the residents that the issue was not about the particular cultural context of virginity but reframed the discussion as a matter of trust and confidentiality of information between the doctor and patients; the latter being universal.

Other residents accepted cultural diversity and preferred that the leaders facilitate the discussions rather than give solutions. Furthermore, they argued that residents have themselves disagreed concerning certain cultural themes as each one of them has a different point of view and background.

**Effectiveness of the Balint seminars**

**Credentialed leaders’ perspective**

Despite some of the above mentioned difficulties, the guest faculty found the seminars to be quite familiar in terms of the troubling doctor–patient relationships presented and the quality of the discussions that followed. The fractional time delays in the visual and auditory signals seemed to them less marked than in commercial television broadcasts. Also the lack of understanding the particular details in various practice settings around Beirut could not hide the basic dilemmas of doctor–patient relationships that appeared universal to both CB and AJ. Common dilemmas include discounting the GP as a mere gatekeeper for the specialist, stress generated by time pressures, emotional distractions and deflections created by staff, family or friends accompanying the identified patients, conflicting professional assessments with attendings and lack of continuity with patients in other clinics.

The struggle to establish some kind of professional identity is challenged by the human emotions that are evoked in the doctor and his/her patient through pain and anxiety about life’s existential meaning. These emotions may induce the doctors into the roles of overconfident, supporting friend, comforting parent, over controlling administrator, or fearful, disengaged bystander. Helping residents learn to stay focused on the role of physician and to recognize when s/he is being distracted or deflected from this role is central to the work of Balint training, which is to make better doctors. This requires the presence of empathic facilitators who teach through modelling the emotions and reactions residents must learn and accept in themselves and in their patients.

The effectiveness of the seminars was measured in part by the cohesiveness of the group: a reflection of trust and intimacy which is essential to the work. It was noticed that the residents, at first, discussed cases seen in the emergency room or inpatients services. With time, and because of a trust that was developed within the group and with the Balint process, they started to discuss cases encountered in their clinics, and progressively more intimate cases. One resident considered Balint seminars to be a kind of group therapy where residents get to know each other. With time, the residents began presenting cases from their own practices, something they did not do at the beginning. Some residents began to reveal their individual blind spots. Their defensive use of altruism was given up and trust allowed disclosure of deeper feelings about patients.

**Residents’ perspective**

The Balint session had an effect on how the residents thought about the patient–doctor relationship. Though the residents were perplexed at times because there were no solutions or right answers and were left with uncertainty at the end of a seminar, they reported that they benefited from the sessions and changed their practice as a result. One resident mentioned that sometimes you will get it later with other patients; you will recognize what
you missed with the previous presentation. Another resident was able to rethink his relationship with patients and reflect in a good way on the specific patient that he/she presented during the Balint seminar. The sessions allowed residents to see things from the patients’ perspective; inspiring new thoughts and ideas for managing troubling patients. In one Balint session, in response to a question posed by the facilitator about how they would respond to the action of the patient, one resident described what her response would have been before Balint experience followed by how she would respond currently.

Training the host leaders
Following the Balint seminar was the time scheduled for debriefing the session between the guest leaders and the AUB faculty. The MUSC faculty listened as the AUB faculty shared their perceptions of the group process, the roles individual residents played and speculated on the kinds of interventions they might have made as group leader. On the occasions when the AUB faculty assumed the role of group member they discussed the similarities and differences between being a member and a leader of the seminar. This debriefing session included an open sharing of the thoughts and feelings by the MUSC faculty; they attempted to place the group’s behaviour in a developmental timeline. The post group discussion focused not only on further illuminating the doctor–patient relationship of the individual seminar but also underlined professional developmental issues the residents were exhibiting in the day’s session. This, as mentioned earlier, gave a sense of the group’s development. The MUSC faculty’s efforts were to debrief each Balint seminar as well as support the AUB faculty in trusting the evolutionary steps that were taking place beyond what may have appeared to be the successes or frustrations of the day.

The time spent among both the host and guest faculty members following the seminar session was modelled on what is considered standard after every Balint seminar and especially in the supervision of leaders in training. Debriefing following a Balint seminar would be practiced by US Balint co-leaders regardless of their credentialed status. If a US Balint leader wanted to be credentialed he/she would be requested to attend several leader intensive training workshops, submit annually six audio/video recordings of their work to a credentialed supervisor for 2 years and finally, co-lead two seminars with a certified co-leader at an intensive. (Both JA and MR have started this process.) Balint seminars through videoconference could be an equivalent supervision review process for leaders seeking credentialing.

It is important to explain to the residents the goals of the debriefing sessions, as some residents were uncomfortable with the fact that their faculty remained at the end of the project to explain the Balint sessions and how they would benefit from them over time. Attendance was compulsory. (ii) Commitment of the guest leaders: the guest leaders were credentialed as supervisors by the American Balint Society. This commitment is important to convey enthusiasm and the power of the process. At times, the host faculty were frustrated by the process because of the residents’ occasional hesitance, the non-tangible nature of the outcome and by the amount of effort and time invested. These frustrations were addressed by the guest leaders whose experiences as leaders enabled them to normalize the frustrations and also show how the group was advancing steadily according to a predictable timeline. (iii) Commitment of the host faculty: the host faculty should have protected time to be engaged in weekly Balint sessions and the motivation to learn and receive training in the field. The host faculty should be trusted and respected by the residents. They must assure the residents that what transpires in the group is confidential and stays in the group, and is never used for evaluative purposes.

Success elements
The success of the Balint sessions relied on three elements. (i) Commitment of the administration: the project was led and encouraged by the chairman of the department (GH). The chairman met with the residents at the beginning of the project to explain the Balint sessions and how they would benefit from them over time. Attendance was compulsory. (ii) Commitment of the guest leaders: the guest leaders were credentialed as supervisors by the American Balint Society. This commitment is important to convey enthusiasm and the power of the process. At times, the host faculty were frustrated by the process because of the residents’ occasional hesitance, the non-tangible nature of the outcome and by the amount of effort and time invested. These frustrations were addressed by the guest leaders whose experiences as leaders enabled them to normalize the frustrations and also show how the group was advancing steadily according to a predictable timeline. (iii) Commitment of the host faculty: the host faculty should have protected time to be engaged in weeklyBalint sessions and the motivation to learn and receive training in the field. The host faculty should be trusted and respected by the residents. They must assure the residents that what transpires in the group is confidential and stays in the group, and is never used for evaluative purposes.

Conclusion
Despite the cultural differences, distant communication and administrative issues, the Balint seminars were quite similar to face-to-face seminars in terms of content and quality of the discussions. Videoconference Balint seminars can help close the gap created by the shortage of credentialed Balint leaders across the world. Our experiences lead us to believe that Balint-group seminars and Balint leader supervision can occur across continents, amongst people of different cultures, using through distance learning technology.

Acknowledgement
We acknowledge Dr Kassem Kassak and Mrs Layal Hnemy for their help in conduction of the focus group.

Declaration
Funding: none.
Ethical approval: none.
Conflict of interest: none.

References


