A Balint Group for Medical Students at

Royal Free and University College School of Medicine

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Abstract:

This is a descriptive paper about an experimental Balint group for first year clinical medical students at the Royal Free and University College School of Medicine, London.
It describes how this group originated, its aims and objectives and what happened in the group, including an account of some of the material presented by the students.

Background:

The medical school has a long history of teaching about the doctor-patient relationship, Balint himself ran a group for medical students there from 1962 to 1969[1] and teaching in communication skills was introduced by general practitioners in the early 1960s. Since 1958 the Department of Psychological Medicine and Psychotherapy has offered first year clinical medical students the opportunity to see a carefully selected patient for once-weekly psychotherapy for a year, with weekly supervision, as a way of helping them to learn about the doctor-patient relationship.[234] It has remained a successful and popular option for students, and has been copied by other U.K and European and North American medical schools, but is only available to a very small proportion of the annual clinical intake . This year 90 students, (out of a newly expanded clinical intake of 360) asked to be considered for the scheme. 50 attended an assessment interview but as there were only 14 places Dr Peter Shoenberg, Consultant Psychiatrist in Psychotherapy, decided to offer an alternative weekly Balint group for a period of 3 months, to some of the remaining students, who could not be placed on the student psychotherapy scheme. 11 students were selected and offered the chance of joining one of 2 groups, one to be run by Peter Shoenberg (PS) and the other by an Accredited Balint Leader and GP, Heather Suckling (HS).

HS was already working part-time at the medical school as a tutor to 1st and 2nd year (pre-clinical) students for the Professional Development Spine.. This course was developed in line with the recommendations of *Tomorrow's Doctors* [5]and includes Ethics and Law, Clinical Skills, Evaluation of Evidence, Health Promotion, Community Orientated Medicine and Communication Skills. The whole course emphasises the importance of patient-centred medicine. The Community orientated medicine course includes introducing a group of students to patients and encouraging them to elicit a history from a patient, but the Communication Skills' teaching is behavioural rather than reflective; so for example there is emphasis on the value of the use of open and closed questions, eye contact and body language. Although this is an invaluable part of the course HS was concerned that that students could make this a somewhat mechanistic process, rather than one which allows the patients to tell their own stories. She was aware of the success of introducing medical students to Balint groups in Germany[6] and Poland[7] and was already considering approaching the medical school about the possibility of running a Balint group for students, at a later stage in their training, when they were seeing patients regularly, when she was approached by PS.

Consent was obtained from the medical school authorities to run a pilot project for 3 months. A small amount of funding was secured to pay HS a nominal fee, PS led the group as part of his teaching commitment .It was planned that the students were to come to the group in their own time.

What happened:

10 of the 11students invited attended a preliminary meeting, at which the ground rules were agreed, and the Aims and Objectives were discussed (see Table 1) ,and a preliminary Evaluation Questionnaire distributed. One student dropped out after this meeting, but the remaining 9 students remained throughout the 13 weeks.

The first case discussion groups were on 6th January 2004. For the first 4 weeks PS and HS each took a group as arranged, but subsequently, with the agreement of the students, the groups merged and ran with the two leaders.

Table 1

BALINT GROUP for MEDICAL STUDENTS

AIMS AND OBJECTIVES:

Aims of the Group Sessions:

1. To provide the students with an opportunity to explore the emotional aspects of their work in a safe environment
2. To increase the students understanding of their patients' communication
3. To provide support and supervision* for the students
4. To encourage the students to reflect on their work

Objectives:

After the course the students will:

1. Be able to consider their clinical encounters in a new light
2. Become aware of the significance of the relationship between the doctor/student and the patient
3. Be able to recognise the feelings which are evoked by the interaction with the patient and be able to use these for the benefit of the patient
4. Become aware of the emotional meanings of patients' physical symptoms
5. Be able to use the group to express and process anxieties and frustrations about their work
6. Recognise the inherent value of the consultation itself
7. Become aware of their own limitations
8. Value their own humanity and personality and the effects of these on the patient

*supervision in the psychotherapeutic sense

The students were invited to discuss encounters with patients who continued to occupy their minds. As in a traditional Balint group, the emphasis was on the relationship between the patient and the student and the emotional, rather than the clinical aspects of the consultations. Follow-up reports were encouraged and helped to provide continuity. Initially, as the students began to get to know and trust each other, there were general but important discussions about how difficult it was for the students to meet with patients, to develop their roles and to confront illness and death. Later, the discussions were on a deeper level and explored the emotions and personalities of the individual patients and their effect on their illnesses and the interaction with the students. Likewise the students recognised the effects on their own emotions and how these and their personalities affected the consultations and the outcomes for the patients.

