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Meeting with the patient: Between fascination and routine, certainty and doubt – how do doctors cope and develop emotionally and cognitively?

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Dear Colleagues, there is a seductive touch in the theme of our congress. Uncertainty is basically unpleasant and complexity can be overwhelming. However, recognising it can make you a much better doctor. These issues are indeed both important and insufficiently addressed in medical training and in our continuous professional development.

Being a good enough doctor is not only about finding the disease and its cure. It is equally important to know who the patient is, who is suffering. An even more difficult issue is: What kind of doctor and person am I and how might that affect my relationships with my patients? How am I relating to my patients, listening, teaching, reaching out? It is very individual.

We accept theoretically and in principle that the body (of our patients and ourselves) can be the timeless carrier of frustrations, painful emotions and disappointments for example. However, it is the art of clinical practice to relate to this fact. Many GPs are psychologically gifted and have a natural talent for human relationships. Through reflection groups, we can learn to relate to our patients and treat them with a deeper understanding without giving up our efficiency and medical technical thinking. On the contrary – we become more efficient by thinking more clearly about complex matters. This makes for a "deeper" diagnosis of the patient (see Puel below).

Many of our patients come to us with a mixture of "incomprehensible" symptoms and complaints. Often they have a hidden agenda – also more or less hidden to themselves. Now talking psychosomatics: by having encapsulated symptoms in the body, the individual is helped to carry on without being overwhelmed. Until it becomes too much. That is when people consult their GP. These states can also become too much for the doctor. Our own vulnerabilities can be activated (like a neurotropic virus) which may result in these patients being, consciously or unconsciously, maltreated: over-/mis-/undertreated. Hospital doctors tend to take extreme measures to rule this out and the iatrogenic sequelae in these cases may entrap the medical profession forever. However, the risk for enmeshment exists in the GP practice as well and abuse of doctors takes place just as much as abuse of patients. It is crucial for the efficient use of the national health resources that such patients meet with a doctor who manages to both care for the patient and stay with his own common medical sense. We all know this is easier said than done.

We will introduce you to a training method, a professional reflection group named after its founder Michael Balint. A controlled study has proven Balint group work to be very useful for GPs [1]. Adhering to names usually signifies a tendency towards sectarianism, such as Jungian or Freudian. Do not worry. We are not, and we will avoid being seductive.

