

Original Publication

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# Group Self-Reflection to Address Burnout: A Facilitator's Guide

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## Abstract

**Introduction:** Inadequately supported clinicians risk burnout, which is prevalent among them. Balint-like groups can be utilized to address clinician stressors and augment interpersonal skills by exploring the clinician-patient relationship. **Methods:** In January 2012, we initiated the Clinical Case Discussion Group (CCDG), based on Michael Balint's Balint group, at the Boston University School of Medicine Section of General Internal Medicine. The CCDG is an interprofessional group discussion founded on self-reflection of patient cases designed to tease out ethical, psychosocial, and medical issues that impact the clinician-patient relationship. The format consists of a facilitator-led small group session including 5-10 minutes of case discussion followed by open group discussion. In April 2014, we conducted a cross-sectional survey of clinicians who participated in the CCDG to evaluate the group's ability to foster skills in self-reflection, empathy, response to patient challenges, personal awareness, and tolerance of uncertainty, and to address clinicians' personal and professional stressors. **Results:** More than 75% of clinicians surveyed agreed that participation fostered skills in tolerating uncertainty, increasing empathy, and navigating difficult patient relationships. All respondents agreed the group developed skills in self-reflection. At least 40% of clinicians reported some degree of isolation, professional stress, and personal stress; group participation addressed these issues at least 70% of the time. **Discussion:** This self-reflection case discussion group, incorporated into academic clinical practice, supports the professional development of a broad cadre of clinicians and addresses both personal and professional stressors. Clinical departments should consider systematically implementing similar groups in practice.

## Keywords

Editor's Choice, Professional Competence, Clinical Competence, Professionalism, Faculty Development, Self-Assessment, Physician-Patient Relations, Group Processes, Balint Group, Educational Medical/Methods, Balint-Type

## Educational Objectives

By the end of this activity, learners will be able to:

1. Demonstrate increased ability to discriminate the patient's emotional needs from the clinician's emotional reaction by identifying these separate needs during case presentations.
2. Improve reflective listening skills as demonstrated by responding to others' case presentations and commenting with curiosity, responding nonjudgmentally, and avoiding problem solving for others.
3. Identify how the clinician's own emotional responses enhance personal understanding of the patient's personality and problems as demonstrated during case presentations.
4. Demonstrate a sense of shared mission and connection by volunteering to present multiple times per year and by sharing one or more thoughtful reflections.

## Introduction

At our university-affiliated, urban safety-net hospital, the primary care leadership in conjunction with faculty developed a self-reflection discussion group called the Clinical Case Discussion Group (CCDG) as a forum to support frontline clinical providers with challenging patients. The CCDG was started to foster a patient-centered approach among colleagues, develop a broader understanding of the barriers to successful patient management, tease out psychosocial and structural barriers such as inadequate social

## Appendices

- A. CCDG Facilitator's Guide.docx
- B. Cases.docx
- C. Survey.docx

*All appendices are peer reviewed as integral parts of the Original Publication.*

supports or health care access affecting patients, and encourage a team-building atmosphere among providers to help address the needs of patients with multiple social needs. On a broader level, it was aimed at increasing provider resiliency and vitality to counter the stress of primary care practice with underserved patients.

The CCDG is modeled after the Balint group, a method of case presentation consisting of a small group of physicians led by a facilitator, usually a psychologist, who discuss the physician-patient relationship in the context of a doctor-patient interaction, normally a clinical office visit or several clinical interactions over time. Michael Balint developed this method to assist physicians who were addressing the complicated medical and psychosocial needs of patients in the context of a devastated post-World War II Europe.<sup>1,2</sup> The Balint group's purpose is to change the way that doctors think about their relationships with their patients, change the interaction between patient and doctor, and eventually use this relationship to facilitate a therapeutic effect on patients.<sup>3</sup>

