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The Doctor, the Task and the Group

*Balint Groups as a Means of Developing New
Understanding in the Physician-Patient Relationship*

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Abstract

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The general practitioner has a central position in the health care system, but demands have increased and there are signs of exhaustion in the corps. Patient-centredness is beneficial for the patients and probably for the outcome of health care. In Balint groups general practitioners study and gain further understanding of the physician-patient relationship by means of the participants' own experiences.

This thesis aims at studying experienced effects of Balint groups on the working life of general practitioners. General practitioners with and without Balint group experience are compared by means of a questionnaire, using statistical methods. General practitioners with Balint group experience are interviewed. Both these studies show positive experiences of Balint group participation in the physicians' working life in terms of feeling of control and satisfaction, and on relations to patients, particularly patients with complex problems.

A new instrument for measuring physicians' degree of patient-centredness is presented. It can be used in groups of physicians to evaluate training programmes or by the individual physician to detect decline in patient-centredness as an early sign of burnout.

Balint groups are viewed critically in interviews with Balint group leaders, focussed on difficulties and dropouts from the groups. Balint groups are found to fit into modern theories of small groups as complex systems, submitted to group dynamics that are sometimes malicious. Professionally conducted Balint groups seem to be a gentle, efficient method to train physicians, but with limits. Participation of a member demands a stable psychological condition and an open mind, and obligatory Balint groups are questioned.

The thesis concludes that Balint groups are generally beneficial for general practitioners' working life as a means to enable the physicians endure, even thrive in their job. The method facilitates development of new understanding of the physician-patient relationship with possible positive effects for the patient as well.

Keywords: General practice, Balint group, Patient-centredness, Competence, Physician-patient relationship, Continuous professional development

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List of Papers

This thesis is based on the following four articles, which will be referred to in the text by their respective Roman numerals:

- I. **Balint training makes GPs thrive better in their job.**
Kjeldmand D, Holmström I, Rosenqvist U
Patient Education and Counseling 2004;55:230-235
- II. **How patient-centred am I?
A new method to measure physicians' patient-centredness.**
Kjeldmand D, Holmström I, Rosenqvist U
Patient Education and Counseling (in press)
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- III. **Satisfaction and sense of security.
GPs' experience of Balint group participation –
a qualitative study.**
Kjeldmand D, Rosenqvist U, Holmström I
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- IV. **Difficulties and dropouts in Balint groups.**
Kjeldmand D, Rosenqvist U, Holmström I
Manuscript

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Cover: "The general practitioner caught between a rock and a hard place".
Limestone formation at Moens Klint, Denmark, photographed by the author.

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1. Prologue

”Don’t just do something – sit there!”

(M. Courteney, member of one of the first Balint groups, in a lecture for the Swedish Balint Society 1997)

Some years ago I returned to my practice after four months away for research and one of my first patients was a man who had been my patient for ten years. We had been through a great deal together, his partner’s illness and death, his own desperation and depression afterwards, and his worry about how he would be able to take care of his children himself. He was a frequent visitor because of his chronic illnesses and fear of cancer. He always gave me a box of chocolates at Christmas.

Before I called him in I looked through his records and my heart sank. He had been many times both to my colleagues and at the emergency ward because of a severe pain following a herpes zoster which he had had some months before. I couldn’t think of any medication that had not been tried, and I was anxious when he came in – what could I do?

He greeted me, gave me the chocolates with a brief embarrassed smile and sat down. “I have been really ill and nobody has helped me”, he said, “so I came here last Friday again, but when the nurse said that you would be back again today, I thought that I would wait. Since then I haven’t had any pain and I have slept during the night, without medication. What should I do now with all my jars of pills?”

I cannot think of a more beautiful example of the extraordinary power and importance of the physician-patient relationship. If I hadn’t already understood that, I would have been even more embarrassed than the patient, but instead I relaxed and thought: “of course – that’s right, I have been away. I am back now and that’s important, and that’s how it should be.”

This was a good encounter and a good physician-patient relationship that lasted for many years. It was not an easy one and the patient was often worried and sad. He was not healthy and not too complying, but we made the best of things and endured it together. Patients like him are common in general practice and the frustration of not being able to cure them weighs heavily on the shoulders of the general practitioners. They can handle these relations in different ways. They may close contact at arm’s length and claim that this patient’s problems are not the responsibility of the health care system. Alternatively they may struggle to satisfy the patient’s needs by taking

in all their sorrows and giving back consolation until the physician's soul is empty and sad and burn-out knocks at the door.