A total of fifty cases were discussed in the 17 group sessions. Initially several cases were discussed briefly at each session and there was more time spent on general issues, but as students became more confident they were able to discuss individual cases in much more depth A list of themes of the cases presented was kept, but as a total of 64 themes were identified, they will not be discussed in detail here. At the end of the 3 month period the students were asked to complete a second evaluation questionnaire.

We were impressed by the honesty and openness of the students, their ability to reflect on their work, their powers of observation and their intuitive acceptance of a holistic, patient centred approach. However, not all their experiences demonstrated the positive effects of being "patient-

centred", particularly in relation to medical students. In the present climate of efficiency and limited

resources in the NHS, patients rarely stay in hospital for more than a few days and so it is

sometimes difficult for students to find patients to interview. Some patients are very ill, others are fed up with being interviewed and others want to demonstrate their right to refuse to be seen by students. One student described how he had been walking towards a patient, trying to look pleasant and encouraging, about to ask her permission to interview her when she glared at him and said:
"No! I said "no" to the students yesterday, say "no" today and will say "no" tomorrow! You cannot talk to me!" Several of the students had come across this particular patient, but they all found it upsetting although they laughed in the group, relieved to find that they were not alone.
Other examples were brought where the patients gave remarkably different stories to different students or even to the same student on different days. Whereas experienced doctors are familiar with this, it is clearly very distressing for students.

Even in the early smaller groups the students were able to share feelings with each other. One of the students talked about seeing a poor wizened old man in his eighties with severe peripheral arterial disease. She said he had been so emaciated she could see his ribs and his emaciated abdomen as he lay on the bed: he was hardly able to talk and looked like a bag of bones, with one leg amputated. She expressed how shocking it had been when his remaining leg had moved. It had all been so upsetting that she had burst into tears afterwards when she spoke to her mother on the phone. This led to a discussion about the relationship between what you see, and what you feel, and the fear that this man had aroused in her of growing old herself. This was followed by a discussion about the fear of touching patients. Another student described a patient who had come to the Casualty who was so badly burned, from being in a fire that one could not tell the colour of his skin, but all one could see was ash covering his body and how his hair was charred. The student had got ash on her skin from examining the man. It had all been very threatening and frightening. She said she had wanted to cry and realised it would be good to cry. The group expressed the view that one should be objective if one wanted to become competent.

The student who had told us the previous story now told us another one, about taking the history of a man on a cardiology ward. He had kept on interrupting her to talk about the loss of his wife, as she tried to persist with the medical history. He said, "I 'm sorry, but I want to talk about Kate". By his bedside was a picture of Kate. Apparently he had been looking after this wife with Parkinson's disease; during this time had lost 4 stone in weight. The group wondered what the student should do, because the patient had refused to have counselling, yet he so obviously wanted to talk. Someone suggested that this student should return to him later, but what would happen if he began to talk about something the students could not handle? Another student suggested that it was best when somebody talked about something that was difficult, just to say nothing and listen. PS commented that this case showed how important the patient's emotions were, and how the student needed to have real emotions themselves, in order to be empathic.

Later, after the groups merged and when there were two leaders, the students were able to consider deeper issues. One student described her first experience of seeing a patient dying in the Casualty Department. He had died of a third heart attack: she described her surprise at the very peaceful expression on his face, which contrasted with the heart-rending screams of the relatives in the corridor and the anxieties of the Casualty doctors that they might have missed a high serum potassium.. The group discussed how this

first experience of seeing a death had affected the student. She denied that it had been upsetting, yet her eyes were filled with tears.

In this larger group our discussions explored the histories of patients who did not fit into the hospital system: One student described a very demanding and abusive young homeless drug addict who had wanted her to make the phone call to a Homeless Persons Unit, which she had done. But when she had demanded that she fetched some orange juice for her, the student had refused to do this, as she did not consider it to be her role. Another student presented an angry, rather litigious patient, who was convinced that the ENT surgeons, who had put grommets in her ears, had caused her to develop tinnitus subsequently. She described how the two Consultants had patiently listened to this demanding and aggressive patient, yet she still had not been satisfied, even when they had offered to take the grommets out. The students talked about why people were angry, why they were hypochondriacal: one student suggested that it might be to do with a private unhappiness with perhaps a broken marriage in the background.