The Balint group has been thought to help modify burnout among physicians. By definition, burnout is job related and situation specific. It is driven by factors such as excessive job demands coupled with inadequate resources and lack of control.<sup>4</sup> At least 60% of physicians experience burnout at some point in their careers.<sup>5,6</sup> Known causes of burnout include depersonalization, isolation, exhaustion, and lack of efficacy.<sup>7,8</sup> Interventions that target stress reduction among clinicians can reduce self-reported burnout.<sup>9</sup> The Balint group's impact on burnout has not been well studied. Of the few studies that examined the effect of burnout using quantitative measures, most either lacked statistical testing or were too underpowered to detect statistical significance.<sup>10</sup> However, one study did find a significant decrease in burnout after 10 months of participation; a subsequent qualitative analysis suggested that Balint groups may ameliorate burnout by addressing emotional exhaustion.<sup>11</sup> Emotional exhaustion has been associated with work loss (absenteeism and reduced functioning at work) and impairment of emotional and social functioning.<sup>12</sup> Other studies found that practitioners involved in Balint groups were more aware of their feelings, had a greater ability to cope with helplessness, and had less burnout. Participants felt more in control of their work environment, less inclined to refer out, and less inclined to order unnecessary tests.<sup>13,14</sup>

Here, we differentiate the Balint group from the CCDG, discuss the implementation of the CCDG, and present the results of a cross-sectional study to highlight potential benefits of the CCDG. To our knowledge, this is one of the only published uses of a Balint-like innovation among postgraduate providers in an academic internal medicine practice.

#### Description of the Balint Group and the CCDG

The original Balint groups were composed of general practitioners from separate, independent practices who were recruited through advertisements. The participants were experienced full-time physicians and were similar in terms of professional qualifications and experience.<sup>15,16</sup> These Balint groups aimed to shed light on difficult patient interactions, deepen providers' understanding and valuing of interpersonal skills, help providers understand their limits, and maintain a forum for providers to continuously increase their awareness of these interpersonal issues. The groups started with a case presentation followed by group discussion. The groups met weekly in 90-minute sessions. Patient cases were chosen by the presenter and were cases that they subjectively deemed difficult or made the presenter uncomfortable. Discussions within the groups were kept confidential. Today, Balint groups continue to exist, and several international organizations certify Balint leaders.<sup>14,17-21</sup>

Our CCDG is similar to the Balint group in several ways. The CCDG is not meant for teaching and is nonhierarchical.<sup>14</sup> Participants are all practicing clinicians who have completed their training. Case presentations focus on the clinician-patient relationship, and cases are usually presented without the use of notes. Presenters generally volunteer to present cases but occasionally are asked to present by facilitators. In choosing a case, only one guideline is followed: to choose a case that the practitioner subjectively deems difficult or that makes them uncomfortable. Technical and medical details are avoided, and the groups are kept small.<sup>15,20</sup> Like Balint groups, the CCDG focuses on self-discovery and the day-to-day aspects of work.

However, the CCDG differs from Balint groups in key ways. The Balint group is composed solely of physicians: generalists and a psychiatrist facilitator. The CCDG is interprofessional, including social workers, nurse practitioners, and clinical pharmacists, depending on availability and interest. The inclusion of allied health professionals helps broaden the discussion to include interprofessional relationships or the relationship between the provider and the system of care.

The Balint group has a singular focus: how the doctor's personality affects patient care almost independent of the actual treatment prescribed.<sup>2</sup> The CCDG focuses not only on the clinician-patient relationship but also on fostering a collegial work environment. In contrast to the Balint group, team building is an explicit goal of the CCDG. The Balint group is not concerned with team dynamics as the providers involved do not work together. The Balint group also does not have an explicit goal to understand system-level issues in navigating patient care. The CCDG deviates from the traditional Balint group by allowing for customization regarding issues specific to the department and system under which the providers practice and by increasing acceptance by the faculty as a homegrown initiative, rather than one that is imported or top-down.