I think that I understood what happened in this encounter because I had been a member of a Balint group for several years. In the Balint group, we had talked about our patients and how it felt to meet them, and about our fears and ambiguities and, little by little, understood more about what the physician-patient relationship was all about. How you can talk openly about feelings with patients and ask the difficult questions about peoples' miserable lives that give them headaches and loss of lust. We had learned that in the consultation we have the responsibility to make the patient feel safe and able to look at his or her life with new eyes. To create this safety for the patient we as general practitioners need to feel safe and have courage. We should not be afraid. What was after all the worst possible scenario? That we did not make it in time for coffee, or that the patient got angry? It almost never happened, but the numbers of deep, rewarding encounters increased. We experienced that these patients that we called "uschh" (the sound you make when you see their name on the day's list) changed into fellow humans full of nuances, and we had regained our empathy towards them. The most fascinating experience was that just talking about a difficult patient-relationship could solve it; the next encounter was often much easier.

The reader of this thesis will probably benefit from knowing that I have been a general practitioner for 18 years and I have been a member of a Balint group for more than 10 years. I have studied to become a Balint group leader and lead two Balint groups for four years.

My Balint group membership has been a strong and important experience, which I wanted to share with as many colleagues as possible. My preconception was that Balint groups are good and that was my incentive to do this work. This view has become much more diversified during the research process.

2. Introduction and aims

According to both popular and professional literature, several of the actors in the health care system of today suffer badly. The public are afflicted with distrust, the patients feel dissatisfied [1] and the health care workers are tired and burned-out [2-4]. The physicians are confused over their role, healers or gate-keepers, and the costs rise [5, 6]. How can we address these problems?

The personal meeting between the patient and the physician is central in health care. The encounter takes place between two persons who both contribute with experience and competence, necessary for reaching the goal of the encounter. It is a challenge to help the patient without sacrificing the physician. This means that the encounter should be both patient-centred and physician-centred at the same time. This is the focus of the work in the Balint groups. Thus Balint groups may contribute to solve some of the problem of the modern health care system. Physicians in the Balint group can learn how to understand their role and meet the patients in a patient-centred way, make use of their professional competence and at the same time protect them selves against burn-out.

Yet, if Balint groups are to be introduced in a larger scale as a means to increase both general practitioners' work satisfaction and their competence in the physician-patient relationship, it is necessary to be critical and scrutinize the method. Balint groups have not been studied from this point of view. Indeed, there are few studies done, and they are short termed and not directed at whether Balint groups affect physicians' well-being at work. Comparative studies are few as they involve considerable methodological problems, and they do not include specialist general practitioners. The way the general practitioners comprehend their physician-patient relationship and their role in it is important, because their comprehensions may affect their actions [7]. Yet no instrument exists that can measure these comprehensions. The experiences from satisfied members of Balint groups with focus on possible effects on the members' work-life are not studied. Furthermore, when Balint groups are effective in some ways do they have side-effects as well? Whether Balint groups can do harm to people has not been studied.

To explore these issues the studies of this thesis were performed, to investigate the experiences of the protagonists, the members and the leaders of the Balint groups.

Outline of the thesis

This thesis has three main areas of interest: the general practitioner, the task of general practice and the Balint group.

I will start by giving a background to these aspects in Chapter 3. First I will describe general practice in Sweden and then some aspects of the task of general practice, specifically the concepts of patient-centeredness and improvement of competence through reflection. Thereafter I will go into the field of groups for health care professionals in general, and Balint groups in particular. Then the methodological background of the thesis is described.

Next the four studies are presented. In Chapter 4 and 6 the implications of Balint group participation for the general practitioners are described. In Chapter 5 the physician's personal view of patient-centeredness is focussed on. The fourth study takes a critical viewpoint in actively seeking negative aspects and problems in Balint groups and is presented in Chapter 7.

In Chapter 8 I discuss methodological and ethical issues in this field of research. Finally, in Chapter 9, follows a discussion of the overall results and their implications for practice and further research.

Here and there quotes from the interviews with general practitioners and Balint group leaders will be used as illustrations.

In this thesis I address myself not only to the scientific society, but also to general practitioners as well as other people interested in Balint groups. I have chosen an outline that I hope will satisfy the expectations of those readers.

