

Virtual Mentor

American Medical Association Journal of Ethics
July 2012, Volume 14, Number 7: 551-554.

MEDICAL EDUCATION

Investing in Each Other—Balint Groups and the Patient-Doctor Relationship

Steve Crossman, MD

Have you ever felt dread or fear at the thought of opening the door to see a patient? Has an overwhelming feeling of despair or frustration suddenly come upon you after seeing certain names or your appointment list for the day? Do you ever feel too close, too connected to a patient and worry about keeping your distance? If none of this sounds familiar—then just wait, because it will. If you have experienced such feelings, does it make you an incompetent, unethical, or unprofessional physician or student?

I would like to open this commentary with a brief description of something extraordinary that is very rarely made available to medical students in their education. Here we go.

Pete was standing outside room 10-312 doing whatever he could to delay opening the door and greeting Mr. Smith, who had been on his service for 2 weeks now with no discharge in sight and whom he dreaded seeing. Thank goodness for e-mail—one of the best ways ever invented to procrastinate. A reminder e-mail for the group meeting that afternoon appeared on the screen of his phone. Nothing else new. Feeling too guilty to launch into a quick game of solitaire, Pete finally knocked on the door and pushed it open, forcing himself to smile when he said good morning to the patient waiting inside.

As he was checking e-mail for the last time before leaving the hospital, he once again saw the reminder for the group meeting. Kicking himself for not waiting until he got home to check, he made the hike over to the Department of Family Medicine and took the elevator up 14 floors. Pete was actually relieved to sit down in the circle of chairs amongst his peers and faculty.

When Dr. Crossman asked for a case, all of a sudden Pete sat up, leaned forward and claimed the moment to discuss his relationship with Mr. Smith. Pete did as he was asked, minimizing the clinical facts of the case and instead focusing on his feelings about Mr. Smith. He was surprised to find himself telling the group about his dread and his sadness and his fear. Thankful to be done, he scooted his chair back and listened for the better part of 45 minutes while his peers put themselves in both Pete's and the patient's shoes, describing how each would feel in the relationship described.

Pete left the group feeling supported and comforted, but more than that, excited to see Mr. Smith again. The next morning outside of room 10-312, Pete felt hopeful. He didn't look at his phone once before knocking on Mr. Smith's door.

During their preclinical years, medical students are indoctrinated in standards of professionalism and the principles of medical ethics. While professionalism standards may vary some by institution, the ethical principles are clearly, and in the United States explicitly, defined by Thomas Beauchamp and James Childress. These four principles of medical ethics are:

(1) Beneficence—obligations to provide benefits and to balance benefits against risks; (2) Nonmaleficence—the obligation to avoid causing harm; (3) Respect for autonomy—the obligation to respect the decision-making capacities of autonomous persons; and (4) Justice—obligations of fairness in the distribution of benefits and risks [1].

However, it is much more difficult to implement these principles when every physician, every patient, every relationship is unique, and when perspectives are so different. Applying these four straightforward ethical principles then is crucially dependent upon context. Returning to Pete, what did he experience that allowed him to become unstuck in his relationship with this patient? In other words, what was it that allowed him to step beyond himself and his reactions to Mr. Smith and enabled him to return more fully to his professional role as healer? It was a Balint group.

Michael Balint (1896-1970) was a Hungarian-born psychoanalyst who spent decades exploring the nature and power of the patient-doctor relationship. His name has become synonymous with a group process through which health professionals and health professional trainees can gain a better understanding of and ability to use the patient-doctor relationship to provide ever better care. Balint groups are ongoing around the world; in the United States they have been used primarily during residency training, initially in family medicine but now in many other disciplines as well.

Dr. Balint's most famous work, *The Doctor, His Patient and the Illness*, was published in 1957 [2]. I was amazed when I first read this book, nearly 50 years after it was published, at how the dilemmas described by doctors in England in the 1950s were so very similar to much of what I struggled most with in my own practice in rural Virginia. The aspect of the book that resonates most with me is Dr. Balint's description of the doctor-patient relationship as a "mutual investment company." In this relationship-as-investment-company analogy, physician and patient each contribute with the implied expectation of mutual gain: the physician wants to help the patient and make a living and the patient wants to feel better.

The invested assets of physician and patient are acquired cautiously over time and then must be carefully managed if the full return is to be achieved. As with any long-term investment, over time the doctor and patient need to add to, borrow from, and

lend their assets. A strong and stable investment history builds trust and confidence that allow risks to be taken. This confidence and trust also allows short-term stress and volatility to be accepted and weathered without any lasting harm. The result of sound investing and careful cultivation is a powerful and meaningful patient-doctor relationship.

The process of the Balint group is straightforward. There are three steps: case presentation, clarification of facts, and speculation regarding what might be happening in this relationship. A group member presents a challenging case. The challenge, rather than being a clinical question of what test to order or what medication to prescribe, is a challenge concerning the ongoing relationship the presenter has with a patient. The presenter describes from memory the patient, the relationship, and the dilemma. There are no notes, no vital signs, and no lab values involved. After this presentation, group members have the opportunity to ask questions to clarify issues of fact. Questions focus on things such as the patient's age, the patient's family structure, or whether the patient has a job.

After that, the presenter's work is done, and she is asked to sit back and reflect on what is said as the group works through the case. Group members begin to speculate by putting themselves, in turn, into the shoes of the patient and the student or physician described in the presented case. Using "I" statements, group members express what they would be feeling if they were the patient or caregiver in the relationship.

In the scenario above, one group member might well describe how helpless and useless he would feel caring every day for this patient who was not getting better. Another group member would very likely note, as the patient, how much she values Pete's daily visits and how important it is to have someone on the medical team who comes in every day without rushing right back out. Trained group leaders facilitate the process, maintaining an environment of respect, ensuring confidentiality and safety within the group, protecting the presenter from being judged, evaluated, or pressured in any way, and carefully monitoring the discussion to be certain that both the physician and the patient are given due attention.

This patient-doctor relationship provides the context necessary for the best possible application of ethical standards. In today's challenging medical world where training and practice alike are being stressed by increasing standards for compliance, ever-expanding knowledge and technology, compressed in terms of both time and space, and compartmentalized (e.g., hospitalist, night float, and so on), ethical challenges are sure to increase. Balint groups give us a model and a process that, together, show us how to invest as much as we possibly can in our relationships with patients to create the context needed for delivery of the best possible care.

References

1. Beauchamp TL. Methods and principles in biomedical ethics. *J Med Ethics*. 2003;29(5):269-274.

2. Balint M. *The Doctor, His Patient and The Illness*. New York: International Universities Press; 1957.

Steve Crossman, MD, is an associate professor of family medicine at Virginia Commonwealth University in Richmond, where he completed medical school. He divides his time between teaching and seeing patients, both in Virginia and in Honduras. Dr. Crossman is a credentialed Balint group leader and a member of the Council of the American Balint Society.

Related in VM

[Medical Students Learn to Tell Stories about Their Patients and Themselves](#), July 2011

[Multiple Exposures—Reflective Writing in the First Year of Medical School](#), July 2011

[The Art of Writing Patient Record Notes](#), July 2011

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2012 American Medical Association. All rights reserved.