EXCERPTS FROM

"BALINT SEMINARS IN A FAMILY PRACTICE RESIDENCY"

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... Family Practice Program Director's Dilemmas

The director of a family practice residency program faces many dilemmas in facilitating residents' learning of the relevance of behavioral sciences to Family Practice. The vast panorama of issues in the psychological and social realm related to practice can be approached in myriad ways. There are didactic ways, lectures, presentations, TV tapes (including the resident's using a tape of his own interview), etc. Also very common are preceptor modes in which the senior physician and junior physician work together in the office. This is ubiquitous but has the effect of slowing down patient care and, being one on one, is very expensive. Dr. Ralph Zabarenko, a psychoanalyst, while on the Staunton Clinic Staff worked in Dr. Joel Merenstein's office in this way and their report[1] is of interest. "Rounding" on inpatient service is another approach. There is also supervision in which a psychiatrist or other mental health supervisor has one or two trainees present cases for discussion. Some aspects of the burgeoning consultation-liaison experience and literature are relevant here, see Lipowski[2]. There are various kinds of case seminars in which a case is presented to a group. This report is of using continuing case seminars in a particular way.

Balint Seminars - Development

"Balint Seminars" is used to refer to a method of "research-cum-training" of Family Physicians developed by Michael and Enid Balint in the Tavistock Clinic in London in the early 1950's. Michael was a remarkable human being -- an analyst student of Ferenczi in Budapest where psychoanalysis was less distant from medical practice than in the Western European tradition.

Michael was constantly watching for a way to make psychoanalysis relevant to medical practice and found it in alliance with Enid in the "Tavi" seminars. The reasoning and development is described in the first appendix of the book "The Doctor, His Patient, and the Illness" [3]

As was his practice he began publishing right away, his first article appearing in the British Medical Journal in 1954[4]. Three books contain the best reflection of their twenty years of work in the field. They are: above referred to "The Doctor, His Patient and the Illness," "Psychotherapeutic Techniques in Medicine"[5], now unfortunately out of print, and "Six Minutes for the Patient"[6]. The latter reached print after Michael's death in December, 1970....

...Balint Seminars - Definition and Focus

... What are Balint Seminars? They are small group sessions of physicians with one or two analytic consultants discussing, over time, problem cases and exploring the doctor's options in assessment, in treatment, and in following the case in practice.

"Our aim is to help the doctors to become more sensitive to what is going on, consciously and unconsciously, in the patient's mind when the doctor and the patient are together" [4 (app.1)]...

... More recently I have stated that "The doctor is learning to use himself more effectively as a therapeutic instrument in whatever professional situation he finds himself." He finds an increase in perceptions and ability to think, and learns a wider variety of responses. [13]

As I close these preliminary remarks I'd like to return to two special emphases of Michael. One is -- that an apopropriate training program not take the doctor away from his practice. [4 (app.1)]

The other, he emphasized again and again: "One reason for the failure of traditional courses (and approaches) is that they have not taken into consideration the fact that the acquisition of psycho-

therapeutic skill does not consist only of learning something new: it inevitably also entails a limited, though considerable change in the doctor's personality.[4] (app.1)

In my experience the salient personality change is in the doctor's capacity to listen and to realize that LISTENING IS DOING SOMETHING!...

...Achievements

... The principal differences between using the method in residency and with practicing physicians is that some more time is spent dealing with cases that are "not mine," especially in the first post graduate year (corresponding to the internship year). Considerable time may be spent on the "care" of attending physicians and hospital staff. This can be useful in thinking about different physician's styles, etc., but is not as rewarding, either for the residents or consultants, as discussions of "my case."

We have learned to emphasize very early that this seminar focuses on their family practice and on cases for which they have continuing responsibility. They are strongly encouraged to spend as much time in the family practice unit as is available, and bring those cases to the seminar as much as possible. The early stages of a group is the place where preceptor participation, including presenting a case, can catalyse the group. The most enthusiastic groups settle down to work vigorously after one of the residents has brought a case which stimulates vigorous discussion and alternatives are proposed. When the presenting doctor has implemented one of the alternatives and can report a favorable movement in the doctor-patient relationship and in the care of the patient, a working group is formed.