Aims

The overall aim of this thesis is to study Balint groups and their effects on the general practitioner.

Specific aims of the studies

- I To determine whether and how general practitioners participating in Balint groups differ from other general practitioners with regard to satisfaction with their work situation and their perceived competence in handling patients with psychosomatic problems.
- II To describe a new method to determine physicians' own understanding of their patient-relationship with regard to patient-centeredness.
- III To study Balint group-participating general practitioners' experience of the influence their Balint group participation has had on their working life.
- IV To study possible negative aspects of Balint groups by exploring Balint group leaders' experiences of difficulties and dropouts in their groups.

Overview of the studies in this thesis

Study	Participants	Data collection	Data analysis
I	41 general practitioners :	Questionnaire	Student's T-test
II	20 Balint group participants and 21 as a reference group		
III	9 general practitioners with more than 2 years in Balint group	Interview	Phenomenological analysis
IV	8 Balint group leaders	Interview	Systematic text condensation

Table 1. Overview of the four parts of the thesis, the participants and the methodologies.

Terminology

I have chosen to use the term “general practitioner” and “general practice” in stead of “family physician” and “family medicine”. I consider the differences between them insignificant, which is supported by the literature [8].

Doctor means teacher, physician healer, but somehow “doctor” connotes to relationship more than physician does. Michael Balint used the term “Doctor” [9] and so has the literature that followed in his footsteps up to our days [10]. I have chosen to mostly use the term “physician” because it is used as a specific designation of persons practising the profession of medicine.

Competence will be used as equivalent to capability, which is in concordance with The Oxford English Reference Dictionary, although some recent literature differentiate between the phrases [11].

The term “young physicians” will refer to physicians in their educational stages and not yet specialists, thus including both interns and residents.

3. Background

In this chapter I will describe general practice, characteristics of the speciality, the education and the organization of general practice in Sweden. Then I will try to give a picture of the working conditions of many general practitioners in today's primary health care. The working conditions determine to a large extent how the physicians can execute their tasks, which is the next subject to be described. Here I will concentrate on the relational aspects, namely the concept of patient-centeredness, and omit the medical tasks. I will then give a short introduction to theories on how competence can develop by means of reflecting on and understanding of one's work-experiences. Thereafter follows a chapter on groups. First the historical background of the Balint groups, a description of the method and the literature. The issue of obligatory Balint groups is touched upon. Then the theory of small groups as complex systems is described and put in relation to psychodynamic concepts, relevant to the methods conducted in the Balint groups. Then I go through some different types of groups for health care professionals, each of which resembles and differs from Balint groups. The chapter ends with some basic issues on methodology and rigour in research.

The general practitioner

Ideally the general practitioner should be both generalist and individualist. Generalist in the meaning of being knowledgeable about all specialities within medicine in the widest sense and even about life as such. The general practitioner should be able to recognize signs of illness and health in all the forms that they take in the individuals. Therefore individualist, meaning to know the people who show the signs that they want interpreted, because signs have different meanings in different people. The general practitioner should use both aspects the whole time. General knowledge from multi-centre studies should be applied to the patient in the consultation if it works there as well [12].

I have come to realise, that it is very much problems with relations and their own problems, that the patients come for. That the medical problems are not always that big, or that they are quite easy to solve or not – either they are easy to solve or they cannot be solved. [...] If one only was involved with

the biomedical issues there would not be much to do, I think, but so much is about the patients' attitudes to illness and suffering. (participant)

The speciality of general practice

General practice was established as a speciality in Sweden in 1982 with the introduction of a compulsory training programme in general practice.

The political intention in Sweden is to let primary health care take a leading role in the health care system, both as a gatekeeper towards the specialized and expensive hospital care, and as a promoter of primary and secondary prophylactic health care especially aimed at the national diseases, e.g. diabetes mellitus. The financial means have not really followed the political intentions [13] and the financing of primary health care has not covered the increased demands from the public. The proportion of general practitioners has slowly increased and about 15% of new specialist authorizations in 2004 were in general practice [14].

The speciality of general practice has had difficulties finding its common foundation and defining the task. Important work has been done both internationally [8] and in Sweden [15] to accomplish this. The speciality is defined as the integration of the broad generalized medical competence with the expertise in the individual perspective of the patient. It is essential that young general practitioners incorporate this theoretical foundation in their education because it will give them the possibility to gain an integrated and defined professional identity.

