Balint Groups as a Means to Increase Job Satisfaction and Prevent Burnout Among General Practitioners

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ABSTRACT

PURPOSE General practitioners (GPs) occupy a central position in health care and often have demanding working situations. This corps shows signs of exhaustion, and many consider quitting their job or plan to retire early. It is therefore urgent to find ways of improving GP's satisfaction with their work. One approach might be Balint group participation. The aim of this study was to explore GPs' experience of participating in Balint groups and its influence on their work life.

METHODS We conducted a descriptive, qualitative study. Nine GPs who had participated in Balint groups for 3 to 15 years were interviewed. A phenomenologic analysis was carried out to describe the phenomenon of Balint group participation.

RESULTS The GPs perceived that their Balint group participation influenced their work life. Analyses revealed several interrelating themes: competence, professional identity, and a sense of security, which increased through parallel processes, creating a base of endurance and satisfaction, thus enabling the GPs to rediscover the joy of being a physician.

CONCLUSIONS The GPs in this study described their Balint group participation as beneficial and essential to their work life as physicians in several ways. It seemed to increase their competence in patient encounters and enabled them to endure in their job and find joy and challenge in their relationships with patients. Balint groups might thus help GPs handle a demanding work life and prevent burnout. These groups might not suit all GPs, however, and additional ways to reduce stress and increase job satisfaction should be offered.

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INTRODUCTION

General practitioners (GPs) derive greater satisfaction from encounters with patients that develop and maintain relationships and prioritize the distress of patients as compared with encounters that focus on technical aspects of care.[1] Yet the work of the GP includes emotionally difficult situations, the witnessing of suffering, anxiety, and death, as well as contacts with despairing or demanding patients who cannot be satisfied.[2,3] As stated by Arnetz, "The doctor-patient relationship is the core of the profession; while it is often gratifying, it is also a source of severe emotional risk."[1]

Consequently, there are serious signs of exhaustion among GPs in western societies.[5-8] Such is the case also in Sweden. Recruiting new physicians to general practice is difficult, and many GPs want to quit or retire early.[8-12] Burnout is a major problem among physicians in general, and preventive strategies are needed.[7,13]

A helpful strategy for overcoming and unburdening oneself of difficult experiences may be to share them with others.[7,14,15] For the GP, however, this

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is not easily accomplished. Patients are scheduled regularly, which may result in seeing a patient with a common cold directly after seeing a patient with a terminal illness. Physicians are limited in their ability to share their experiences because of confidentiality, and there is little tradition of debriefing or supervising activities in general practice. Physicians are left with 2 possibilities: either unburdening themselves at home or suppressing the emotions with eventual bad consequences for mental health in the long run.[15] Moreover, many GPs are confused about their role and obligations in an increasingly secularized and diversified world where people seek explanations and solutions to their miseries in the health care system.[9,16] These circumstances may lead to mental overload, conflicts of values, and a feeling of loss of control, which are important factors leading to burnout.[17-19]

Continual professional development and reflection in peer groups might be an approach for avoiding burnout. Balint groups may provide such opportunities for GPs and supply them with strategies for handling their work life. Balint groups are active worldwide, but most countries have few of them.[20] In Sweden, approximately 40 groups were active in 2003, one-half of which had specialists in general medicine. In the United States, Balint groups are widely used as an educational activity during residency in family medicine,[21,22] whereas in Europe, many Balint groups consist of GP-specialists with a wide range of experience.

In Balint groups, physicians are trained to implement basic psychodynamic principles with special attention to the physician-patient relationship.[23] The aim is to improve physicians' skills in handling their patients while simultaneously controlling their personal involvement and awareness of their own feelings during patient encounters. The groups comprise 4 to 10 physicians and 1 or 2 leaders, and meet regularly for several years. At the group meetings, members spontaneously describe patient encounters and the group discusses these encounters, focusing on the story and the feelings it arouses, to facilitate new ways of understanding the physician-patient relationship.[24] The founder, Michael Balint, talked of creating "a limited though considerable change of his [the physician's] professional personality."[23]

Research on Balint groups is limited and mainly restricted to short-term interventions in faculty settings.[25-29] Balint and coworkers allowed the group leaders (all psychoanalysts) to grade each member's capability of comprehensive reflection on his or her relationships with patients. One-half of members were assessed to have made progress in the groups.[30]

In a previous questionnaire study, we compared GPs participating in Balint groups with GPs not having access to Balint groups.[31] The Balint group participants scored significantly better on issues concerning perceived work environment and control, competence in handling patients with psychosomatic issues, and satisfaction in work. To date, that is the only published study considering the effects of Balint group participation on the work environment. The aim of this study was therefore to explore more deeply GPs' experiences of Balint group participation and its influence on their work life.

METHODS

We chose a descriptive, qualitative design because of the nature of the study, focusing on the lived experience of the informants.[32]

Sample and Setting

In Sweden, most GPs work in primary health care centers and are employed by county councils. We conducted a strategic sampling[32] of informants by contacting the known Balint groups in southern Sweden to obtain names of participating GPs with more than 2 years of Balint group experience. Efforts were made to get a varied sample in terms of sex, age, professional experience, and geographic setting. We contacted 10 potential informants via e-mail and told them about the study. All agreed to participate in an interview, but 1 withdrew later because of lack of time. All informants signed an informed consent contract before the interview. The study was approved by the Ethics Committee of the Faculty of Medicine at Uppsala University.

Interviews

The interviews were carried out during 2002-2003 by 1 author (D.K.) at each informant's workplace. The interviewer had not previously met any of the informants, but they knew that she was a colleague with Balint group experience. The interviewer used an interview guide with open-ended questions that asked informants about their reasons for joining a Balint group; their experiences in the group, both good and bad; whether the group had influenced their work life and encounters with patients; and how they would describe their group experience to a colleague without this experience. To obtain rich and personal descriptions, the interviewer explored and clarified the informants' experiences with probing questions, such as, "Could you give a concrete example?" and "What do you mean by that?" The interviews were conducted in Swedish, lasted 45 to 75 minutes, and were audio recorded and transcribed verbatim by the interviewer.

Analysis

Modern phenomenology originated from the philosophy of Edmund Husserl and has since developed into

empirical research methods.[33-35] Because we sought the meaning of the informants' experience of Balint group participation, we used the empirical phenomenologic psychological method[35] for our analysis. This method is similar to Giorgi's descriptive phenomenologic method[34] in its stepwise procedure but allows more interpretation. The researcher condenses the interview texts, traces out the meaning of the texts, and judges the relevance to the description of the phenomenon in question, while actively holding back his or her own preconceptions. The steps of the analysis are displayed in Table 1.

The analysis was carried out primarily by 1 author (D.K.) in close cooperation with the other author (I.H.), who actively took part in each step in the process. Differences were resolved by open discussions. The interviewer's preconceptions were addressed in the interviewing phase by actively asking informants for negative experiences, and in the analysis phase by bringing prejudices out for open discussions between authors and in seminars, thus allowing critical scrutiny of the process.[32]

Table 1. Steps in the Analysis of the Interviews

Step	Description
1	All the interviews were read through repeatedly to get a good grasp of the whole
2	The text was divided into meaning units. A meaning unit starts when the content of meaning shifts
3	Each meaning unit was examined closely and condensed into what was relevant to the research question, and the informant's language was changed into the researcher's language
4	The transformed meaning units were reformulated into themes and subthemes
5	The themes and subthemes were related to each other in a general structure of the studied phenomenon

RESULTS

Informants

The 9 informants participated in 6 different Balint groups led by 6 different leaders. They were 4 women and 5 men, aged 42 to 60 years. Eight informants were Swedish; 1 was a first-generation immigrant. They had at least 3 years of experience as specialized GPs and were permanently employed at health care centers in different geographic settings. The duration of their Balint group experience ranged from 3 to 15 years (mean, 8 years).

