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Have you ever had a difficult patient? You know, the type who comes to your office with a litany of complaints and sicknesses for which there seem to be no solutions, and who expects immediate relief or even a miraculous cure. Or, have you ever lost a patient who was dear to you? You know, the woman who fought valiantly against breast cancer—an exceptional human being, who over time became a friend, almost a sister to you. A person so close to your heart that she will be greatly missed. Or, the young child, struck by a car, and rushed to the emergency department, who despite your best efforts could not be saved. How difficult it was to break the news to his parents, devastated by pain and sorrow. Or, have you ever been attracted to a patient? Oh! The ultimate taboo. An inexorable attraction, that can't be discussed because there is zero tolerance for such feelings.

What do you do then, with these troubling emotions?

Perhaps you talk to a colleague? Perhaps you talk about your day with your spouse or someone close to you? Perhaps you confide in your best friend?

Perhaps?

It is also possible that, assailed by so many emotions, you decide to do nothing. Simply accept the situation. Tough it out. Endure in silence. Isn't this what we expect from a good family physician: to be strong, valiant, and beyond reproach? In academic terms, we talk about expertise and competencies. Until it all becomes too difficult to manage, and you find yourself on the cusp of burnout—or worse, becoming cynical. Therefore, it's not surprising that many family doctors decide to limit their practices and reduce their case loads.

Faced with so many emotions, it is justifiable to ask ourselves if general practitioners should have the right to a "rest area."

On page 245 of this issue, Michael Roberts discusses the matter in a commentary titled "Balint groups. A tool for personal and professional resilience."¹ Balint groups were devised by English psychoanalyst Michael Balint 50 years ago and were initially offered as post-graduate training for general practitioners. Essentially, a Balint group reviews cases reported by doctors and defines the interpersonal challenges they face in an effort to improve patient care and clearly delineate physician services. It is worth noting that this process does not involve individual or group psychotherapy; the


patient-physician relationship remains the central feature of associative work.² The goal is to enable doctors to share viewpoints and discuss events that have had an effect on their professional lives in order to enhance the doctor-patient relationship.

Since then, many variants of the Balint group model have been established, such as Balint-pedagogical and Balint-psychodrama groups. The latter combines 2 techniques: the Balint group and the psychodrama. By introducing the psychodramatic game, the caregiver is asked not only to recount, but also to role-play the patient-physician relationship, and to relive those moments while being observed by other participants invited to take part in the psychodrama.^{3,4}

In his commentary, Roberts asserts that the benefits of Balint groups have been demonstrated.^{5,6} He also mentions that these groups are quite widespread in American academic settings. He cites a survey of American residency programs in family medicine, of which nearly half included Balint groups. In addition, 65% of those surveyed said that participating in Balint groups was necessary.⁷

In Canada, however, Balint groups are rarely part of any academic training programs in family practice (D. Berskon, personal communication, February 2012). Nor are they mentioned in articles published in our journal. Surprising! Are we so much better than others?

Canadian family physicians certainly need a place to talk, whether within a Balint group or another model, allowing them the opportunity to discuss their patients and patient-physician relationships.

A sort of rest area. 

Competing interests

None declared

References

1. Roberts M. Balint groups. A tool for personal and professional resilience. *Can Fam Physician* 2012;58:245 (Eng), e246-7 (Fr).
2. International Balint Federation [website]. *Intro to Balintwork*. Leiden, The Netherlands: International Balint Federation; 2012. Available from: www.balintinternational.com/balintwork.html. Accessed 2012 Feb 2.
3. Cain A. Introduction du psychodrame-Balint dans la formation psychologique des médecins : le psychodrame-Balint : pourquoi? *Psychothérapies* 1993;13(1):7-10.
4. Fontaine F. Le psychodrame-Balint, fantastique instrument de formation de la relation médecin-malade. *Prim Care* 2002;2:12-4.
5. Kjeldmand D, Holmström I, Rosenqvist U. Balint training makes GPs thrive better in their job. *Patient Educ Couns* 2004;55(2):230-5.
6. Kjeldmand D, Holmström I. Balint groups as a means to increase job satisfaction and prevent burnout among general practitioners. *Ann Fam Med* 2008;6(2):138-45.
7. Johnson AH, Brock CD, Hamadeh G, Stock R. The current status of Balint groups in US family practice residencies: a 10-year follow-up study, 1990-2000. *Fam Med* 2001;33(9):672-7.