Education and continuous professional development

Basic medical education in Sweden is 5½ years at university, followed by 18-21 months of internship. In order to specialize as a general practitioner the physician has to work five years as resident at a primary health care centre. This includes formal courses and periods of duty at specialized in- and out-patient clinics. The resident physician plans the education together with the supervisor and the medically responsible manager, who decides when the resident has reached the level of a specialist.

Sweden has no official control system of general practitioners' education after specialization. The Swedish Medical Association has set as a desired goal that 10-15% of the work time should be spent on education [16]. Yet this is far from the reality. The average work time a Swedish general practitioner in 2000 spent on education was 1.5 hours per week [17].

The medical industry has to a large extent taken the initiative to educate the health care professionals and sponsored education has been popular among general practitioners. The last years' discussion of bribery has made the authorities put strict limits on these activities, and other organizations have started to arrange courses. The future will reveal who is going to take

responsibility over the general practitioners' continuous professional development.

Organization

In Sweden most general practitioners work at Primary Health Care Centres and are employed by the County Councils. Many organizational models have been tested, depending on local circumstances e.g. political majority in the county councils. Approximately 25% of the health care centres are run by private enterprises and are most common in the large cities. During the last decades radical changes to the organization have been implemented several times with varying success. Basic agreement and ambitions exist among the involved parties that the primary health care, impersonated by the specialized general practitioner, should be the core of the health care system, and that all citizens should have the possibility of a steady general practitioner contact. A common way to organize this is to let people write their names up on the list of a general practitioner. The optimal size of these lists is a matter of discussion; the Swedish Medical Association recommends 1500 patients for a full-time working general practitioner. At the moment this is impossible to implement because there is a shortage of general practitioners [18]. The recruitment to the speciality has been difficult because of the speciality's low prestige and reputation of hard work.

Working conditions

The scenario of a general practitioner's work life could be described in the following way: a flow of encounters with people presenting all kinds of problems from the most innocent pain in a muscle to fatal diseases or severe mental conditions. The general practitioner is expected to meet every patient with interest and empathy and must be skilled enough to distinguish between those who need the attention of specialized colleagues and those who are better off staying in primary health care. This should be accomplished quickly in the stressful atmosphere of a full waiting room with competing disturbances of young colleagues and nurses asking for advice. In addition to this, the general practitioner should answer telephone calls from public authorities, the patients and their relatives or colleagues from the hospital. The general practitioner is responsible for the population on his or her list, in case of vacancies even for patients from other lists, and in addition nursing homes, child welfare centres and other commitments. Apart from personal encounters there is the administrative work. To that comes the obligation to take part in the training of interns and residents, education programmes and quality improvement projects.

This may seem like an exaggerated description of a nightmare, but is the way many general practitioners work [5, 19], and as long as it is manageable

it can be enjoyable. Hard-working physicians are not unusual, but the problem rises when they lose control, when the work-related stress turns from “the spice of life” to “the kiss of death” [2, 20, 21]

Physicians today experience changes in their prerequisites of work. In the industrialized countries the traditional values and the nature of the medical professions are questioned leading to the need for new guidelines [3]. Changes in the health care sector have challenged the traditional role of physicians in several ways [5]. Today, a physician’s work does not carry the same high status as it did before, and general practitioners are of the opinion that the public is more demanding and less respectful of medical professions than before [22]. In addition, the patient’s rights to information, to choose between caregivers and to get a second opinion have recently been strengthened in Swedish legislation [23]. Furthermore, physicians have previously possessed appreciable autonomy and been the leading power in the health care team, an influence that is no longer evident [24].

The general practitioners’ encounters with their patients include emotionally difficult situations, witnessing suffering, anxiety and death, as well as contacts with despairing or demanding patients that cannot be satisfied [25]. Many general practitioners are confused about their role and obligations in an increasingly secularized and diversified world where people seek explanations and solutions to their miseries in the health care system [22, 26]. During the past decades, the Swedish health care system has undergone major structural changes and financial cutbacks. These financial cutbacks have resulted in staff reduction, and increased distress and workload among personnel [4]. Stress and job dissatisfaction among physicians might in turn negatively affect the care and satisfaction of patients. Patients are more dissatisfied and complain that they have not been listened to [1, 27], which might result in repeated visits to health centres and unnecessary referrals. Investments in technology and organization as well as the patient’s own resources cannot be fully used. Thus, the physician-patient relationship is the core of the profession, but while it is often gratifying, it is also a source of severe emotional risk [4].

