THE ROLE OF BALINT GROUPS IN HELPING FIRST CLINICAL YEAR MEDICAL STUDENTS DEVELOP THEIR PROFESSIONAL IDENTITY AND SAFEGUARD THEIR BOUNDARIES

BY DR SOTIRIS ZALIDIS

INTRODUCTION

First clinical year medical students are at a crucial point in the development of their professional identity. Because less time separates them from lay persons than hospital consultants they tend to identify easier with patients, particularly when they are of a similar age to the student. Also they have just started coming into contact with seriously ill patients who are in the grip of powerful, feelings. These may be experienced by the students as intrusive and overwhelming and may threaten their sense of self and emerging professional identity. Because emotional distance and clinical neutrality is the default cultural setting of medical education, medical students are vulnerable to emotional detachment. Emotional detachment may seem a tempting solution because at least initially, not feeling anything provides a form of self-protection against emotional responses that the learner finds complicated or distressing. Students are on the look-out for role models and are quick to notice the negative emotions of hostility, indifference, frustration and impatience that their supervisors express as well as the positive emotions of caring, compassion and kindness shown towards patients (Shapiro 2011). Their professional identity will be influenced by identifications with the role models they choose.

BALINT GROUPS FOR MEDICAL STUDENTS

The importance of influencing medical students was not lost to Michael Balint. In the early 1960s he pioneered groups for first clinical year medical students at University college hospital. When he published his paper on this work in 1969 they had been running for seven years. At the time he was exploring to what extend students could apply the patient centred medical model to their patients and what kind of help the student could give the patient in this way. After a long break, in 2004 the groups were re-instatement in a modified form in response to the increasing emphasis on communication skills. This was achieved thanks to the combined efforts of Dr Peter Shoenberg, head of the psychotherapy department of University College Hospital and Dr Heather Suckling who in 2004 added Balint Groups for Medical Students to the already very successful Student Psychotherapy Scheme that had been running at University College Hospital since 1958. This presentation is a short version of a longer paper that is included in a new book coming out next year edited by Dr Shoenberg and Dr Yakeley. The book contains contributions from members of Dr Shoenberg’s department who describe their educational work with medical students.
The medical landscape has changed significantly since Balint’s time. It has become almost impossible for students to follow up patients because they change their teaching attachments so frequently. Nowadays the first clinical year medical students are offered modified Student Balint Discussion groups for ten weekly sessions in which they can present and discuss encounters with patients that have left an emotional trace. The emphasis in these groups is on helping the students to increase their awareness of patient’s emotions and their own reflective self-awareness. In this way we hope to give these students a deeper understanding of the doctor patient relationship. In 2011 a new development in the curriculum required that the students write an essay at the end of their ten sessions in the group, in which they are expected to give an account of an encounter with a patient and how their discussion in the group changed their perception of it. These essays have proven to be a unique feedback opportunity. The four essays that follow give expression to the range of emotions that students are called to deal with in their daily experience.

FOUR EXAMPLES OF PATIENTS DISCUSSED BY STUDENTS IN BALINT GROUPS

1. LEARNING ABOUT BOUNDARIES

One of the few opportunities to follow up a patient over a period of several months is provided by the year three cancer project. The aim is to increase student understanding of oncology medicine. It encourages students to meet a cancer patient and follow him up for a total of five visits at the hospital or outside.

In her essay, one of our medical students wrote movingly about the help she got from the discussion at the Balint group of her incredibly distressing and disconcerting experiences that she found overwhelming.

The patient, a middle aged married woman, had become terminally ill and had been admitted to the hospice. The student wanted to experience the new environment and asked whether she could visit her there. She was shocked however to discover how ill the patient looked and how upset her relatives were. The patient’s mother started crying and she was made acutely aware of just how terribly sad and desperate the situation really was. She felt identified with the patient’s relatives and after a couple of hours talking by her bedside the patient’s husband offered her a lift to the station in his car. As it was raining heavily she accepted. When they arrived at the station the husband started crying and the student felt misplaced and out of her depth and unsure of how to proceed. She also started crying. After a little while they both began to compose themselves but the student was so upset by the experience that she took the wrong train and did not realise she was going in the wrong direction until an hour had lapsed.

The Balint discussion helped her realise that part of her discomfort was not a failure to meet patients’ expectations, but rather was the result of her undefined role. Was she acting like a medical student? A friend? A confidante?

Who was the patient? The cancer sufferer, her mother or her husband? Being outside the hospital and in the husband’s car blurred the boundaries and this placed her in a position of uncertainty and unfamiliarity.

The student was also helped to reflect on the emotional burden of this experience that to some extent resulted from an identification with the patient and her family. In the
group discussion her compassion was validated. She felt elated when she heard that many doctors feel inadequate because they do not feel compassionate or empathetic towards their patients. She realised that she was well endowed in this area and that she should not feel burdened but rather privileged to have been in that position.

The opportunity to discuss and reflect on her feelings in this unfamiliar situation helped the student become more aware of the problems of the threat to professional boundaries in a non-clinical setting. It also helped her to appreciate her capacity for empathy and how this capacity could compromise her professional identity in the absence of professional boundaries.

