Balint groups and palliative care - a short review

Abstract

The most important element for the treatment of a patient is to recognize the words learned for our masters: “first of all, do not do harm”. As human beings, doctors have been exposed not only to the suffering that comes from the patients, but also the internal emotions that this suffering or another element (i.e. “difficult patients”) brings to the encounter between the physician and its patient. To recognize and understand those elements makes the physician masters of its own intern self and helps primordially the relationship with his/her patient. One way to achieve this equilibrium and understanding is throughout Balint Groups. In this short review we will gather important information about Balint Groups to show the relevance of the topic, as well as demonstrating the benefits of a health care system which includes Balint Groups into the expected skills that some physicians are expected to develop. Our main aim in this short review is also to make each reader aware the importance of Supervision Groups in Palliative Care orientated from Michael Balint perspective. We search to focus on the important aspects of the Balint Groups, as well as it application in Palliative Care.

Keywords: palliative care, psychoanalytic therapy, cancer, encounter, physician

Introduction

The first thing above all in Medicine is to not do harm (primum non nocere). This well-known phrase, which is mostly repeated during medical training in several medical schools, reminds us the importance of a harmless intervention in patients. Nevertheless, when we think about the word “intervention”, mostly images of different drugs or procedures comes to our minds. Perhaps, it is frequent to apply this sentence to considerate which of the following options might be suitable to generate a better response or healing when a person is ill or is dying. But something is missing. We are lacking of consideration, that our own self, our image is also a sort of “drug” for the patient. It is not about the drug we gave, but also how or under which circumstances we gave. It is a sum of factors that are added to the treatment itself, which lay on the physician-patient relationship and must be considered when we heal. In a way, we are like a drug when we stand in front of a patient. Therefore, without willing it, we could modify different psychological structures in the therapy and maybe be detrimental to someone that in that precise moment need us. In a way, without knowing it, we play an essential role in the therapeutic process. That is why, we review shortly about this topic. It is important to be aware of many unconscious mechanisms that play an important role in the interaction with the patient and could sabotage our intervention as planned, ending up in doing more unwilled damage than expected. Our main objective in this short review is to make each reader aware the importance of Supervision Groups in Palliative Care orientated from Michael Balint perspective. We search to focus on the important aspects of the Balint Groups, as well as it application in Palliative Care.

What is a Balint group?

The Balint Groups, named after the psychoanalyst Michael Balint, were supervision groups done in the late 1950s to study the relationship between doctors and its patients. Balint searched in those groups to help doctors to concentrate and to develop hearing skills towards difficult relationships with patients. Later on, the aim of the groups changed towards the focus mainly on the study of the physician-patient relationships. The idea that held Balint, throughout those experiences, is that doctors are similar to drugs. When they communicate with patients, his/her self interacts, playing a significant role on the development of the therapy. He used a term to describe this phenomenon: “the drug doctor”. Our activities, our unconscious emotions, our delays, our misunderstandings express unwilled effects on the medical act, which Balint described as the “secondary effect” of this “drug doctor”. All his observations and experiences with general practitioners were collected and published in his book “The Patient, The Physician and its Illness” in 1957.

Originally they joined around 9 or 10 general practitioners and 1 moderator (a psychotherapist with psychoanalytic orientation). Those groups met once a week, in order to check the progress of the patient regarding the spaked elements of the problematic physician-patient relationship held it before. Nowadays the Balint-Supervision Groups are spread in 22 countries and most of the established techniques have changed through the years. The leader (s) and the group members gather around a circle (traditionally) and before starting, the leader (a psychiatrist or psychotherapist) ask if a member of the group has a study case. In this case, the presentation is absolutely voluntary. There are Balint groups that prepare the case before the formal presentation to the therapist. Other groups make it spontaneously, that means the leader(s) and the group members gather around a circle (traditionally) and before starting, the leader (a psychiatrist or psychotherapist) ask if a member of the group has a study case. In this case, the presentation is absolutely voluntary. There are Balint groups that prepare the case before the formal presentation to the therapist. Other groups make it spontaneously, that means the volunteer talks without any previous preparation about the difficulties and the patient who has been on the physician’s mind. During the presentation, the group must hear the story without any interruption. After the presentation, the leader invites to questions or interventions from the group, related from what was heard. In this section, there are not only formulated questions but advices, emotional reactions and speculations as well. The group leader will gently direct the presentation into the work of the case itself.
There are also variations, depending on the country and the group, after the case is presented. One of them is the clarification of some details. After that, the leader asks the presenter to take situ in order to continue with the exposition of the case. Normally, the presenter remain in silence for the next 20 or 30 minutes.\(^3\) That also guarantees, that the group itself stops making more questions and then the leader began its observations regarding the presented case. The presenter is allowed to respond to what is observed, when he/she is invited to join.\(^7\) Finally the session finishes when the time has run out. One or two presentations, including follow-ups, in a 90-minute session may take place in the next appointment. The presenting doctor may be invited to have the last word of the case. Then the leader(s) should ask for a next presentation for the follow-up. After that, he/she (leader) would thank to everyone. It is not allowed to search for a solution or to give a summary from what it was seen.