Lack of control is one of the factors that may lead to burn-out [21, 28]. There are serious signs of exhaustion among general practitioners [6, 29]. In a survey in 1998 among members aged 55-64 of the Swedish association of general practitioners, less than 50% planned to continue work fulltime till the age of 65 and 20 % planned to finish completely aged 61. Similar results were obtained in a survey in England in 2001 [22, 30, 31]. These senior physicians constitute a large part of the corps, and their experience and competence is important especially in training and tutoring the next generation of general practitioners.

Hence, the general practitioners need help to gain control over their working life. This may be achieved by defining and limiting their task. Let us now look at the task of the general practitioner.

The task of the general practitioner

How can we define the task of a general practitioner? As curing ordinary people for their ordinary diseases? Yes, but although knowledge of medical details and practical skills is necessary, it is not enough. The relation to the patient must be established before the agenda for the encounter can be agreed on and the medical procedures begin [32]. Often there are no medical problems in a strict sense; the patient's visit to the general practitioner is grounded on psychological factors, e.g., fear of illness, social discomfort or unhappiness [9, 26]. This means that the range of problems that turn up in the encounter is extremely wide and it is crucial not to turn discomfort or unhappiness into illnesses. Iatrogenesis is a strong force [9], and if the doctor tells you that you are sick, then you probably are, even if you just feel unhappy. At the same time the general practitioner must detect "real" medical disease, in need for biomedical treatment. This means that the task of the general practitioner is to see, meet and understand the whole patient in his or her whole context, in other words, be patient-centred.

We have discussed it, we call it: "the view of wholeness" – but what is "wholeness"? Sometimes it is not just the patient, but also the spouse, who comes in and talks the most. And in fact, wholeness is also both patient and doctor, both make a wholeness that we must acknowledge, and Balint has assisted, of course. To see wholeness and the immense importance the context or the wholeness has to how a person feels. (participant)

Patient-centredness

Already 50 years ago Szasz and Hollender (1956) described three different basic models of the doctor-patient relationship: (1) the model of Activity-Passivity, the active doctor does something to the passive patient, resembling the adult-infant relationship; (2) the model of Guidance-Cooperation, still with clear active-passive component, but in which in a more subtle way, the patient obeys the expert doctor who has the power in the relationship, as between adult and child; and (3) the model of Mutual Participation, with two grown-up persons joined in a partnership aimed at enabling the patient to help himself [33]. These models are still applicable on the physician-patient relationship.

Michael and Enid Balint were among the first to introduce the term of patient-centred medicine [9, 34]. They both contrasted "patient-centred" to "illness-centred" and discussed the risk of the split in the doctor between curing physical illness and being a psychotherapist. They perceived that the general practitioners in their groups found ways of being flexible to the needs of the patients, to be open to "the variety of ways the doctor can be used".

The concept of patient-centredness has been discussed and elaborated by many authors, e.g. [8, 35-39]

Levenstein, in [40], defined six interconnecting components of a patient-centred process:

1. Exploring both the disease and the illness experience
2. Understanding the whole person
3. Finding common ground
4. Incorporating prevention and health promotion
5. Enhancing the patient-doctor relationship
6. Being realistic.

Mead and Bower clarified the concept further and defined five aspects of the patient-centred physician-patient relationship [41, 42]:

1. The bio-psychosocial perspective, a perspective on illness that includes consideration of social and psychological (as well as biomedical) factors.
2. The “patient-as-person”, understanding the personal meaning of the illness for each individual patient.
3. Sharing power and responsibility, sensitivity to patients’ preferences for information and shared decision-making appropriately to these.
4. The therapeutic alliance, developing common therapeutic goals and enhancing the personal bonds between doctor and patient.
5. The “doctor-as-person”, awareness of the influence of the personal qualities and subjectivity of the doctor on the practice of medicine.

In this definition they include explicitly the physician as an active participant in the relationship in a new way. Not as the power-active and patient-pacifying illness-focused doctor, but as a human being with good and bad qualities, empathetic ability, blind spots and susceptibility to disturbing events in daily life.

This is coherent to the description of patient-centred medicine by Enid Balint et al’s as a “two-person” medicine. The physician and the patient are influencing each other all the time and cannot be considered separately [43]. It is recognized that the understanding of emotional exchange as an expression of transference and counter-transference can be used for therapeutic purposes with great impact (see page 30).