Themes and Subthemes

Our analysis of these GPs' experiences of how their Balint group participation influenced their work life revealed the following interrelating themes: *competence*, *professional identity*, and a *sense of security*, which increased through *parallel processes*, creating a base of *endurance and satisfaction*, thus enabling them to rediscover the joy of being a physician. The themes and subthemes that emerged from the interviews are displayed in Table 2. We further describe them and give examples through quotes below. The quotes were translated from Swedish to English by a professional interpreter.

Table 2. Themes and Subthemes Resulting From the Analysis of the Interviews

Themes	Subthemes
Competence in the physician-patient encounter gained in the Balint group	Naming, tracing, and handling difficult emotions
	Knowing oneself
	Preparing oneself for difficult encounters
	Understanding mechanisms of bad encounters
	Viewing the patient as a whole person in a biopsychosocial coherence
	Understanding why patients seek health care
	Being proactive in consultations
Professional identity as recognized in the group	Recognizing difficult encounters as a special and challenging task as a general practitioner
	Learning the limits of one's abilities and obligations
	Understanding patient-centeredness as a prerequisite of being a general practitioner
	Having a shared working condition, showing tolerance toward colleagues
	Mirroring oneself in others' stories leading to increased understanding of the tasks of a general practitioner
Sense of security developed in the group	Long relationship with the other group members
	Weaknesses and mishaps are tolerated
	Permissiveness, openness, and sincerity in the group
	Confidentiality, frames, and firm structure
	Feeling of not being alone even between group meetings
	Long experience leads to feeling of security
Parallel process: general practitioner–patient and Balint group–general practitioner	Long relationship with both patients and group
	Learning to listen patiently to narratives of discomfort
	Acknowledging changes over time in both group and patients
	Changing one's behavior permanently takes time
Endurance and satisfaction	Having good times together, breathing space
	Balint group enhances satisfaction with work
	Balint group counteracts burnout
	Together recognizing the good sides of work

Competence

The informants reported that Balint group participation increased their competence in controlling encounters

and handling emotions—both patients' and their own. They reported being able to recognize and name emotions, such as anger, which enabled them to talk about the emotional elements in encounters. They could more easily trace the sources of emotions, whether they originated from their own activated conflicts or were projected from their patients, as exemplified by the following narrative:

I had such problems with a man in his 40s, whom I experienced as extremely help-seeking; I felt as if he crept up onto my lap, and it was really difficult. I spoke about it in the Balint group, and I understood that it was his regression in his situation that I felt. When we met the next time, I was more prepared and it did not happen again. ... I know that I went to that encounter without fear, and that was great.

The informants perceived that they had gotten to know themselves better and could more often understand what happened when patient encounters went wrong. They had also learned ways of keeping structural control over the encounters and being prepared for difficulties, and when the encounter dragged, often put their finger on the heart of the matter:

You come back to what it is about—the pain is not the primary cause, you see what it really is about and you can resist the flow of words from the patient describing the symptoms and break in and focus on what it is really all about ... powerlessness and discomfort ... yes, be more prepared and guide the conversation onto another level.

Another aspect of competence the GPs emphasized was that their approach became more patient centered. Balint group participation was regarded as important for their increased understanding of the patients' psychosocial situation and the important role it played in patients' actions in relation to health care, as voiced by one informant:

We have discussed, we call it "the view of wholeness," but what is wholeness? Sometimes it is not just the patient, but also the spouse who comes in and talks the most. And in fact, wholeness is also both patient and doctor, both make a wholeness that we must acknowledge, and Balint has assisted, of course, to see wholeness and the immense importance the context or the wholeness has to how a person feels.

Professional Identity

Informants recognized that viewing the patient as a person and not merely as an illness was a central part of their professional identity as GPs. They described how encounters with "difficult" patients had developed into rewarding relationships and how they were really curious about how the next meeting would turn out. The heavy burden of difficult encounters had become a challenge, as is evident in the following comment:

Before I joined the first Balint group, I always thought that the patient who I was about to see, that it would be hard and tiresome. But afterward, this feeling that you have when you are about to enter to see the patient, open the door and so on ... it had disappeared, it felt more like, when best it felt like this is going to be exciting, it will be difficult, but I think I can manage.

The informants reflected on the roles of the GP and seemed to have found useful guidelines. They had understood that there were limits to what they as GPs could accomplish and also to the role they should play in their patients' lives. They perceived that they had been helped by the Balint group to understand that not everything that went wrong was their fault—that patients had responsibility too, and that this shared responsibility was important both for the patients and for their own survival as GPs, as exemplified by the following statement:

But this "being nice," that is, after all, only that you have difficulties putting limits—and that is devastating in the long run, both for oneself and for the patient. You end up digging your own grave. I think the straight way to burnout, that is "just being nice." You are not nice when you do somebody a disservice. So the strength as a doctor ... definitely the best strength you can have as a doctor is the ability to say no. Understand me right, for the benefit of the patient, of course. Accepting anything and doing everything that the patient demands, then you are not a doctor, you do not devote yourself to the art of medicine, you become some kind of checkout assistant and it will lead to an immense dissatisfaction in your work.

The informants also perceived that participation in Balint groups had increased their understanding and empathy for colleagues—not only their fellows in the groups but in general. They found it easier to talk about difficulties and even to ask for help in everyday life, especially when their Balint group included colleagues from their workplace.

It has definitely become easier I think, too, to understand, not only the colleagues in the group, but that you understand that colleagues can often have tough times in their work, are tired, and you don't judge so easily. You regard your colleagues, I think, with greater justice. Otherwise maybe you just think that you yourself are overloaded and work away, are fed up, and maybe you are, but you have an understanding of the other person too.

Sense of Security

Informants described the Balint group as a place of freedom, as a part of one's work life but still free from the ordinary run-of-the-mill responsibilities. The work in the group was very intense and sometimes revolutionary, but also full of tolerance and without performance anxiety. Participants felt safe there, safe to

uncover insecurity and mishaps, as exemplified by one informant's comments:

Some years ago I was accused of malpractice, and I was strengthened by the group. To be able to talk about it was very important. I was freed then, but I benefit from this all the time, as one always feels threatened by new accusations. We live with this difficult first judgment of cases and suddenly you do something wrong. It makes it easier to live with that thought when I know that we support each other.

The safety developed over a long time and was guarded by the firm frames of the group's structure and confidentiality. The company of peers gave the participants support, and this feeling of strength and security remained with them between the meetings, as told in the interviews. The informants emphasized that their membership in a Balint group was very important and far more valuable than short, intensive courses in consultation techniques. For example, one informant said, "It is enough just to think of the group, then you sort of gain strength in a situation when you feel it's heading in the wrong direction in the contact with a patient."

Parallel Processes

The relationships between the GP and the Balint group on the one hand and between the patient and the GP on the other were established over a long time and were interpreted to be parallel to each other. The process in the Balint group often mirrored that in the physician-patient relationship, and identifying this association had great educational impact for the informants.[30] In the group, physicians could put themselves in the patient's shoes, with the attendant feelings of weakness and insecurity, and maybe thereby come to understand the patient's perspective. For example, one informant shared the following:

I don't think that Balint has turned me into a nicer doctor, ... but I think that I can reverse the perspective better, the patient perspective, and maybe better understand why certain feelings arise between some patients and oneself.

Informants described how they were able to transfer elements of the work methods from the Balint group (eg, maintaining a firm structure, focusing and accepting strong emotions, patiently listening to narratives of insecurity, shame, and discomfort) to the physician-patient relationship. As an informant put it, "We have got used to listening for quite a while."

The possibility of having to follow a patient narrative in a series of meetings enhanced informants' learning of patience in building relationships and tolerating insecurity. One informant observed, " ... but it is like that with patient contacts as well. As a genuine GP, you are well aware that it takes time; it's like that in the Balint group as well."

