


Virtual Balint Groups During COVID-19: Exploring Race and Equity in a CHC-Based Family Medicine Residency Program

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Abstract

The Lawrence Family Medicine residency was created in the 1990s as the first community health center- sponsored residency with the goal of reducing health disparities. Balint groups have been a part of the wellbeing and behavioral health curriculum for many years. The population of Lawrence, MA is primarily a resource-poor, Latinx, immigrant population. In March of 2020, the Covid pandemic highlighted health disparities in this community. The spike in cases in 2020 also impacted the residency community with overwhelming needs of sick and dying patients in newly created, resident and faculty-run Covid units. Our early ignorance about transmission, prophylaxis, treatment and even prognosis made the work incredibly difficult. George Floyd's murder added the additional stress of social unrest in response to a persistent pattern of racism and unequal justice. To help process trauma residents felt working in terrifying conditions, often in medically futile situations with patients who spent their last hours without family at the bedside, we turned to biweekly Balint groups and added additional resident support sessions on the off weeks. Residents seamlessly adopted videoconferencing as the Balint platform, allowing them to attend a group session without risk of infection. The residents, being a diverse group, were able to offer multiple perspectives and process the traumatic issues of disproportionate suffering for their patients, uncertainty and frustration of the COVID-19 pandemic and systemic

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racism. We found a video Balint group permitted residents to explore their divergent experiences and feelings and offer support to each other in a very uncertain time.

Keywords

balint, COVID-19, videoconferencing, family medicine

Introduction

The events of the early spring and summer of 2020 were undeniably shocking. As family doctors working in both outpatient and inpatient settings, we watched as the world was swept up into a global pandemic and were witness to before-unimagined levels of suffering and death. In our community health center in northeastern Massachusetts, we also witnessed how this suffering was not evenly distributed, but instead was more commonly impacting communities of color and those living in poverty. As a means of processing and growing from this experience, we turned to our Balint groups, expanding them to include faculty and modifying aspects to create a safe environment for discussing the racial and economic inequity we saw in our own community. Ultimately, Balint served as a solid backbone for our discussions. Here, we aim to describe our experience with Balint groups and Balint-inspired discussion groups focused on issues of racial inequity on a virtual platform. We will share our efforts to engage as a community regarding challenges of diversity, equity, and unequal suffering during the emotionally charged early months of the COVID-19 pandemic. With the benefit of the Balint principles of divergent perspectives, time for reflection and opportunities to vent and share hurt, our discussions were rich and thought provoking. As expected, this was not accomplished without challenges. We hope to continue to learn from our challenges and build successful group spaces to suit our community's needs.

Lawrence Family Medicine Residency (LFMR) is a 4-year residency program operated out of a community health center in a largely immigrant community. We recognize the importance of diversity in enhancing our ability to be the physicians our community deserves. Lawrence, Massachusetts is a small city comprised largely of recent immigrants to the US from mostly the Caribbean, Central and South America. According to the most recent US census data available, approximately 80% identify as Hispanic/Latino, and 78% speak a language other than English at home.¹ Spanish is the predominant language spoken by our patient population, with small clusters as well of Vietnamese, Cambodian, Haitian-Creole, and Portuguese. Our community health center was founded with a purpose: to address the unmet medical needs of this immigrant population. Similarly, the residency program grew out of a calling to train the next generation of physicians to care for our community and other communities like it. With the needs of our community in mind, LFMR provides a dedicated Spanish language curriculum with the goal of proficiency by the end of residency, significant

community medicine involvement, and a health systems curriculum to further understand models of care delivery.