Roter analyzes the nature of the patient-physician relationship and suggests the term “relationship-centred” medicine as more comprehensive than patient-centred because it “recognizes the role of relational reciprocity to optimal integration and synthesis of both the biomedical and life world perspective” [37]. The relationship is a system of powers and a theory that only recognizes one of the persons will be insufficient. A high patient power in combination with a physician that does not exercise any power, will lead to

consumerism and the clinical competence of the physician will be of no value to the patient [44].

Estimating patient-centredness

The concept of patient-centredness may be difficult to grasp and thus estimating it naturally is even more difficult. As McWhinney expresses it: “Our first task is to recapture the capacity to respond to our patients prereflectively and spontaneously”, in [40]. How can we measure prereflectivity and spontaneity? Or is it a question of measuring communication skills? [45] Counting the number of questions from the physician to the patient about psychosocial background, or maybe the number of seconds that the physician lets the patient talk before interrupting? And is patient-centredness the same in all cultures? [46].

The literature on measuring patient-centredness is voluminous and rich. A multitude of methods are described and used, some of them are tested for reliability and validity. Here I will only mention the two prevailing. A well-known coding method is Roter’s Interaction Analysis System (RIAS) in which behaviours of relevance to patient-centredness in recorded consultations are coded [47]. Pendelton’s consultation schedule is commonly used in educational settings [35].

One of many problems of measuring patient-centredness is the indistinctness of the definition of the concept [48]. The whole discussion of patient-centredness has the characteristics of an area of intense development, where authors make their own definitions and instruments for research. Different instruments are compared, as Mead and Bower do thoroughly in their review from 2000. They conclude that no existing instrument took into account the above mentioned fifth dimension of patient-centredness, the doctor as person [41]. The instrument described in Study II aims at meeting this need.

One interesting question is whether patient-centredness is always equivalent to high patient satisfaction and thus can be measured by patient-satisfaction instruments [49, 50]. Patients may be satisfied with less than optimal care [32, 51, 52]. Alternatively they may prefer traditional physician dominated care giving little room for doubt and insecurity [53]. Patients may even prefer bad care. Examples of this could be antibiotics for common cold or groundless sick leave certificates.

Developing new understanding may sometimes hurt [32, 51, 54]. Maybe patients occasionally have to be provoked or a little dissatisfied in order to understand something new about their condition and thereby become more capable in qualified self-care.

Patient enablement may be one result of a patient-centred approach, but do we know anything about outcome?

Outcome of patient-centredness

Is it important how the physician meets the patient? Does it have implications for the patient or for results of the health care system?

As mentioned above there are considerable problems in answering these questions. They depend on the different definitions of the concept of patient-centredness and the problems of deciding what the outcome that could be investigated is. Still much research has been done and I will present some of it.

The majority of the published literature demonstrates high patient satisfaction with and preference of patient-centredness, and here the evidence is quite convincing [55-58], but not conclusive. Ong et al found that the affective quality of the consultation, whether the doctor was angry or friendly, and not patient-centredness, was the most important factor in determining these outcomes [59].

Effects of patient-centredness on the health care system can be studied on several levels. One level is the diagnostics, and some studies demonstrate that patient-centred practice increased the efficiency of care by reducing the number of diagnostic tests and referrals [58, 60], a topic considered in Study I. Another level is to demonstrate effect on the health and the health care behaviour of the patients, and some studies do this [51, 58, 60].

The complexity of the concept of patient-centredness and thereby the difficulty of comparing studies in this area is demonstrated in a review by Michie et al. They found two distinct ways of patient-centred behaviour, either the health care professional focussed on understanding the patient's perspective or they sought to activate the patient into taking control in managing of their illnesses. The latter had the best association with good health care outcomes than the former [61].

This research has quite convincingly demonstrated that the patient-centred approach is positive for the satisfaction of the patients. The evidence is not quite so convincing when it comes to the outcome on the level of medical effects and health.

What patient-centredness does to the physicians is less investigated. Haas et al find that the patients of physicians who have higher professional satisfaction may themselves be more satisfied with their care [62]. Is the patient-centred way of meeting patients of any value to the physician or is it expensive in terms of time and energy? Study I and III may contribute to answering this question.