Endurance and Satisfaction

The Balint group was described as a recurrent place for positive time together with colleagues, a breathing space in an otherwise rather lonesome work situation. In the words of one informant:

[The Balint group is] another type of contact, which is needed because of so much work alone. So it is nice to meet colleagues, when you know that during these hours we will discuss important issues.

Informants described how very sad and troublesome experiences were often difficult to handle without sharing them with others. They were able to use the Balint groups to unburden themselves of these heavy experiences.

I had some very heavy incidents, with young patients dying, younger than me, boys, or young men, whom I knew; and the policemen were very rude. Those situations gave me really bad feelings that I got help and support with in the Balint group ... in a very good way. It was so powerful, that I could have ended as a doctor the next week, such strong emotions; I was completely misused in my profession. But I could get back my joy in work. ... this was very important; it is the most important event I have brought to the Balint group.

The informants regarded the Balint group as a means of avoiding burnout but also noted that it demanded a long-term commitment, as exemplified by the following comments:

[Without the Balint group] ... I might have been charged with malpractice—for prescribing too much medicine, maybe. Or I would have had too many patients and been burned out. I would not have been able to handle the burden. I would have been more sensitive to critics or when patients get angry for some reason.

There are those who think that Balint, that's something you do for a couple of years, and then you have learned it, but that's not the way it is. We work with people, and all the time new difficulties turn up, new emotions, that is, unless you become a zombie.

Even though serious matters were discussed in Balint groups, the groups were not described as a solemn place. On the contrary, the informants related a creative and vitalizing atmosphere with fun and laughter, and with the permission to search for and find the joy of the work as a GP.

I think it's easier to endure, yes, the everyday work, and even see the charm in the work. You should not forget that, it sounds as if it is a way to manage the hardships, but we see the new ... develop as a human being as well, develop the good sides. The job as a GP is such terrific fun, actually. I can't think of another job like it. Maybe there are others, life is so big, but there are such exciting things you experience in the meeting with patients.

DISCUSSION

Key Findings

Mental overload, conflicts of values, and perceived loss of control are important factors leading to burnout.[17-19] Participating in Balint groups could be one way for GPs to develop strategies to handle difficult situations, rendering them less sensitive to stress. Our findings point to the Balint group as a means for achieving such competence because this method is based on reflection about difficult patient encounters and making use of frustrating experiences and emotions. In this study, we did not directly explore how exactly this competence is achieved, but several mechanisms likely play a role. Some of these mechanisms could be the healing and developing effect of structuralizing painful experiences in narratives,[37] the increase in understanding of complex events or relationships by reflection in a professional setting,[38] and the access to peers empathetically engaged in one's distressing situation.[39] This situation could resemble the patient's situation in the consultation, and thus the GP may understand more about what it is like to be the patient. Group leaders facilitate the process by clarifying questions and suggestions, while carefully protecting the safe milieu and keeping the focus on the physician-patient relationship even when it is difficult—much like the role GPs assume in the patient encounter.

In addition, Balint group participation may lead to an improved physician-patient relationship and may foster a patient-centered approach, as noted by Mead and Bower.[40] The results from our study support these benefits. The patient-centeredness learned in Balint groups, by enhancing optimum contact between the physician and the patient, may also satisfy the ethical demands that physicians face. Conflicts between ones ethical demands and reality in ones working situation may lead to burnout according to Maslac et al.[17] By viewing the patients in a patient-centred way, the physicians may experience coherence between their ethical expectations of the job and the reality, in which GPs can only achieve goals acknowledged by the patients and possible in their context. Thus the patient-centred view may lead to enhanced satisfaction in work and less risk of burnout.

The confusion of roles and responsibilities of the GP did not seem to bother these physicians. They had found ways of setting boundaries while at the same time enhancing their patient-centered approach. Freeing themselves from self-induced demands of omnipotence and defining what they actually could do well was crucial to the GPs' process of positively defining their professional identity, which for such a long time many of them had defined as doing whatever nobody else could or would do. The Balint group thus may be a place to learn the patient-centered way[40] of being a GP while maintaining a healthy work life.[7]

In our view, physicians need guidance, feedback, and support just as much as factual knowledge. In this respect, Balint groups provide an important safe and confidential area for unburdening and containing activity, and GPs should be allowed to participate if they want to. This method demands a long-term commitment, and it should probably be considered more as maintenance than as merely another kind of continual professional development activity. After all, physicians are expensive, more expensive than advanced technical equipment, the maintenance of which no one would question. It should be noted, however, that Balint groups might not be a suitable method for all GPs, and other ways of promoting stress reduction and increasing job satisfaction should be offered in addition.

Methodologic Considerations

We wanted to explore the lived experience of being a GP participating in a Balint group, which made the qualitative approach appropriate.[32] As in qualitative studies in general, our study sample was small and the transferability of findings may be limited to people and settings with characteristics similar to those studied here.[25,30,41] We did not explore negative aspects of Balint groups and problems with dropouts in this study, but we will do so in a forthcoming study.

The interviewer was a GP with Balint group experience, which raises some concerns about methodology. The researcher should know the field in order to generate appropriate interview questions,[42] but the shared understanding between the informants and the researcher may create blind spots that hinder exhaustive communication, such as effective follow-up questions. On the other hand, the topic of this study relates to emotionally charged episodes, disclosures of mishaps, and feelings of inferiority, as told in the Balint groups. Shared understanding may encourage informants to disclose more about their experiences because they feel safe and confident with a colleague.[43] The second author's complete lack of Balint group experience enhanced neutrality during analyses.

This study did not aim to explain how results are achieved in Balint groups, but it is an important issue to explore further, as is the extent to which patients experience a better relationship with their Balint group–participating GPs. Although difficulties and dropouts in Balint groups are subject to research,[29] it is also important to develop methods to predict which physicians will benefit from Balint group participation.

Implications

Michael Balint introduced Balint groups as a way to improve GPs' competence in handling patients with neurotic problems and in delivering some minor

psychotherapy in primary health care for the patients' benefit. A spin-off effect of these groups might therefore be a reduction in the pressure on secondary health care and the economy. Our study suggests that Balint groups may have additional positive consequences. The GPs we interviewed emphasized that Balint groups were their means of avoiding burnout. They described how they together in their Balint groups found joy, challenge, and enthusiasm in their relationships with patients. Patients should benefit from having competent GPs with these incentives. On a larger scale, enabling GPs to endure or even thrive in their job is critically important to the health care system as well.

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Burnout, Psychological Skills, and Empathy: Balint Training in Obstetrics and Gynecology Residents

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Abstract

Objectives To assess burnout, behavioral-medicine skills, and empathy among obstetrics and gynecology residents before and after implementation of Balint training.

Methods This was a prospective educational study. Balint training was introduced into the obstetrics and gynecology residency curriculum in July 2005. All 36 residents were approached for this study. The Psychological Medicine Inventory, the Maslach Burnout Inventory, and the Jefferson Scale of Physician Empathy were administered prior to initiating training and at 12 months. Baseline and 12-month scores were compared by Wilcoxon signed rank test.

Results Seventeen residents completed baseline and 12-month questionnaires: 6 were postgraduate year (PGY) 1, 3 were PGY-2, 6 were PGY-3, and 2 were PGY-4. At baseline, 70% of participating residents reported high burnout scores. Burnout and empathy remained unchanged at 12 months. Psychological medicine skills improved at 12 months.

Conclusions This study showed that obstetrics and gynecology residents are at high risk for burnout. Interest and confidence in handling psychological aspects of patient care improved at 12 months after the introduction of Balint training.

Introduction

The American College of Obstetricians and Gynecologists Council on Resident Education in Obstetrics and Gynecology and the Accreditation Council for Graduate Medical Education (ACGME) have placed new emphasis on obstetrics and gynecology residents' acquisition of skills in professionalism and patient-provider communication.[1] In the late 1950s, Michael and Enid Balint[2] identified the therapeutic properties of the doctor-patient relationship with family physicians in the United Kingdom. They developed a group-training method, now called Balint groups, to help physicians better understand their role in the doctor-patient relationship and to help physicians gain interpersonal skills.