Balint groups have been well-established among 2–4th year residents for many years and were reinvigorated just prior to the pandemic with the training of family doctors to lead groups. Balint groups are intended to help group members explore professional relationships more deeply and to purposefully engage in cultivation of empathy. It seems natural that this type of group would lend itself to discussions of diversity and equity. The American Balint Society's (ABS) core values of authenticity, compassion, empathy, and reflection are certainly necessary for any open discussion of difference. Furthermore, ABS has recognized the value of diversity within Balint groups stating, "greater diversity enhances the Balint experience, which provides a safe space of inclusiveness and safety for discussion of difficult dialogues, and exploration of personal or collective biases."²

Experiences of COVID-19 at LFMR

When COVID-19 came to our community, the health center, community hospital, and residency program worked together to begin to care for the sick, the dying, and the scared. In March – June 2020 Lawrence was one of the nation's hardest hit communities, and our hospital and clinic were quickly filled with suffering, requiring rapid adaptations to how we delivered care. Our residents and faculty staffed the COVID-19 unit created at our hospital, worked alongside our intensivists to care for the critically ill, and staffed an additional intensive care unit for ventilated patients with the diagnosis of COVID-19 pneumonia. The hospital was transformed into an eerie dystopia, as physicians around the country will remember in their own hospitals. Plastic sheeting hung in corridors. Faceless doctors and nurses cared for countless patients, pinning nametags and enlarged photos onto protective gowns to maintain some level of humanity in our work. No visitors were allowed, so families said goodbye to their loved ones via phone calls, and residents sat in lieu of family, holding hands and offering what little comfort they could. After a breathless death, phones were sanitized, and our physicians in training moved on to care for the next patient waiting in the emergency room for a bed.

As medical professionals, we had limited understanding of how the virus was transmitted or how it affected our patients, as evidenced by the often changing and confusing guidance from the CDC. Additionally, personal protective equipment (PPE) shortages had us sterilizing disposable N95 masks for re-use, utilizing face-shields made from at-home 3D printers, and rallying donations from local businesses. We had even fewer tools to treat our patients. Despite the hard work of many at our institutions, the disparities in care for COVID-19 were stark. At first, we did not have remdesivir, the first antiviral available that had any efficacy against the virus. Our patients who needed it were transferred to academic centers in Boston, 28 miles away. Those patients whose treatment was successful came back to Lawrence weak and flaccid, sometimes requiring feeding tubes to maintain their nutrition. Families would learn how to use

various machines in the home, taxing families and primary care clinics that were already strained by the pandemic. Later, we did not have enough ventilators for all patients who needed them, requiring weighty decisions from our physicians and physicians in training to distribute limited resources. And when even ventilators failed those who needed them, there was extremely limited access to extracorporeal membrane oxygenation (ECMO), a machine that provides oxygen to the body while bypassing the lungs. Without this, patients died in Lawrence, leaving our providers to explain to family members that this treatment was simply not available to their loved one.

On May 25, 2020, as cases were finally declining in our COVID unit, George Floyd was murdered. This was a tremendously difficult time for our residents and faculty, especially those from historically marginalized backgrounds and those who identified as Black. As protests erupted around the country, there was little support from our hospital administration towards the Black Lives Matter (BLM) movement. It was a divisive time at our hospital. The health center administration encouraged engagement, discourse, and visual shows of support for BLM, going so far as to purchase lapel pins for any interested residents to wear. On the other hand, hospital employees were discouraged from wearing or exhibiting supportive statements for BLM in the hospital setting. Our residents and faculty, already exhausted from helplessly watching our mostly black and brown community suffer the brunt of a pandemic, went to work advocating for a show of support. This ultimately resulted in a new diversity, equity, and inclusion committee at the hospital.

Balint Groups and the Crises of 2020

This time was emotionally draining for most residents and faculty. There was significant cognitive dissonance: caring for an underserved community that experienced significant racism and othering, while not being able to express or support a movement that advocated for the very patients we served. We turned to our experience with Balint to help our residents and faculty start to heal from the compounding traumas we were experiencing as a community. We also had to adapt the Balint process to the ongoing crises: first, we were forced to transition our previously established bi-weekly groups to a virtual platform. Then, as we appreciated the power of coming together as residents, we invited faculty to a virtual Balint group as well. Finally, we utilized Balint principles to create support groups specifically to engage in conversations regarding the racial trauma and disparities we were seeing. While these were not classic Balint groups with a case and presenter, Balint-trained faculty were able to create a safe space for divergent perspectives and difficult conversations.