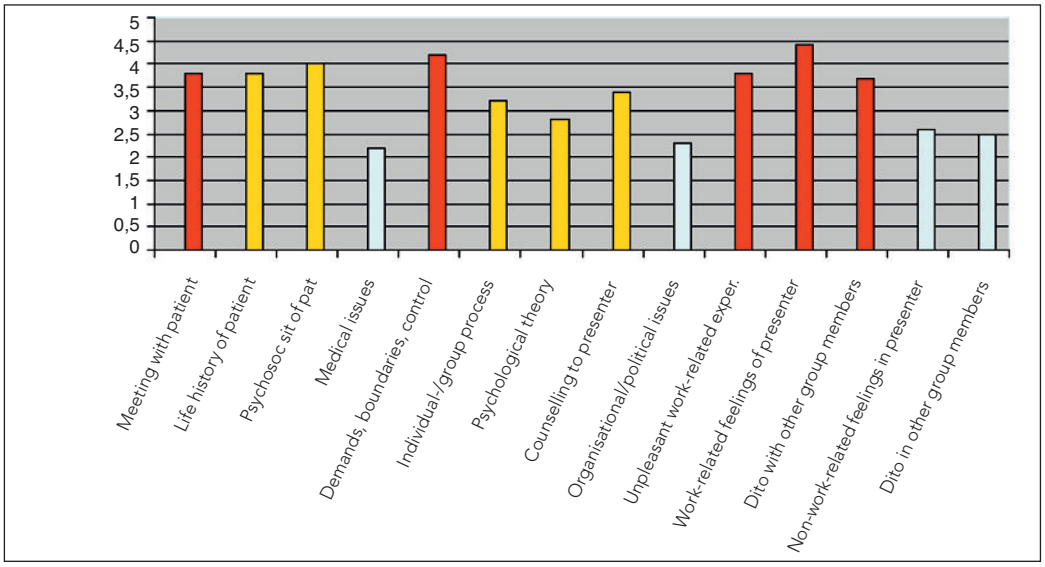

Figure 1
Evaluation of the contents of Balint work over one semester by members of a group of experienced GPs [3].
The core issues (marked red) for a professional development group should score high. Secondary items (marked yellow) are significant but should score a bit lower. Less attention should ideally be given to strictly medical problems, organisational problems and experiences of the group members that are not work related (marked blueish).The diagram above illustrates this assesment. Central Balint work issues take a larger part than intermediary ones, which take more space than non Balint group issues.

The structure of a professional reflection group

Balint groups focus on patient-centered medicine and the doctor-patient relationship.

This focus is *complementary* to medical technology and must be recognised as such if we are to execute our medical skills in an efficient way. Our general message to you today is: *Form professional reflection groups!* But – *do it in a professional way!* This is in order to avoid unexpected side effects and unnecessary negative outcomes.

The group should meet, at least initially, once a fortnight for 90–120 minutes. The group size, including 1–2 leaders, can be 6 to 14 members. Group work, once the trial period is over, is meant to be longterm. There should be an even distribution of case presentations between the group members. The discussions take place under absolute confidentiality!
A Balint group should be supportive and friendly, creating "a safe place" for its members. As experienced leaders, we know it can be difficult for physicians to become aware of their own personalities, strengths, weaknesses, feelings and impact of personal experiences for example. Shame and fear of aggressive criticism can make it hard to talk about difficulties. The leader must have a sensitivity to protect and care for the vulnerability implied when a doctor is exposing his/her uncertainty about daily clinical events, particularly in the beginning. Trust emerges gradually.

The group work – demands and focus of attention
How should group work be done? It has to be adapted to circumstances rather than to dogmas. However, there are many pitfalls and the forming and maintaining of a *working* group demands professional skills of the group leader(s) with regard to:
– group competence
– psychological/psychosomatic competence
– "cultural" competence – knowledge of the working conditions of the group members

As previously stated, it is crucial that the group is perceived as "a safe place" for its members. Consequently, it is important to recognise and maintain the boundaries of the professional development group and to differentiate it from other groups, such as
– group supervision and teaching,
– team super/-intervision,
– administrative/medical decision making conferences,
– psychotherapy groups, active treatment of burn-out syndromes in doctors etc.

The boundaries tend to be overlapping zones [2] which makes it even more urgent for the leader to be observant. One (of many) way of checking that we keep a proper focus in group work, is to use a questionnaire for evaluation and quality assessment. Thus we can i.a. check that the group work mainly stays doctor-patient centered.

Problematic topics often discussed in Balint groups are
– fears of being reported by patients: realities versusprofessional paranoia/obsessiveness
– unresolved painful encounters with patients, guilt feelings
– confusing encounters with patients
– meetings with open conflicts, break-down of doctor-patient relationships
– emotionally overwhelming meetings
– falling in love, seducing situations – both ways!
– fear of being criticised by colleagues and superiors, and disloyal colleagues
– difficult medical-ethical decisions on choice of treatment and other ethical problems and conflicts

Working in Balint groups will not solve all the problems but it will be helpful in increasing the awareness and sensitivity of the doctor. In this way, our clinical work can be improved. One initial administrative step is to make the time for regular Balint group work available.

References
1 Kjeldmand D. The Doctor, The Task and The Group, Uppsala University 2006.
2 Jablonski H. An attempt at defining Balint work – is there a heartland, and if so, which are the neighbouring countries? Proceedings of the 13th International Balint Congress, Berlin 2003.
3 Jablonski H. A method for assessment and evaluation of Balint work, Proceedings of the 14th International Balint Congress, Stockholm 2005.

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PrimarySpots

Der Auftrag

Ich bin
aus einem Nein gemacht
geformt aus wenn und dann
Schicksalsschuldenträger
Echo einer Angst

Ich bin
ein schmaler Felsvorsprung
die Eisschicht auf dem Tod
Tänzer über nichts
Wunschkind in der Not

Thomas Schweizer, Hausarzt in Liebefeld BE