Balint groups involve 6 to 12 physician participants and 2 group facilitators. At the start of these case-centered discussions, a participant volunteers to provide an account of a specific patient encounter. Cases are often prompted by a difficulty the clinician is having in the relationship with a particular patient. The focus of discussion is the story of a specific encounter and the emotions and attitudes aroused by the presentation; medical or technical facts are avoided. Participants are asked to consider and imagine their own reactions, emotions, and behaviors pertaining to the specific physician-patient encounter from the perspectives of both the physician and the patient. The safety of the group is maintained through clear guidelines regarding confidentiality and respect.

Balint group training is currently used in over 50% of family medicine residency training programs.[3] Balint sessions not only provide training and skills in understanding the doctor-patient relationship and help develop empathy, but they may also be a resource for improving job satisfaction and reducing physician burnout.[4–8] Burnout is a psychological term that describes a condition characterized by lack of personal and professional satisfaction, symptoms of emotional exhaustion, and depersonalization in relationships. Burnout is present in many professions. It is associated with impaired performance and decreased mental and physical health. The Maslach Burnout Inventory is the most-studied measure of burnout. Burnout is very prevalent in physicians, with

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estimated rates of 25% to 60%.[9] Studies[10] suggest that burnout is also very prevalent in residents. It has been shown to affect obstetrician-gynecologists throughout their career paths—from residents to departmental chairs.[12–15]

Very few studies[4,7,16,17] have assessed the association between Balint training and physician outcomes using validated instruments for empathy, behavioral-medicine skills, or burnout. Even fewer studies have implemented Balint training within a surgical or procedurally oriented subspecialty. Our goal was to introduce Balint training in a large academic obstetrics and gynecology residency program curriculum to help address ACGME requirements for focused training in the competencies of professionalism and interpersonal skills and communication. The aim of this study was to assess burnout, behavioral-medicine skills, and empathy among obstetrics and gynecology residents before and after implementation of this new curriculum by using validated measures.

Methods

Introduction of Balint Training

We introduced Balint group training as a required component of the obstetrics and gynecology residency program curriculum beginning in July 2005. This initiative was the collaborative effort of 4 faculty members (2 obstetrician-gynecologists, 1 pediatrician, and 1 psychiatrist), 3 of whom are credentialed as Balint leaders by the American Balint Society. These faculty members facilitated two 1-hour group sessions once a month during protected, mandatory educational time. These two sessions were held concurrently in separate rooms. One group consisted of first- and second-year residents; the other was composed of third- and fourth-year residents.

Study Methods

This study received exempt status by the University of Pittsburgh Institutional Review Board. On the first day of the new Balint curriculum, all 36 residents of the Department of Obstetrics, Gynecology, and Reproductive Sciences were approached about participating in the research study by a departmental assistant who was not involved with the residency program. The investigators and faculty members leading the groups were not present at the time of recruitment and were blinded to which residents chose to participate.

All residents participated in Balint training. Those residents who agreed to participate in the study completed the Maslach Burnout Inventory, the Psychological Medicine Inventory, and the Jefferson Scale of Physician Empathy prior to initiating the course and at 12 months. Study participants were queried about demographic information including year in training, age, race, marital status, and subspecialty interests. Additional demographics were not obtained, in order to protect the identity of participants.

The Maslach Burnout Inventory–Human Service Survey is a validated, 22-item self-report measure.[18] Each item is scored using a 7-point Likert scale. The survey assesses 3 domains of burnout: emotional exhaustion (9 questions), depersonalization (5 questions), and personal accomplishment (8 questions). Scores for each subscale are recorded as high, medium, or low. For both emotional exhaustion and depersonalization subscales, higher scores correspond to higher degrees of perceived burnout. Lower scores on the personal accomplishment subscale correspond to higher degrees of perceived burnout. In this study we report the high-risk scores in each subscale. According to Maslach Burnout Inventory scoring, high-risk scores for each subscale are defined as $\geq$27 in emotional exhaustion, $\geq$10 in depersonalization, and $\leq$33 in personal accomplishment. Overall moderate-to-severe risk of burnout was defined as high-risk scores in 2 or more of the 3 categories.

The Psychological Medicine Inventory is a validated, 11-item self-report survey with a 9-point Likert scale that has been previously used to evaluate the effects of Balint training.[4,7,19] Items are designed to assess residents' levels of interest, ability, or confidence in dealing with psychological aspects of patient care. A higher score indicates higher interest and ability in psychological medicine. As performed by Turner and Malm[4] and Adams et al.[16] changes in individual questions were assessed.

The Jefferson Scale of Physician Empathy is a validated quantitative measurement used to assess levels of physician empathy.[20] It contains 20 statements answered using a 7-point Likert scale, from 1 (strongly disagree) to 7 (strongly agree). Ten items of this scale are positively worded and ten items are negatively worded, requiring reverse coding. The scores range from 20–140. A higher score on the scale indicates greater empathy.

Descriptive statistics were performed. Baseline and 12-month continuous data were compared using the Wilcoxon signed rank test. Statistical analysis was performed using SPSS software version 12.0.1 (SPSS Inc, Chicago, IL).

Results

Complete data were available for 17 residents who completed both baseline and 12-month questionnaires. The baseline demographics of the respondents are summarized in TABLE 1. Participants included the majority of first- and third-year residents. Nonparticipants were primarily second- and fourth-year residents. Additional demographics were not available for nonparticipating residents.

At baseline, median scores (range) for each burnout subscale were as follows: emotional exhaustion, 35 (15–44); depersonalization, 14 (4–23); personal accomplishment, 33 (26–42). At baseline, 13 of 17 residents had high burnout scores in the emotional exhaustion subscale, 15 had high burnout scores in the depersonalization subscale, 9 had high

TABLE 1 **Baseline Demographics of Respondents**

		N = 17
Mean Age, y	28 ± 2.2	
Year in Residency, No. (%)	Postgraduate year 1	6 (35.3)
	Postgraduate year 2	3 (17.6)
	Postgraduate year 3	6 (35.3)
	Postgraduate year 4	2 (11.8)
Race, No. (%)	Caucasian	12 (70.6)
	Asian	5 (29.4)
Marital Status, No. (%)	Married	8 (47.1)
	Single	9 (52.9)
Subspecialty Interest, No. (%)	None	8 (47.1)
	Family planning	2 (11.8)
	Maternal fetal medicine	3 (17.6)
	Oncology	1 (5.9)
	Urogynecology	3 (17.6)

burnout scores in the personal accomplishment subscale, and 13 had high burnout scores in more than one subscale.