Patient privacy and confidentiality are an important aspect of the CCDG, as with any other educational medium. Although personal patient identifiers are not shared, some of the clinicians in the group may recognize the patient through the details of the narrative because they have cared for the patient or family members as part of the interdisciplinary team or through cross-coverage. Non-HIPPA-related identifiers such as age and gender and either first name or initials are used in telling the stories. CCDG participants are bound to confidentiality of the discussion content and do not share outside of the group.

CCDG facilitators also deviate from traditional Balint group facilitators. The Balint group is a very specific approach, and its training of facilitators is meant to decrease variance within the groups. CCDG facilitators are not American Balint Society credentialed. Our facilitators were all familiar with Balint groups, but their exposure to Balint groups and the Balint philosophy varied. Experiences ranged from participating in or supervising Balint groups to simply attending a conference on the Balint group or being knowledgeable about Michael Balint and his work. A decision was made to forgo formal training due to the literature suggesting that primary care physicians are adequate leaders for Balint-like groups, the lack of objective data indicating an advantage to the group when facilitators are trained, and the recognition that the CCDG deviates from the traditional Balint group.<sup>14,22</sup>

## Methods

### Implementation

The CCDG began in January 2012 with clinicians affiliated with the adult primary care practice at Boston Medical Center Section of General Internal Medicine. The implementation of the CCDG took approximately 6 months, beginning with repeated discussions with clinical leadership and two sessions in which the CCDG was described for clinical faculty and staff during clinical meetings. Two months prior to the sessions, the discussion groups were included in the department schedule, the physical space needed for the sessions was reserved, vendors were identified for refreshments, and a core group of facilitators and backup facilitators were identified. We sent announcements and reminders at least 1 month prior to our first session and a week prior to each subsequent session. The groups were generally held in a

conference room or the charting rooms at the clinic. We provided a continental breakfast before each group meeting. Each group had one defined leader or facilitator per session. Additional facilitators participated as group members. Of note, no audiovisual materials were used in the groups. Presenters were identified ahead of time by volunteering to the program coordinator or lead facilitator.

We invited frontline attending physicians ( $n = 57$ ) and certified nurse practitioners ( $n = 6$ ) to participate. Occasionally, nonphysician clinical staff, including social workers and clinical pharmacists, participated in the group. All CCDG participants were practicing clinicians who had completed training. Approximately 30 providers attended the CCDG on a regular basis. To maintain functional group sizes, three groups ran simultaneously, with about eight to 12 people in each group. The six facilitators included four clinician-educators, a psychologist, and one clinician-investigator. Two facilitators were assigned to each group; however, one facilitator served mainly as a backup role to cover absences. A facilitator's guide is included in Appendix A, and a sample of cases discussed in previous CCDG meetings is provided in Appendix B. Each session lasted 60 minutes. A sample agenda follows:

- 0:00: check-in to review ground rules.
- 0:05: case presentation.
- 0:15: interpretation of the clinician-patient interaction/relationship (going around the room one by one).
- 0:30: open discussion.
- 0:55: wrap-up and close.

Case presentations focused on the clinician-patient relationship. Presenters volunteered cases on an ad hoc basis or were encouraged to present based on discussions with individual providers throughout the weeks prior to the group. The case presented was chosen by the presenter. Presenters were instructed to choose a case they perceived as difficult. Case presentations lasted 10 minutes, after which each listener was given the opportunity to individually offer reflections on both the case and the clinician-patient relationship. After everyone had spoken, the facilitator opened the group up to free discussion of the specific clinician-patient relationship or meaning of the case to participants. Technical and medical details were minimized to focus on the clinician-patient interaction. The facilitator encouraged group members to avoid either problem solving for the presenter or sharing their own similar stories ("me too") in order to focus on the presenter's case. Near the session's close, it was the facilitator's responsibility to alert the group to the approaching end, wrap up any last-minute comments, and remind participants about the next meeting. The groups met six to eight times per year.