Another student described a case of a woman who came to an incontinence clinic complaining that she became incontinent of urine only when she passed a certain building. We all agreed that this might be a psychosomatic case, where one had to take into account the patient's personality as well as their illness.

In another session a student described the story of a man who had already had a coronary by-pass, who was now presenting with unstable angina pectoris. In the doctor's notes the social history only recorded "lives with wife", but the student had allowed him to tell his story. The patient had told her that his wife was becoming increasingly frail. He had wanted to move from their house, which he felt was much too big, but the wife had not wanted to move. On the day of his admission to hospital the weather had been very cold, he had been busy all day, and then he had had a very heavy meal, after which he had to do the washing-up on his own. It was then that his angina had come on. He had ignored it for one and a half hours before feeling able to call for help. The student commented that the doctors had seemed only to be interested in the medical problems, when in this case it was clear that this man's social and personal circumstances were so relevant. Another student said that in the Care of the Elderly department, the psychosocial situation of the patient was always considered carefully and another said that general practitioners also tend to consider the whole patient more than hospital doctors and are aware that they need to consider the patient's beliefs and expectations.

The ensuing groups included discussions of patients with dementia and facial disfigurement, and how doctors dealt with these frightening and painful situations. Other groups focused on patients who were difficult historians, or who were devious with the student. The students wondered if it was because they *were* only students, after all. In one group, a student described a young patient with ulcerative colitis who said he preferred to talk to her, rather than the doctors, because she was nearer his age. She had found the closeness in age a challenge. Two students said they preferred to be with younger people, but another student said he preferred older patients with whom he felt safer.

A recurring theme was the problem the students had in finding patients with whom they could spend enough time to listen to their personal story, as well as obtaining a systematic medical history. Often there were so few patients that they interviewed patients in pairs. Often they would say that they were "only students" who "were in the way" and sometimes considered a nuisance by both patients and staff. Inevitably this feeling reduced their confidence.

After thirteen weeks the group came to an end. The students said how much they had appreciated being given time to talk about their work with patients, to hear other people's views, and that this had given them a fresh outlook and helped them to see things in a new light. They said it had been a revelation to realise that they, as students, could be useful to patients, and that it had stopped them feeling so alone with difficult problems. They also said that it had emphasised the need for them to listen to the patients stories and had increased their confidence, so they did not feel obliged to constantly bring the patient back to the purely medical problem

CONCLUSION

In contemporary medical culture remarkable scientific discoveries have radically improved the treatment of many life-threatening diseases; so that everyone's expectations are much higher .The failure to cure is too easily seen to be the fault of the doctor, and the obsession with health targets and reduction of waiting times for patients to be seen, has often been at the expense of time spent in listening to the patient. The culture of

large teaching hospitals has also changed with a greater emphasis on rapid through-put of patients and increasing specialization of units which may be so large that they have little to do with each other. The divorce of Mental Health trusts from the main medical hospital trusts has had many complex consequences, not least a new kind of splitting of psychological from somatic care.

How are we to help medical students to negotiate this brave new world in such a way that they can hold onto and enhance their natural emotional sensitivity and become competent but also caring doctors? Students go into medicine with many important ideals which may be too easily lost along the way. Whilst the teaching of professional attitudes, including learning basic communication skills is very much to be lauded as a development, students also need time and support to reflect on their new experiences in relating to patients if they are ever to achieve an emotional maturity as doctors. We have found this experience of running of a voluntary Balint group for these students deeply rewarding as a way of trying to reach this goal, and believe it may offer a way forward for the many rather than the few in this new era of expanding medical schools.

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[3] Shoenberg P (1992) The student psychotherapy scheme at the University College and Middlesex School of Medicine: its role in helping medical students to learn about the doctor-patient relationship. *Journal of the Balint Society* **20:** 10-14

[4] Bloomfield I, (1992) Student psychotherapy and its role in helping medical students to learn about the doctor-patient relationship. *Journal of the Balint Society* **26:** 15-18

[5] General Medical Council (2002) *Tomorrow's Doctors: recommendations on undergraduate medical education.* General Medical Council: London

[6] Otten H, (1998) Balint work in Germany. *Journal of the Balint Society* **26:** 16-19

[7] Jugowar B and Skommer M (2003) The effectiveness of Balint training for medical students. *Proceedings of the 13th International Balint Congress* 104-108. Berlin.

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