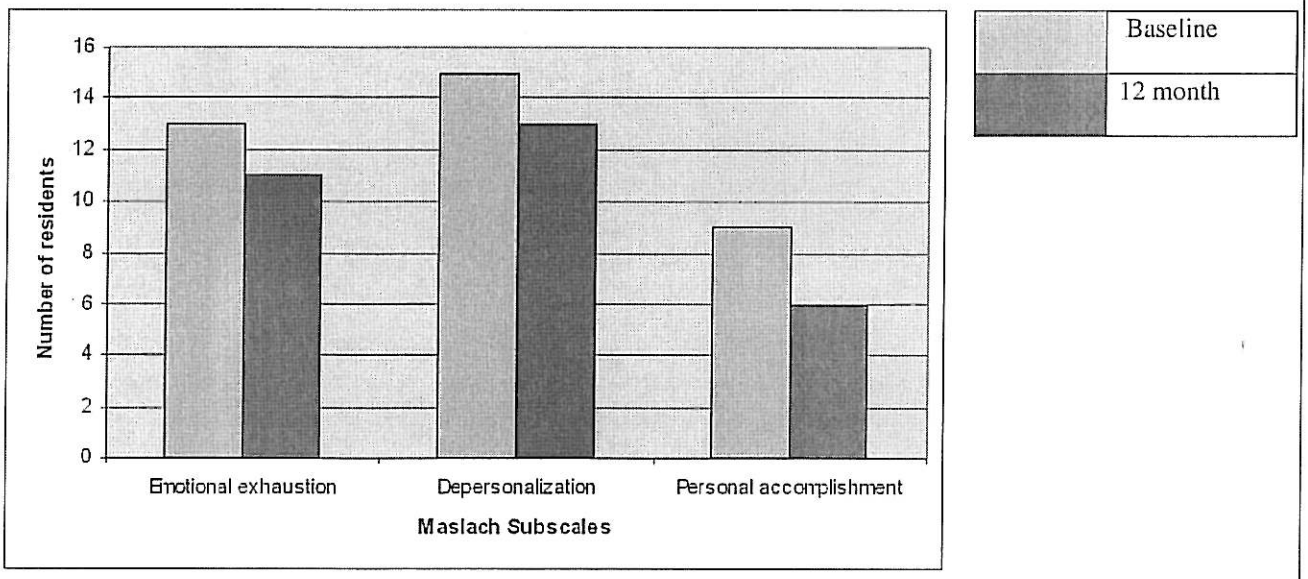
At 12 months, the number of residents with high burnout scores in each subscale decreased. Two fewer residents had high burnout scores in depersonalization and emotional exhaustion, while 3 fewer residents had high burnout in personal accomplishment (FIGURE). Median scores (range) for each subscale were as follows: emotional exhaustion, 34 (8–40); depersonalization, 15 (3–23); personal accomplishment, 35 (23–46). Changes in subcategory and total Maslach scores were not statistically significant. The majority of residents of all 4 classes (≥70%) had moderate-to-severe burnout (defined as high-risk scores in 2 or more categories) at baseline and 12 months.

Psychological Medicine Inventory overall scores improved at 12 months when compared with baseline scores. Three of the Psychological Medicine Inventory scores for individual questions showed a statistically significant improvement at 12 months (TABLE 2). Jefferson Scale of Physician Empathy scores remained unchanged at 12 months with a median (range) of 113 (92–129) at baseline and 12 months.

Discussion

One of the most striking findings of this study was the high levels of resident burnout. This study is one of few studies that provide objective assessment of obstetrics and gynecology residents before and after Balint training. In our study, the majority of participating obstetrics and gynecology residents (≥70%) had moderate-to-severe burnout (defined as high-risk scores in 2 or more categories) both at baseline and 12 months after Balint training began. These findings are similar to those found in the small number of studies that have examined burnout in residents.

FIGURE **Number of Resident Responders (N = 17) With High-Risk Scores for Burnout at Baseline and 12 Months in Each of the 3 Subcategories: Emotional Exhaustion, Depersonalization, and Personal Accomplishment.**[a]



[a]differences are not statistically significant

TABLE 2 **Median Baseline and 12-Month Total Psychological Medicine Inventory Scores and Individual Questions Showing Significant 12-Month Improvement (Higher Score Indicates Higher Interest and Ability in Psychological Medicine)**

	Median Baseline Score (Range)	Median 12-Month Score (Range)	*P* Value
Total Psychological Medicine Inventory	66.0 (47–81)	74.5 (60–88)	.074
Individual Psychological Medicine Inventory Questions With Significant Improvement			
Question 7: Ability to use consultation from social workers, psychologists, psychiatrists, and community mental-health agencies	7 (3–8)	7 (6–8)	<.008
Question 8: Ability to make appropriate treatment decisions based on patients' psychological needs	6 (2–7)	7 (3–8)	<.038
Question 9: Ability to be psychologically therapeutic with patients	5 (2–7)	7 (3–9)	<.02

Martini et al[10] described burnout among 321 residents in different specialties using the Maslach Burnout Inventory. Overall they reported that 50% of residents met the criteria for burnout, and obstetrics and gynecology residents had one of the highest burnout rates at 75%. Other studies of obstetrics and gynecology residents[13–15] have reported burnout rates of 58% to 83%. Differences in criteria used in these studies to define the extent of burnout preclude a direct comparison in burnout rates. The high level of burnout is likely due to multiple factors, including challenging interactions with patients, lack of work-life balance, and demands of a surgical subspecialty. Among residents in this study, the largest number of high-risk scores was found in the depersonalization subscale, while the personal accomplishment subscale had the lowest number of high-risk scores. High personal accomplishment was thought to contribute to lower overall burnout scores in a study of obstetrics and gynecology department chairs.[15]

Emotional depletion and depersonalization are responses to prolonged occupational stress and lead to a sense of emotional withdrawal toward coworkers and patients.[21] A better understanding of residents' experiences is needed to identify sources of emotional exhaustion and depersonalization and to identify methods to ameliorate their impact on young trainees. Although several authors have proposed Balint training as a possible antidote to burnout in physicians,[4–6] no studies have examined the effects of Balint training on burnout using a validated scale. Residents in our study demonstrated a trend toward improvement of burnout levels; however, due to limitations in our study design, we are unable to substantiate this.

Our study showed improvement in some aspects of behavioral-medicine skills of obstetrics and gynecology residents at the 12-month assessment. Residents reported an improvement in ability to use consultation, ability to make appropriate treatment decisions based on patients' psychological needs, and ability to be psychologically therapeutic with patients. While individual Psychological Medicine Inventory items are not independently validated, we explored individual items, as did Turner and Malm[4] and Adams et al.[16] who found improvement in individual and total Psychological Medicine Inventory scores in family medicine and obstetrics and gynecology residents who completed Balint training compared with residents who did not.

Our study found no difference in baseline and 12-month Jefferson Scale of Physician Empathy scores. Similarly, Cataldo et al[15] found no difference in empathy scores between practicing physicians who had attended Balint training during residency versus those who had not attended. Hojat et al[21] reported empathy scores for physicians in various specialties and found the highest scores in practicing psychiatrists (mean score of 127 ± 5.5). Practicing family physicians and obstetrician-gynecologists scored significantly lower than psychiatrists (mean scores of 120.5 ± 12.6 and 119 ± 10, respectively). Our resident participants' mean score was 112 ± 12. While this score falls within the standard deviation of the scores reported by Hojat et al, it is 7 points below the mean of practicing obstetrician-gynecologists. Numerous explanations can be offered for lower scores in this study. Skills in empathy may develop through experience and may be lower in trainees. Ability to be empathetic may be affected by stress level and degree of burnout. Empathy scores may also reflect the amount of emphasis that is placed on interpersonal skills during training.

Our study had several limitations. The small sample size limited our precision, power, and generalizability. The participation of only 47% of the residents increased the significant potential for selection bias and likely lead to the lack of statistically significant results. Participants may have been more receptive to or interested in Balint training.

Participants may also have been more distressed and willing to participate, biasing results to a higher prevalence of burnout. Since we lacked a comparison or control group, we were unable to tease out the numerous potential confounding variables, including time, curriculum, or other experiences, that could explain some of the results. The effect of collective resident experiences over the course of the year may explain the change in Psychological Medicine Inventory scores. Although to our knowledge our study had the longest assessment period of any other study evaluating the effects of Balint training, 12 months may still be too short a period to see measurable changes in more complex characteristics such as empathy. The study findings presented in this article focus only on the results of 3 quantitative questionnaires, which may not present a full picture of how Balint training impacted the attitudes, understanding, and experiences of the obstetrics and gynecology residents. All of the instruments utilized in this study rely on resident self-report. Many of these limitations could be addressed in future studies by employing a study design involving control and intervention groups, recruitment from multiple institutions, and mixed methods.

As 1 of only 2 studies that evaluate outcomes of Balint training in an obstetrics and gynecology residency, this study adds to existing work in this challenging area of residency-curriculum development. This is the only study that examined the effects of Balint training as a mandatory part of the residency curriculum using 3 different validated measures.