#### Evaluation

A survey assessed the CCDG's impact on clinicians' interpersonal development and professional well-being. The main outcome of interest was interpersonal skill building. In addition, we looked at relevance of the discussions to daily practice, clinicians' ability to prioritize clinical actions or discussions with patients, and practitioners' impressions of isolation, professional stressors, and personal stressors. The survey included items adapted from prior studies, modified to reflect the practice, experience, and common wording used in our practice.<sup>23-25</sup> After three physicians completed a pilot survey, the survey was revised and distributed to all participants during a CCDG in April 2014 (see Appendix C).

#### Data Analysis

We performed a descriptive analysis of the data and analyzed the relationship between responses and demographic or clinical characteristics using the Fisher exact test for categorical responses or Wilcoxon rank sum test for continuous measures. We dichotomized responses for each section for the purpose of this analysis. For example, we categorized responses of "strongly agree" and "agree" as "agree" (see Appendix C). A mean was calculated for all numerical answers. We used SAS, version 9.3, for our analysis.

To examine the responses to the open-ended questions, two faculty separately reviewed all responses. Themes were developed through this preliminary review. The raw data and preliminary themes were

presented to the facilitators (led by Dr. Jane Liebschutz). Final themes were developed through an iterative process with the facilitators. Discrepancies were resolved through discussion and consensus.

## Results

We distributed the survey to 35 clinicians who attended the CCDG in April 2014, and 25 surveys were returned (response rate: 71%). Table 1 shows the demographics of survey responders. The majority of providers were female ( $n = 16$ , 67%) and were physicians ( $n = 17$ , 71%). Seven (29%) were nonphysicians.

**Table 1.** Participant Demographics<sup>a</sup>

Demographic	No. (%)
Gender	
Male	8 (33)
Female	16 (67)
Clinician type	
Physician	17 (71)
Nurse practitioner	6 (25)
Clinical psychologist	1 (4)
Years at BMC	
<5 years	8 (33)
5-10 years	4 (17)
>10 years	12 (50)
Proportion of job in direct patient care <sup>b</sup>	
7 half-day sessions/week <sup>c</sup>	8 (57)
≤6 half-day sessions/week	14 (43)

Abbreviation: BMC, Boston Medical Center.

<sup>a</sup> $N = 25$ . One survey was inadvertently destroyed prior to analysis, so only 24 were analyzed.

<sup>b</sup>Two missing data points were not included in the chi-square analysis.

<sup>c</sup>Full-time = direct patient care for at least seven sessions per week.

Providers rated these discussions as highly relevant to their daily practice using a five-point Likert-type scale (1 = *low*, 5 = *high*). The mean relevance score of group discussions to daily tasks was high for the ability to prioritize activities ( $M = 3.6$ ,  $SD = 1.2$ ), to communicate ( $M = 4.2$ ,  $SD = 1.1$ ), and to manage conflict ( $M = 4.2$ ,  $SD = 1.1$ ). Experienced clinicians rated their ability to prioritize activities higher than less experienced clinicians ( $M_s = 4.08$  [ $> 10$  years],  $3.75$  [ $5-10$  years],  $2.75$  [ $< 5$  years],  $p = .05$ ). All participants agreed that the CCDG fostered skills in self-reflection ( $n = 24$ , 100%), and the majority ( $> 70\%$ ) agreed that it fostered skills in the other skill areas. The ability to tolerate uncertainty and be aware of blind spots varied by group (Table 2). Nearly half ( $n = 11$ , 46%) of the providers identified isolation and personal stress as a moderate or serious challenge, and 16 (67%) described professional stress to be a moderate or serious challenge. There was no association between the perception of stress or satisfaction and any particular demographic or clinical characteristic. Seventeen (71%) participants found that the CCDG addressed isolation, 18 (75%) personal stress, and 20 (83%) professional stress.