**Why it is important in palliative care?**

After we described the main goals and foundations of the Balint Groups, we can see its importance in the daily patient interaction and treatment. More precisely, is the Palliative Care a scenario in which doctors and therapists experience lots of emotions and sensations that could interact with the patient-physician relationship, limiting the healing approach of the medicine. In that case, we can see that many studies have evidenced the importance of a Balint Group in the Palliative Care. Bar-Sela et al.\(^7\) arranged groups of oncologists (junior and senior residents) guided by a psychologist and a senior oncologist, for Balint-oriented meetings. At the beginning, burnout was mostly prevalent between the junior residents. Then, at the end of the sessions, the burnout scores differences decreased, showing that communication abilities of residents have improved through Balint groups, as well as the feelings of self-accomplishment as doctors.\(^6\)

In other experiences, Stelcer\(^7\) have reported that Balint groups are the most effective tools for improving skills regarding intervention with patients. Especially in oncologic palliative care centers, Balint groups help to develop the ability to conduct patients and understand own feelings and treatment process. Most of the Hospices struggle with the difficulty to being related to suffering and decease of patients, and the opportunities to participate in those Balint groups allows to understand all what is involved on the preliminary phase of dying in patients with cancer, says Stelcer.\(^7\)

In a study applied to a nurse staff, von Klitzing have founded that Balint-Supervision groups have a potential clinical application, being helpful in defining which patients caused more stress in nurses, and helped as well to determine the amount of nurses’ involvement from a palliative care unit with the patients.\(^8\) Epner\(^8\) have studied the importance of Balint groups for communication skills in oncology trainees. They developed a monthly, one-hour communication skills training seminars only for first-year-oncology residents, which included a Ballint-type case discussion groups.\(^8\) Results of the implementation of a curriculum based on communication skills reinforcement, which included Balint groups, helps to enhance and expand those skills and could be used for training programs in the future.\(^9\) Abraham,\(^9\) in a literature review regarding the integration of Palliative Care into Comprehensive Cancer Care, affirmed that Balint groups can serve as a forum for discussion and exploration of grief-inducing clinical encounters, and for normalizing these feelings. Clinicians trained in Balint groups orientated to Palliative Care can obtain self-awareness or mindfulness training, especially for what is “moved” or “touch” during the encounter with a palliative care cancer patient.\(^9\) This would allow the clinician to avoid burnout crisis, as well to understand the natural process of death in a patient who is in a palliative care unit.\(^9\) Finally, Arnold\(^11\) describe the different challenges of integrating Palliative Care into Postgraduate Training in Medical Programs.\(^11\) He refers to different alternatives regarding Palliative Care, mentioning Balint Groups as an example. The Balint Groups help physicians to discuss cases that may cause conflict in them, in order to understand how they actually respond to a crisis related to an encounter with a palliative ill patient.\(^11\)

**Future directions and conclusion**

As we can see, it is important to recognize the different elements of the patient-physician relationship and the unconscious emotional aspects of the physician that appear in the encounter, especially in the palliative care units. The important prevention activities for physicians in order to avoid “secondary effects” in the relationship include the Balint groups as an important factor for prevention.\(^12\) With the help of supervisions and Balint groups doctors and health personnel could externalize their most fears, leave the guilt feelings behind, share feelings of helplessness and to obtain decision and security about the case.\(^12\) The mastery or the comprehension of those elements would help to be prepared to help the patient of the palliative care unit. The total liberation or discharge leads to regeneration in direction to a total freely access to patients, whose contact before was experienced as mostly harmful and restricted.\(^12\)

Finally, the training of medical doctors in palliative care should include Balint groups as a milestone for improving emotional skills during the encounter. We have reviewed that in most cases, the importance of a self-awareness and emotional discharge in such groups help to be conscious of the main interactions and problems that occur during the encounter. It is important to end this short review by saying that we doctors are humans who treat another suffering human. That means not only to dominate the main biomedical theories and treatments, but also to recognize the doctor as a person, who with his/her attitudes and words could improve or harm a therapeutic process. Most important is when the patient who is in front of us is someone that is dying. Controlling and understanding our fears and negative emotions will help us to create a self-mastery and to receive the main issues that concerns the patient who is in front of us and leaving behind our own issues that could injure the patient’s emotions and expectancy.

**Acknowledgements**

None.

**Conflict of interest**

The author declares no conflict of interest.

**References**

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