Transitioning Balint groups to a virtual platform was fairly seamless. There is some evidence that Balint groups can be successful in a virtual setting, with the study most similar to our situation coming out of rural Australia.³ The authors found improvement in scores of work-related well-being with the introduction of completely virtual Balint groups with rural general practitioners. A separate qualitative study published in 2014

demonstrated that utilizing videoconferencing to have virtual group leaders was overall successful, but faced challenges related to technology and scheduling.⁴ Our program was already familiar with the use of Zoom[®] within our clinic, so all participants already had an account and knew basic functionality. Our other didactic learning sessions were also moving to a virtual platform, so it did not take long to become comfortable with this method. Furthermore, we had a strong culture of Balint groups already established, which helped our transition. Obviously, we had our concerns: confidentiality, active participation, lack of eye contact and a general lack of “togetherness” that we were all missing during the height of the pandemic. We ran these virtual Balint groups biweekly. Groups ran smoothly and conversation delved into the deep crevices of the cases with ease. Groups were well attended, but not mandatory. We did not require participants to be visible on video so that our colleagues driving in after working at home for the morning could also participate. As we felt successful with resident virtual Balint groups, we explored adding faculty to our groups.

Groups that included residents and core faculty were similarly held on a virtual platform. Some of the faculty had worked on the wards with residents, but many had experienced COVID only from the outpatient perspective. A case was chosen ahead of time that had touched many residents and faculty. Despite this, with the addition of faculty, the conversations were more stilted and less candid. The faculty had more difficulty expressing their emotions and processing how the family or the patient could feel. It required more work from the leaders of the group to keep the conversation flowing smoothly. Despite these efforts, the residents were by and large the only ones to speak. Ultimately, it was felt by residents that this was not a particularly beneficial endeavor because it felt like the residents were being observed while participating in their Balint group. Several factors likely contributed to this. First, the group was much larger than a resident-only group, which may have affected how willing people were to share their thoughts. Second, while residents had had significant Balint group experience, most faculty were new to Balint groups. Third, the faculty contingent is less diverse on average than the resident group across multiple dimensions, so we had difficulty producing diverse perspectives, which made the group discussion feel less rich.

Eliciting divergent perspectives from group members is one of the most fundamental Balint techniques and we utilized this facet of Balint to make space for processing and healing around the racial trauma we were experiencing. Instead of case-based groups, we held open space among residents to simply discuss experiences, feelings, reactions, and ideas about what we were seeing in our community and what was happening on a larger scale around the country. While these were not classic Balint groups, the core principles of authenticity, compassion, empathy, and reflection were imperative to creating a supportive environment to process the trauma of inequity and the racial violence occurring across the country. These groups were a limited addition to our Balint and support curriculum. Our Balint-trained faculty members facilitated these group discussions and found that the training they did at the leadership intensive course helped them create a safe space and allowed them to draw out themes. Balint leaders

have been shown to understand group dynamics, create accepting groups, and accomplish group tasks.⁵

Conclusion

As we look back, our knowledge of and comfort with the Balint method was a source of strength as we navigated the emotionally draining months of the COVID pandemic, with its tragedy, suffering, inequity and the social unrest stemming from continued racial violence across the United States. We were able to transition our bi-weekly Balint groups to a virtual platform with residents, which was successful in many ways. It was one of the few ways in a virtual world that we were able to feel connected as a resident group experiencing a shared trauma. We have seen attrition in attendance in recent months to virtual groups, but better attendance in person, suggesting there is some component of Balint that cannot be replicated virtually. We were able to include our core faculty members in our Balint groups, even if only briefly. It was not initially successful, but making smaller groups and including faculty more frequently so that the process is not so foreign may make them more fruitful. Currently it's not what our program needs, but we hope to continue to reassess what Balint can provide to us as a learning community. Lastly, we were able to utilize our Balint skills to facilitate a challenging discussion surrounding race, inequity, violence, and trauma among residents. This was not case-based, but instead a safe space for sharing and discussion. There is certainly room to grow, and as circumstances change, we must adapt. We will continue to utilize Balint to connect among residents and faculty as we strive to provide equitable, compassionate healthcare to our community.

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