**Table 2.** Developing Interpersonal Skills

Question	No. (%) Agreeing				<i>p</i>
	All Groups	Group 1	Group 2	Group 3	
Participation in the CCDG has fostered skills in:					
Self-reflection	24 (100)	9 (100)	6 (100)	9 (100)	1.00
Ability to tolerate uncertainty	18 (75)	5 (56)	4 (67)	9 (100)	.03 <sup>a</sup>
Empathy	21 (88)	8 (89)	4 (67)	9 (100)	.12
Increased flexibility to tolerate uncertainty	21 (88)	7 (78)	5 (83)	9 (100)	.20
Increased awareness of my own limitations or blind spots	17 (71)	4 (45)	4 (67)	9 (100)	.02 <sup>a</sup>

Abbreviation: CCDG, Clinical Case Discussion Group.

<sup>a</sup>Indicates statistical significance.

In response to our open-ended questions, participants described the CCDG as unique due to its emotional emphasis, unstructured format, small-group size, and personal nature. Of the 14 who responded to the question about how they would improve the groups, seven providers wrote that they would not change

the format. Nine participants provided suggestions, including increasing the frequency of sessions, increasing the number of cases discussed per session, and having preselected topics. The majority of participants enjoyed the groups, but two noted that they would like more closure at the end of the sessions or specific take-home points.

### Discussion

The CCDG is an easy-to-implement, high-impact innovation with the potential to address the personal and professional needs of a broad group of clinicians, including primary care physicians, nurse practitioners, and behavioral health providers. Providers found the discussions relevant. The group fostered skills such as the ability to tolerate uncertainty, empathize more effectively, and respond to patient challenges while simultaneously addressing providers' own professional and personal stress.

Implementation of the CCDG was made possible by the support of primary care leadership and buy-in from clinical faculty. Clinical leadership provided the protected time needed by clinical faculty to participate in the monthly hour-long sessions, the platform to introduce and promote the CCDG among faculty, and material support such as breakfast. The faculty provided the cases and voices that shaped the group and the discussion. In the organizational culture, the faculty felt unified in the mission to care for the underserved. The structured small-group format allowed the faculty to deepen this sense of connection through honest and open discussions.

The CCDG itself competed with other priorities of the department, including other meetings and educational conferences, making it difficult to have regular monthly sessions. It was also necessary to have a minimum number of backup facilitators available for each group meeting. Prior to implementation, we needed to orient participants through announcements and open discussions months before our first group session. Even though approximately 30 providers attended the CCDG on a regular basis, this was only about 45% of eligible providers ( $N = 66$ ). This level of attendance is in line with other faculty meetings (which involve all faculty, including hospitalists, community-based physicians, and researchers) with a typical attendance of 55%-60%. Further work to promote attendance at CCDG could include incentives for participants such as CME points, reports listing positive outcomes, and clinician champions to support the groups.

Our results are consistent with observations about Balint groups and extend the utility of such groups to an experienced broad cadre of experienced professionals who work together in a primary care clinical setting. Physicians are reluctant to seek help for mental health conditions and stressors, and interpersonal skills are also important for clinical leaders and frontline providers.<sup>26</sup> These skills can help providers respond to patient challenges. In fact, physicians join groups like these explicitly to learn to handle difficult relationships. Physicians find these groups to be a useful forum where they can discuss difficult patients and ethical dilemmas and develop relationships with colleagues.<sup>22,27</sup>

We acknowledge several challenges and limitations to the CCDG format, including lack of appropriate comparison groups, low response compared to the number of group participants, and heterogeneity of the sample. Of note, the difference in group ratings may have reflected facilitator ability or experience. Thus, another step would be to have trained facilitators observe each other and give feedback on the facilitation after receiving the different ratings. In this self-selected group of providers, response bias and social desirability bias may also have affected our results.

This clinical innovation has shown potential to improve the clinical experience for practicing academic clinicians while developing their interpersonal skills and awareness necessary to treat difficult patients or challenging populations. We also found the groups to be acceptable across a heterogeneous population of providers, and that the innovation may be feasibly implemented within the general schedule of a busy academic clinical department.

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#### Ethical Approval

This publication contains data obtained from human subjects and received ethical approval.

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