2. HANDLING EMBARRASSMENT

A female student reported what happened when she was observing the urogenital consultant’s out-patient clinic. The consultant wanted to examine the perineal area of a frail 60 year old man who had received radiotherapy for cancer of the prostate. Without being asked for his consent to have the student present, the patient shuffled to the couch and undressed himself from the waist down. He lay with his face towards the wall and his back towards the student. The consultant examined the perineal area and suddenly stood up and left the room without an explanation leaving the student standing behind the patient who was fully exposed. The student had no idea where the consultant went and thought that he would be back in a few minutes. She found it difficult to know how to react. She did not know whether the examination had finished and had to tell the patient to get dressed. She was totally unprepared for such an experience and was torn between the desire to get out of the consulting room and give him privacy and not wanting to leave him alone without an explanation. Finally as a compromise she positioned herself within the cubicle so that she was not so close to him and not staring directly at him.

Eventually the doctor returned with a colleague who had been involved in the patient’s care. The doctor gave no explanation and made no apologies on his return. When his colleague examined the perineal area, the patient got dressed and the consultation was brought to a close. The patient showed no sign of being displeased with the circumstances of his examination and left on amicable terms with everyone.

In the ensuing discussion the group sympathised with the student about the awkward nature of the situation and discussed ways of handling it.

One of the co-leaders suggested that the intense awkwardness could have been alleviated by naming the feeling and acknowledging the embarrassing nature of the situation to the patient.

One of the students said that perhaps covering the patient with a blanket might have provided some relief.

Another student said that the doctor did not seem to be aware of the student’s stage of professional development and her feelings, and another commented that it seemed as if a doctor who examined patients every day might become used to their nakedness and desensitised to embarrassment. The co-leader emphasised that doctors are not expected to lose their sensitivity and mentioned the example of a candidate who was failed by a medical examiner because he neglected to safeguard the privacy of a
patient when he did not draw the curtain round his bed during the examination, on
the grounds that the patient was blind!
The student felt that the discussion helped her identify the feelings involved and she
felt more prepared to deal with embarrassing situations in the future.

3. DISILLUSIONMENT

A male medical student clerked a patient the day before she was due to have a hemi-
celectomy for removal of a tumour of the bowel. She was friendly and willing to be
clerked and let him take blood. He liked her for helping him and not only did he
explain the surgical procedure to her in detail but also explored her anxieties about
the cosmetic effect of the colostomy.
He saw her again the next day after the operation and realised that there was
something very wrong. She was in a side room and unresponsive and as the surgeons
peeled the dressings to inspect the wound, he saw that the wound had dehisced and
there was a gaping hole in the umbilical region with the colostomy bag in the left
upper quadrant. He felt as if he was staring at an anatomical atlas. It was possible to
see the layers of the abdominal wall, the skin, the fat and the muscle and through the
wound he could see her bowel! As soon as he saw the wound he felt a sense of
revulsion that quickly started to turn into morbid fascination. He felt that the lady
had put her trust in medicine in general and the surgeons in particular and she was
let down. He felt that she had been put in the side room in order to hide the surgical
failure. He felt guilty because he was a student of medicine and medicine had harme-
d her. He would feel embarrassed to meet her again.
In our group discussion we reflected on the fact that medicine has a dark side and is
not ideal. Medical procedures sometimes fail without adequate explanation. The
student hoped that if anything similar would happen to him in the future, he would
find the strength to own the failure and at least offer an explanation to the patient.

4. CONFUSION OF BOUNDARIES

A female medical student I will call Kate, gave a very good account of confusion of
boundaries in her example. She had just finished clerking a patient for her surgical
presentation when she was approached by another patient from the neighbouring
bay. This patient was a slim, young woman who was dressed in casual clothes and
roughly Kate’s age. She was friendly and in an excited way introduced herself as a
final year medical student from another medical school. She was complimentary
about Kate’s clerking, that she had overheard, and said that her own illness
experience provided a really good history and would be willing to offer herself for
clerking. Kate felt dazed by this offer. She had just finished speaking to one patient
and was not prepared for another encounter. When she met her again a few hours
later the patient student was again very chatty and started comparing her own
medical school with Kate’s giving advice about textbooks. She was also interested to
find out what Kate had been learning in lectures and to talk of her own frustrations as
a medical student. However, when she started turning the pages of the medical
records Kate was carrying, Kate closed the file as discreetly as she could and the student patient apologised for her indiscretion. In the group Kate talked of feelings of uncertainty and disorientation in her role when confronted with this person who was patient and student and peer all at the same time. The discussion helped her realise that the confusion of roles might be related to an over identification with patients of similar age to the student, particularly when the patient is also a student. And also that this confusion of boundaries may interfere with clinical judgement and this may be one of the reasons why the General Medical Council discourages doctors from treating family members or friends.

CONCLUSION

When first clinical year medical students meet seriously ill patients, they may identify with them and experience strong overwhelming feelings that can threaten their sense of identity. There is a danger that in an attempt to protect themselves from such empathic distress, students may choose to adopt a detached attitude and avoid all feeling in the short term at least. What method they will choose to protect themselves from affect overload will depend to a certain extent on the role models they choose to identify with and the appropriateness of the emotional support and understanding they will receive. Balint groups for first clinical year medical students provide a forum for discussing clinical encounters in a safe environment that helps them become acquainted with their emotions and contain them by developing reflective self-awareness and understanding. The ten group sessions offered to students represent an introduction to an adaptive way of handling emotions that can lead to a strengthening of the professional identity and a safeguarding of personal boundaries.

BIBLIOGRAPHY