In the second year of the residency in many ways the most productive work goes on as the residents expand "their practices" and have an increasing number of patients for which they have the prime responsibility. They are encountering the varying issues and problems

that facilitate discussion of previously "assumed" aspects of doctoring. Smarr and Berkow[14] outlined the topics discussed there in one year. There is no stipulated agenda. Attitudes and personal feelings are discussed as long as they are related to practice. Special attention is always given to issues behind the surface phenomena -- to the Actual Reason for Coming[12] which are often outside of awareness of both the patient and doctor at first.[9]

The creative work of the group continues into the third year with more cogent reporting and precision of interventions. After the middle of the year the termination with the patients are active. We have experienced almost universally a reluctance to talk actively about this process to begin with. On our insistence that the residents take an active role in bringing up the fact of the prospective termination and give the patient an opportunity to respond, the process continues to be rewarding but on a different level. Most doctors are surprised at the intensity of feeling. This illuminates what others, including Mann,[15] have stated - that it is more than incidentally productive to be forced to talk about and plan for a considered termination. What is an artifact of residency, as far as long term family practice is concerned, turns out to be useful in facilitating the doctor's realization of what terminations mean to him and his patients. Often earlier terminations in the patient's life are reworked at this time. The many mixed feelings about the termination of the group - and the residency, - and anxiety about getting launched into practice, are alaso discussed....

... Achievements

The awareness is growing that in addition to the skills acquired in the use of the self in practice, and in addition to the knowledge imparted and inducted the seminars serve as a stabilizer in the residency program. When a problem is encountered related to the administration ventilation takes place. We can often illuminate the

issues and conflicts involved. When a problem persists we can say, "Why doesn't the resident group take that up with the program director?" and "Let's get on with the case."...

... Problems

One problem is "What to call the seminar?" At St. Margaret's they've always been called "Psych Seminars." I have objected mildly that they involve the doctor's use of himself and are not limited to psychiatry - but other names suggested have not "taken." (e.g. Seminar in Patient Care; Seminar on the Psychological Aspects of Patient Care; Seminar in Pharmacology of the Drug, "Doctor") At another residency program they are called simply Balint Seminars.

A second problem is: should attendance be mandatory?...

...Every six months the consultants go over the resient rosters and report to the program director on each member of the group limited to the following communications:

1. Attends: regularly, irregularly, never;
2. Participates: actively, occasionally, none;
3. There is: evidence of learning, no evidencde of learning....

... Another unfinished question is what should be the participation of the family physician-preceptor? At first glance it would seem logical that they be included throughout as role models. But other considerations come up. Has the family physician participated in seminars or comparable experience? There is no question that in a new group of physicians unacquainted with the process, the participation of an experienced physician, who presents cases to work on, is valuable. This can catalyze the group process by demonstrating "this is how we work on cases here."

If an untrained physician comes, and is willing to presnet cases and work with the group that can be useful, too.

It is my feeling that during some period of the group's work together, perhaps the second year, the availability of a "role model" may limit the experimentation and creative activity of the group in exploring how they want to "doctor".

One problem that merits special mention is that of the qualifications of the consultants. As originally conceived by Michael and Enid Balint this would be a function of psychoanalysts. Analysts who have a respect for the real and emerging role of the family physician and have experience in consulting with groups, are in an excellent position to do so. It certainly would be appropriate to utilize them when available. Throughout the years, however, it has become clear that there has not been an actual stampede of analysts into this activity.

Some of the issues related to this were explained in the report on the Fourth International Balint Conference and are thoughtfully summarized by Thomas Main in his Epilogue.[17]

It is my own feeling that the crucial issue is the consultant's readiness to facilitate the use of the doctor-patient relationship, the most important single ingredient of family practice, in an ongoing way. It is my impression that many people are available and interested in "teaching" who have limited experience in, understanding of, and ability to facilitate the use of relationships over time and that such "teachers" should be used with caution in this enterprise.

Costs

One of the main problems however is cost, and this is not unrelated to who shall be consultants. As implied above we have found it advantageous to have two and it's even an advantage to have one man and one woman. If these are psychoanalysts this would involve a minimum of $80 per two hour session, ($60 for an hour and a half session) per analyst per week, not including travel time and expenses. Such an arrangement takes a big chunk of the budget. It is

understandable that a program director would watch for ways to get "behavioral sciences" coverage at less expense or for a wider unit of time, etc., etc., etc.

Of course I am prejudiced but I encourage a residency director to undertake careful scrutiny whether he/she can get as much maturation of his residents in effectiveness as family physicians for any comparable expenditure.

I sincerely doubt that any other way of handling behavioral sciences and psychiatry will be more effective in preparing physicians for caring for their patients over time.

APPENDIX I

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