The value of Balint training in obstetrics and gynecology residency programs remains unclear. Balint groups do address the ACGME competencies of professionalism and interpersonal skills and communication in a humanistic group environment. However, due to the process-oriented nature of Balint training and the significant limitations of our study, it is difficult to measure the resident outcomes as a direct consequence of Balint training. However, our study clearly revealed a high level of burnout. It also suggested that empathy scores in residents may be lower that that of practicing physicians. Improving physician-patient communication may be a way to lower levels of burnout.[22,23] Balint training is a safe and supportive method of fostering reflection, challenging assumptions, and suggesting alternative approaches regarding difficult provider-patient relationships. Such experiential learning may be difficult to assess using quantitative measurement instruments. Further work using other methods of assessment, such as qualitative evaluation, longitudinal observation, and multicenter design, may be necessary to assess the impact of Balint training. More importantly, this study calls attention to the imminent need to identify the extent of burnout in training physicians and to determine the best way to address burnout in this specialty and across specialties.

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Relationships between scores on the Jefferson Scale of physician empathy, patient perceptions of physician empathy, and humanistic approaches to patient care: A validity study

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B Data Collection
C Statistical Analysis
D Data Interpretation
E Manuscript Preparation
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Summary

Background: Empathy is the backbone of a positive physician-patient relationship. Physician empathy and the patient's awareness of the physician's empathic concern can lead to a more positive clinical outcome.

Material/Methods: The Jefferson Scale of Physician Empathy (JSPE) was completed by 36 physicians in the Family Medicine residency program at Thomas Jefferson University Hospital, and 90 patients evaluated these physicians by completing the Jefferson Scale of Patient Perceptions of Physician Empathy (JSPPPE), and a survey about physicians' humanistic approaches to patient care.

Results: A statistically significant correlation was found between scores of the JSPE and JSPPPE (r=0.48, p<0.05). Significant correlations were also obtained between scores of the JSPE and patients' assessments that their physician was concerned about their feelings (r=0.55, p<0.01), and that the physician took their wishes into account in making treatment decisions (r=0.48, p<0.05). A negative correlation was observed between scores of the JSPE and patient's perception that their physician was in hurry (r=–0.50, p<0.01).

Conclusions: These findings provide further support for the validity of the JSPE. Implications for the assessments of empathy in the physician-patient relationship as related to clinical outcomes are discussed.

key words: empathy in patient care • patient perceptions • validity • humanistic approaches

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BACKGROUND

Empathy has been described as an important element of professionalism in medicine [1,2], and its importance as the foundation for a positive physician-patient relationship has been acknowledged [3–7]. Anatole Broyard [8] indicated that he wanted his doctor to have "magic as well as medical ability" (p.39). This "magic" occurs when a patient feels good about being understood as a result of physician-patient empathic engagement. Such an empathic engagement in patient care can lead to a more accurate diagnosis, as well as patients' increased satisfaction with their care providers, better compliance with their medical regimen, a lower rate of malpractice claims, and more effective coping with the stress of illness (for a more detail literature review see Chapter 10 in [3]).

Empathy in the context of patient care is defined as "a preliminary cognitive (rather than emotional) attribute that involves an understanding (rather than feeling) of experiences, concerns and perspectives of the patient, combined with a capacity to communicate this understanding." [3, p. 80]. This definition distinguishes not only the concept of empathy (as a cognitive attribute) from sympathy (as an emotional or affective attribute), but also places emphasis on communicating empathic understanding with the patient for better clinical outcomes.

In medical education research, physicians' capacity for empathy has been highlighted, but patient's perceptions of physician empathy has not received sufficient empirical attention. This could be due to the unavailability of a psychometrically sound measuring instrument to determine the degree of patients' perception of empathic engagement with their physicians. Considering the current trends in the market-driven health care system in which cost containment takes precedence over building physician-patient relationships, it is timely and important to examine how empathy in the physician-patient empathic engagement plays a role for the purpose of identifying factors that contribute to positive clinical outcomes.

This study was designed to examine the correlations between scores on the Jefferson Scale of Physician Empathy (completed by physicians) along with scores on the Jefferson Scale of Patient Perceptions of Physician Empathy, and patient's responses to a survey about physicians' humanistic approaches to patient care (completed by patients).

MATERIAL AND METHODS

Participants

Total study participants included 36 residents (13 men, 23 women) in different years of residency training (18, 9 and 9 in training years 1, 2, and 3, respectively). The mean age of the participants was 28 years, ranging from 25 to 35 years.

Instruments

The following instruments were used in this study.

1. **The Jefferson Scale of Physician Empathy (JSPE):** This is a 20-item scale that measures physician's self-reported empathy [3,9–11]. Each item of this scale is answered on a 7-point Likert scale (1 – Strongly Disagree, 7 – Strongly Agree). A sample item is: "I try to understand what is going on in my patients' minds by paying attention to their non-verbal cues and body language."

Satisfactory evidence in support of the psychometrics (e.g., construct validity, criterion-related validity, test-retest reliability and coefficient alpha reliability) of this scale among medical students, residents, practicing physicians, nurses and nurse practitioners has been reported [9–13]. This scale has already been translated into 15 languages by researchers in different countries. For more information about this scale visit the following Web site: *www.tju.edu/jmc/crmehc/medu/jspe.cfm.*

2. **Jefferson Scale of Patient Perceptions of Physician Empathy (JSPPPE):** This is a brief survey (5-item) recently developed for measuring patient perceptions of their physician's empathy [14]. Patients responded to each item of the survey on a 7-point Likert scale (1 – Strongly Disagree, 7 – Strongly Agree). A sample item is: "[my doctor] understands my emotions, feelings, and concerns." Psychometric properties of this scale including its construct and criterion-related validities in a sample of residents and their patients in an Internal Medicine residency program have been reported elsewhere [14] (Copies of the scale can be obtained from authors).

3. **Survey of Physician Humanistic Approaches to Patient Care:** This survey was completed by patients, and contained five items intended to measure humanistic approaches to patient care that were used as additional criterion measures. These items were selected because of their conceptual relevance to empathic engagement in patient care. Four of these items were adapted from the Physician's Humanistic Behavior Questionnaire developed by Weaver and colleagues [15], and one was adapted from a questionnaire intended to measure Patients' Appraisal of Physicians' Performance developed by Matthews and Feinstein [16]. These items were also answered on a 7-point Likert scale (Items are presented in Table 1).

Procedures

The approval of the university's institutional review board was obtained for this project. The JSPE was distributed to the residents who were asked to voluntarily complete and return the scale for research purposes. All residents returned the scale (100% response rate).

Patients of these residents were approached in the waiting room by a student research assistant and asked to complete the JSPPPE and the survey of humanistic approaches to patient care. The name of the resident was printed on each instrument. Patients were reminded that their responses would be kept confidential and that their participation or refusal in no way would influence the care they received from their physicians. A research assistant explained the project to the patients as part of educational evaluations, and asked them to voluntarily complete the form.

Ninety patients returned the patient form for all of the 36 residents; however, complete data (all items answered by pa-

Table 1. Validity coefficients for scores on the Jefferson Scale of Physician Empathy (JSPE)[1] and criterion measures.

Criterion measures	*r*
Jefferson Scale of Patient Perceptions of Physician Empathy (JSPPPE)[2]	0.48*
Physician Humanistic Approaches to Patient Care	
Asks me how I feel about my problems[3]	0.55**
Takes my wishes into account when making decisions[4]	0.48*
Is always in a hurry[3]	–0.50**
Shows concerns for my feelings and needs, not just my physical status[3]	0.30
Arranges for adequate privacy when examining or talking with me[3]	0.11

* $p<0.05$; ** $p<0.01$.

[1] The Jefferson Scale of Physician Empathy (JSPE), contains 20 Likert-type items [3,10–13].