If we accept patient-centredness as a desirable and reasonably evidence-based goal, the next question that arises is how to teach physicians to be patient-centred. Here follows a short presentation of contemporary theories of how competence can develop through reflection.

Competence

Competence development is traditionally seen as the acquisition of attributes such as knowledge, skills and attitudes. This view implies that the learning process only involves increasing the amount of knowledge and skills, transferred from the teacher to the student [7]. Contemporary theories have shown that competence is the result of how people understand their work. Thus competence development must involve a new and different, or at least revised, understanding of the studied elements of one's work [63]. This can be accomplished through reflection on lived experiences from the everyday life [7, 11, 64].

Recounting stories of patient encounters and reflecting on what happened and how one as physician felt, thought and acted is a powerful way of learning [65]. It is a way to understand how intuition and evidence-based knowledge were amalgamated with the emotions in the room emanating from both patient and physician and led to decisions [66].

Sometimes new understanding arrives suddenly, as a revelation. In the Balint group literature this is called "flash" [67] and is probably equivalent to Aristotle's "peri-petia" [68]. This means watching a well-known phenomenon and suddenly seeing and understanding something new in it.

The process of developing new understanding through reflection may be painful as it may reveal insecurity and unmask previous misconceptions [64]. Tolerating limited anxiety and allowing constructive and respectful critique may facilitate the learning [9]. This puts demands on the organizers and group leaders in securing firm frames and rules of confidentiality [11]. The processes in the groups should promote and not hinder the feeling of safety that is vital for the members' development.

The next chapter will be on groups. First I will present the Balint group, the historical background, the method and the literature. I mention the issue of obligatory Balint groups. Then some theories on groups are presented: The small group as a complex system, Wilfred Bion's theory of basic assumption groups and Renè Girard's scapegoat theory. Finally some psychodynamic concepts are explained, as they are important parts of the Balint group method.

The group

Groups are basic ingredients in all our lives. We participate in groups in many different connections: in our family, at the workplace and in our free time. Some groups are big and loose, and others are small and tight. Yet they are inherent in being a human being. I will start this chapter by describing Balint groups, which are the focus of my thesis. Next, I will illuminate some theories and basic concepts about groups in general.

Balint groups

History and organisation

Michael Balint was born 1896 in Hungary, as a son of a general practitioner. He studied medicine in Budapest and qualified as a doctor in 1918, but moved for political reasons to Berlin in 1919. Although biochemistry had been his first interest, psychoanalysis became his speciality for the rest of his life. He moved to England with his family in 1939 and worked as a psychoanalyst in London until his death. He published books and articles on sexual functioning and on the development of human relations and founded the British Object Relation School of Psychoanalysis [69-71]. The most well known of his contributions is the Balint groups, which he initiated together with his second wife, Enid Balint, at the Tavistock Clinic in 1951. He saw the general practitioner's central role in the health care system in being the first person to meet the patients' complaints, and the impact of the general practitioner's reaction to them. He invited general practitioners to participate in "training cum research groups" where he led discussions of the physician-patient relationship starting from the physicians' encounters with their patients. His book "The Doctor, his Patient and the Illness" came out in 1957 [9] and since then formations of Balint groups and Balint Societies began to spread around the world [72, 73]. Michael Balint died in 1970, and his wife Enid continued the work and was an important person in the Balint group activity around the world. The International Balint Federation was founded in 1975 and organize International Balint Conferences every second year with delegates from the whole world.

Balint groups in some countries, for instance in the USA have been seen mostly as an educational activity during residency in general practice [73, 74], while in Europe most Balint groups consist of general practitioner-specialists with a wide range of experience.

Balint groups in Sweden

The first Balint groups in Sweden were started by Lennart Kaij, professor of psychiatry in Malmö, in the late 1960s, after he had visited the Tavistock Clinic and attended Michael Balint's groups [75]. The interest among Swedish physicians was low until the 1980s when groups were started at several locations and work-shops were arranged. In 1985, the activity was organized as The Balint Section under Association of Medical Psychology in The Swedish Society of Medicine. The 7th International Balint Congress took place in Stockholm in 1989 as did the 14th in 2005. A formal two-year-long course of Balint leaders has been arranged twice in Stockholm, 1998-2000 and 2003-2005.