[2] The Jefferson Scale of Patient's Perceptions of Physician Empathy (JSPPPE), contains 5 Likert-type items [14].

[3] Adapted from the Physician's Humanistic Behavior Questionnaire [15].

[4] Adapted from Patients' Appraisal of Physicians' Performance [16].

tients) were available only for only 23 residents. Some residents had multiple forms completed by more than one patient (ranging from 1 to 11 patients).

Statistical analyses

For the purpose of statistical analyses, an average score for the JSPPPE and for items of the physician humanistic approach to patient care was calculated for residents with multiple patient forms. Residents served as the unit of observation for all statistical analyses. Descriptive statistics were calculated for the JSPE and JSPPPE. The physicians' self-reported empathy scores from the JSPE were correlated (using the Pearson product-moment correlation coefficient) with scores from the JSPPPE and with patients' responses to the survey of physician humanistic approaches to patient care.

Results

The mean and standard deviations of the JSPE were 118, and 9.2, respectively. The corresponding statistics for the JSPPPE were 30, and 2.8. The Pearson correlation coefficients between the JSPE and JSPPPE scores and measures of physician's humanistic approaches to patient care are reported in Table 1.

Relationship between scores of the JSPE and JSPPPE

The correlation between scores on self-reported physician empathy (JSPE scores) and the Jefferson Scale of Patient Perceptions of Physician Empathy (JSPPPE) was $r=0.48$ ($p<0.05$) indicating a statistically significant overlap between the two measures.

Relationships between scores of the JSPE and responses to the survey of physician humanistic approaches

Scores on the JSPE were significantly correlated with patients' agreement that their physician often asked them about their feelings regarding their health problems ($r=0.55$, $p<0.01$), as well as with patients' perception that their physician took their wishes into consideration when making clinical decisions ($r=0.48$, $p < 0.05$) (See Table 1).

As expected, physician's scores on the JSPE were inversely related to patients' reports that their physician was always in a hurry when examining them ($r=-0.50$, $p<0.01$). Correlations between JSPE scores and the two other items (see Table 1) did not reach the conventional level ($p<0.05$) of statistical significance.

Relationship with the number of patient visits

We obtained the number of patient's visits to the physician from each patient's file. In additional analyses we found that scores of the JSPE and the JSPPPE were not significantly correlated with the number of patient visits. One explanation could be that empathic relationships between physicians and patients are formed in the first encounter, and the number of later contacts with the physician may not change this first impression.

Discussion

The finding that scores on the JSPE were significantly correlated with scores on the JSPPPE indicates not only that there is an overlap between physician self-reported empathy and patient views of empathic engagement with his or her physician, but also provides further evidence in support of the criterion-related validity of the JSPE. The magnitude of the obtained correlation indicates that approximately one-quarter of variation in self-reported physician empathy scores could be predicted by patients' perceptions of physician empathy ($r=0.48$, $r^2=0.48^2=23\%$).

In another study with a sample of residents and their patients in an Internal Medicine residency program, the correlation between JSPE and the JSPPPE did not reach the conventional level of statistical significance [14]. The "ceiling effect" (highly inflated ratings given by patients) observed in that study was described as a possible reason for a lack of significant relationship between the two scales [14].

Caring for a patient is a far more complex task than just treating the pathophysiology of a disease. The often cited quotation that "It is as important to know what kind of man has the disease, as it is to know what kind of disease has the man" (attributed to Sir William Osler) indeed points to the importance of empathic engagement in patient care. Empathic engagement in physician-patient encounters is a crucial variable in generating a feedback loop that is important to patients' physical, mental and social well-being [3]. To the extent that physicians can be more "tuned in" and engaged empathically with their patients, we can surmise that their patients might have better clinical outcomes and cope better with their illness. Thus, not only physicians' capacity for empathy, but also patients' perception of physician empathy can play significant roles in positive clinical outcomes.

As we described previously in the definition of empathy, a key concept in physician-patient empathic engagement is the communication of empathic understanding between physician and patient. Such a mutual understanding and reciprocal exchanges can lead to a more positive patient outcome [3].

CONCLUSIONS

Despite the limitations of this study due to a small sample size, and the non-random selection of participants, the findings provide empirical evidence suggesting that physicians' self-reported empathy and their patients' perceptions of physician empathy are significantly correlated, and both concepts can be measured by psychometrically sound instruments. These measuring instruments have important implications for the assessment of physician empathy. Particularly, more insight into empathy, as reported by the physician and perceived by the patient, is important for the assessments of factors which contribute to positive clinical outcomes, the ultimate goal of patient care.

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A Preliminary Investigation of Balint and Non-Balint Behavioral Medicine Training

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Background and Objectives: *Despite inclusion of Balint training in US family medicine residency programs, little research exists about the effectiveness of this training in improving residents' behavioral medicine skills. This study compared the outcomes for residents who did and did not undergo Balint training to increase residents' psychological medicine skills in two rural training programs.* Methods: *Fourteen residents from two rural community-based training programs were assessed using the Psychological Medicine Inventory, following standard first-year behavioral medicine training. At one residency program, residents then participated in 9 months of Balint training during the second year of residency training, while at the other program they did not. Both groups were reassessed at the end of the second year of residency.* Results: *Only Balint-trained residents showed gains in self-reported psychological medicine skills, abilities, and confidence beyond levels developed in year 1.* Conclusions: *Balint training enhances the levels of residents' self-reported psychological medicine skills, when compared to standard behavioral medicine curriculum for first- and second-year family medicine residents.*

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Teaching behavioral medicine and providing small-group support to family medicine residents are two requirements of family medicine residency training.[1] Balint group training, which aids in meeting both of these requirements, has become an established part of the behavioral medicine curriculum in many family medicine residencies.[2] Nearly half of US residency programs (48.3%) recently reported using Balint groups as part of their behavioral science curriculum.[3]

While the method of Balint training has been described in detail elsewhere,[4,5] at the core of this training method is a small group of physicians who meet regularly to examine their own patient-physician relationships, through the group members' patient case presentations and faculty-facilitated discussions. This method of exploring the dynamics of their patient interactions, and of gaining insight into their own reactions to patients, may help physicians more effectively meet the biopsychosocial needs and challenges of their patients.[6-9]

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Effectiveness of Training

There is a small but growing body of research that attempts to understand what happens in Balint group training, particularly as it applies to family medicine residency programs in the United States. How effective are these groups in enhancing residents' behavioral or psychological medicine skills?

One recent study questioned the validity of Americanized versions of Balint training that are frequently offered to US physicians in training.[10] Residency programs that offer what they are calling Balint groups appear, at times, to be mixing traditional, analytically based reflective models with educational or didactic interactions, support functions, or residency administrative issues.[11] One study has attempted to provide us with a topology for understanding the kinds of ineffective roles that residents self-report in Balint groups.[12] While this empirically based, qualitatively derived topology helps us understand some of the challenges residents face in patient care, it leaves us with unanswered questions about the effectiveness of such Balint training in improving residents' skills.

Other research examined the psychological medicine abilities of 41 graduating family medicine residents using the Psychological Medicine Inventory (PMI).[13]

Although this was not a study specifically designed to evaluate the benefits of Balint training, graduating residents who had participated in Balint group training showed higher scores than did their non-Balint-trained classmates in the areas of physician self-awareness and awareness of patients' reactions to their physician.

Building on this previous work, the study reported here sought to assess the effectiveness of Balint training in increasing family medicine residents' psychological medicine skills beyond the level of skills obtained through traditional behavioral medicine training during the first and second years of residency. The hypothesis we tested was that residents who receive Balint group training in addition to their standard behavioral medicine rotation will show greater positive changes in PMI scores across time, when compared to residents who complete only standard behavioral medicine training.

Methods

Participants

All participants in this study were second-year (PGY-2) family medicine residents in two community-based, university-affiliated training programs in the same rural, western state. All residents in the PGY-2 year at both training sites were included in the study.

Both programs used a longitudinally integrated behavioral medicine curriculum (one behavioral medicine faculty member in each program who provided "curbside" consultation, daily availability in the clinic and hospital, participation in discussions between residents and physician preceptors, didactic sessions, chart review, and recommendations) combined with a 1-month outpatient rotation in community psychology/behavioral medicine during the first year of residency training (PGY-1).

Group 1 consisted of six residents from one of the programs. There were four males and two females, all Caucasians, in this group. The residents had a mean age of 30.1 years, with a range of 28–33 years. Group 2 was made up of eight residents from the second program and was comprised of eight males, all Caucasians, with a mean age 30.4 years and a range of 26–34 years. Residents in both groups were matched with their residencies through the National Resident Matching Program, having sought a rural, primary care training program in a western state.

Group 1 residents completed the standard first-year behavioral health curriculum and began 9 months of twice-per-month Balint group training in October of their second year. The Balint group met for 1 hour, following noon conference, mid-week, resulting in the group's residents being scheduled out of 1 hour of afternoon clinic or specialty rotation every other week for the remaining 9 months of this study. Group 2 residents also completed the standard first-year behavioral health curriculum but did not participate in Balint training.

Instrument

We assessed participants' abilities in behavioral medicine with the Psychological Medicine Inventory (PMI) developed by Ireton and Sherman at the University of Minnesota. The PMI is an 11-item, paper and pencil, self-report survey instrument, with a nine-point rating scale for each item. Items are designed to assess residents' levels of interest, abilities, or confidence in dealing with psychological aspects of patient care (eg, "ability to make appropriate treatment decisions based upon patient's psychological needs," "skill in developing good doctor-patient relationships," "awareness of my own feelings, values, and needs"). The PMI was chosen for this study because of its high face validity and initial psychometric properties in assessing psychological medicine skills, abilities, and confidence issues, especially as they relate to the patient-doctor relationship, the principal focus of Balint training.

In previous research, the PMI demonstrated convergent validity through strong correlations between residents' self-ratings and independent preceptors' ratings of the same attributes. Also, instrument-item analysis and factor analysis indicated two factors in overall scores: factor 1—clinical psychological abilities (interviewing, diagnosis, consultation, and treatment) and factor 2—psychological sensitivity (doctor and patient relationship skills, awareness of self, and awareness of patients' reactions to physician).[13]

Procedure

Both Group 1 (Balint) and Group 2 (non-Balint) residents were assessed with paired, repeated measures (matched subject responses, pre and post intervention) using the PMI. Baseline assessments for both groups were made during the week of initiation of Balint training for Group 1 (first week of October of PGY-2) and repeated for both groups, 9 months later, at the end of the PGY-2 training year, during the last week of June.

All assessments were anonymous, with residents marking their rating scale with a personal identification code that only they could identify and match on repeated measure. No identifying information was collected on individual residents, and instruments were filled out in a group setting. This study was reviewed in advance and approved by the University of Wyoming's Institutional Review Board under the heading of curriculum evaluation.

Data Analysis

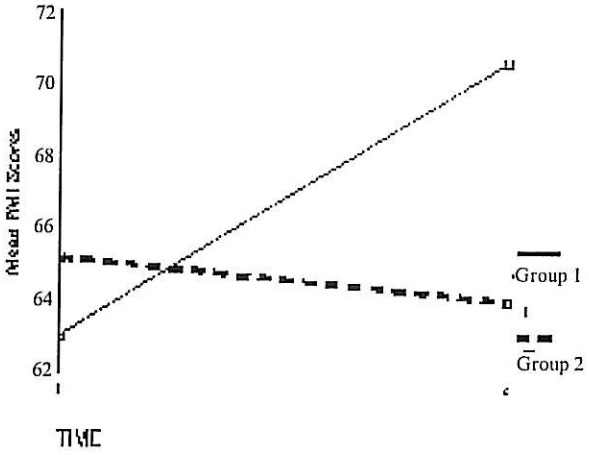
We computed change scores in PMI for each group over time. This was done by subtracting the pre-score PMI from the post-score PMI for each subject. At this point an independent samples *t* test was conducted on the change scores to see if there was a significant difference between the two groups. We also conducted a Levene's test for equal variance, along with a power calculation on the results. Analysis was performed using SPSS for Windows v11.0® (SPSS, Inc, Chicago).

Results

All 14 participants from Group 1 (Balint) and Group 2 (non-Balint) completed this study and the pre and post assessments. Means and standard deviations for each group are shown in Table 1. The result of the independent samples *t* test on the post-pre PMI change scores was significant (t (12)=2.570, P=.025). The result of this test indicated that scores in Group 1 (Balint) increased more positively than did scores in Group 2 (Figure 1). Levene's Test for Equality of Variances supported the assumption of equal variances (F (1,12)=0.073, sig.=0.792). A calculation of power for this result yielded an observed power of 0.66, indicating that much of the difference between the Group 1 and Group 2 change scores could be attributed to the intervention.

Figure 1

Group by Time PMI Scores



PMI—Psychological Medicine Inventory

Discussion

Increasing residents' skills and confidence in dealing with psychosocial and behavioral aspects of medicine is an implied outcome of education in family medicine. Our preliminary research into the effectiveness of Balint group training supports the conclusion that Balint training enhances the levels of residents' behavioral medicine skills, when compared to a standard behavioral medicine curriculum for first- and second-year family medicine residents. Despite the small sample sizes, changes were significant and attributable to the addition of Balint training in Group 1.

Limitations

This study's limitations include the lack of random assignment of the residents to the two training conditions (standard and Balint). However, the two groups of residents were similar in age and in their selection of these particular rural, community-based, university-affiliated programs for their family medicine residency training. The residencies are both part of a single university division and, as such, are subject to the same curriculum review and supervision.

The self-report method of assessing changes in resident skills, ability, and confidence is also a limitation of this study. While self-efficacy is important in successful learning and professional development, these self-reported changes need to be verified by external raters and/or measures of behavioral change in patient interactions.

In a study with such small sample sizes and a single ethnic representation, generalization of results is also limited. This study also did not attempt to assess differences in effect by gender of resident, something that also would be worth investigating. Finally, this study was limited to a particular region and focus: rural training in the mountain west. No conclusions are drawn about residents' skills or interests in other regions or

Table 1

Mean Total and Item PMI Scores

	Mean Total Score (SD)	*Item 1*	*Item 2*	*Item 3*	*Item 4*	*Item 5*	*Item 6*	*Item 7*	*Item 8*	*Item 9*	*Item 10*	*Item 11*
Group 1												
Pre	63.0 (6.84)	5.7	4.8	7.0	6.3	4.5	4.8	6.0	5.3	5.3	6.2	7.0
Post	70.5 (10.03)	5.8	6.0	7.5	7.0	5.3	5.7	7.5	6.5	5.5	6.3	7.3
Group 2												
Pre	65.1 (6.47)	4.8	4.9	6.6	6.9	5.8	5.4	6.8	5.8	5.0	6.0	7.4
Post	63.9 (9.76)	4.3	4.5	6.8	6.5	5.3	5.0	6.9	6.1	5.5	6.3	6.9

PMI—Psychological Medicine Inventory

the effectiveness of Balint training in more-urban programs.

Conclusions

As a preliminary investigation, this study provides enough support for the effectiveness of Balint training in enhancing residents' behavioral medicine skills that a larger study appears warranted. Such a study would have to be large enough to include multiple training programs and require that both the behavioral medicine training and the Balint group training be standardized as curricula. While previous researchers have raised doubts about what constitutes Balint training in US residencies, the American Balint Society has now created a credentialing program for faculty leaders to reasonably assure uniformity of training across groups and programs.[2] With this necessary step, we may now be able to construct larger-scale studies of the effectiveness of this training method for developing more empathic and effective physicians.

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