Balint groups in Sweden can be initiated by physicians, Balint group-leaders or by the county councils. There are often considerable practical problems connected to this, which is probably why the number of groups in

Sweden is low. The problems consist of the general practitioners' feeling of stress and shortage of time, making it difficult to get together enough general practitioners to form a group, lack of leaders, especially in the countryside, and reluctance from the managers of health care centres to let the physicians spend time on this kind of activity. The number of active Balint groups can only be estimated because no obligation to report exists. According to the latest inventory in 2003, approximately 40 groups are active in Sweden, about half of these with residents. Some other specialists are engaged in Balint groups and a few Balint groups exist for physiotherapists and occupational therapists [76].

The Balint group method

A Balint group consists of 4-10 physicians who want to improve their competence in the physician-patient relation and the encounter with the patients. The group is characterized by stable frames, concerning members, schedule and confidentiality, and meets every 1-4 weeks for 1-2.5 hours. There are one or two leaders in each group. They are most often psychotherapists, psychoanalysts or general practitioners, and have had special training in the method. The discussions start from one member's account about a patient-encounter that raised emotions, worries of some sort or was just puzzling. After telling the story and presenting the problem the presenter should be allowed to be quiet, listening and receptive, while the other members discuss and reflect their feelings, associations and thoughts, which the case has initiated.

The role of the leader(s) is to keep the frames and rules, protect the presenter from attacks and questioning, and seek to focus the discussion on the emotions and fantasies of the group members around the related encounter. Medical, technical and organizational issues are avoided, but now and then psychodynamic concepts are named and explained. A very important duty for the leader is to keep the discussion limited to the professional experiences of the members. Their private life is not discussed and the group is not allowed to develop into a therapeutic group.

Example of a case in a Balint group, (short and fictional version):

Leader: Has anybody got a case?

Doctor A: Yes. I have this woman, a little younger than I am, and she has this pain in her neck and shoulders. Has had it for several years. And she comes here so often and she is so depressed. I have prescribed antidepressant, which she takes, but I don't see any improvement. She cries and it is so heavy – I can hardly bear it. And I feel sorry for her, but I don't see how I can help her; she is so lonely and everything in life is against her - so she's stuck, somehow.

Leader: Now the group can talk about it, but leave A in peace for a while.

Discussion follows where several ideas and propositions come forward that could explain the "stuckness" of the case. Then this happens:

Doctor B: I don't understand it, A doesn't sound like she used to. It is as if she is like the patient, without hope and power. I wonder if she feels she is the patient.

Now A cannot keep quiet anymore: Oh yes, I can see it! I identify with the patient. And then I am completely useless to her, I can't help her. I have to stand back, be myself and find my strength again in the relation.

This is an extremely abbreviated example of how new understanding can be created in a Balint group. "A" understands in a new way some important aspects of her relationship with the patient. In the group a parallel process (see page 30) is enacted where she takes the role of the patient and is negative and pessimistic, just like the patient. While the group discusses the case, "A" sits back, listens and reflects. When "B" relates his feeling that "A" is changed (as an expression on the transference/counter-transference going on in the relationship, see page 30) she is able to grasp this and understands suddenly the relationship in a new way. This new understanding makes it possible for her to meet the patient in a new way and search for new openings together with the patient.

The Balint group method focusses on training, not teaching [9]. The groups continue for years, and gradually a sense of security develops allowing the members to undergo the "little but significant change in their professional personality", described by Michael Balint. This change takes time; according to Balint two years are needed [77].

In the Balint group the patient case is a means to focus the physician in the physician-patient relationship and is not in itself the issue of attention. The physician keeps the responsibility of the patient's care and treatment. This is emphasised, and the fact that the patient's name is not revealed strengthens this principle. This is a point where the Balint group method differs from many supervision groups, where the supervisor by virtue of the status of expert, shares responsibility with the trainee for the specific, identified patient.

The Balint group method has developed successively and other methods than verbal discussions have come into use. Leaders with different psychotherapeutic training and skills have made use of their competence aiming at further enlightening the physician-patient relationship. These methods have for instance included role-playing and drawing. At the international meetings in 2003 and 2005 more profoundly new ways of conducting the groups were presented. Some of these are sculpturing [78], active and guided imagination [79], and "prismatic" Balint groups [80]. Moreover behavioural psychotherapy, which is increasingly used in primary health care, influences the work in Balint groups. Naturally this gives rise to discussions among Balint group people about what is the right method and where the limit goes to what a real Balint group is. How much can the method in the Balint group be changed and it can still be called a Balint group? Michael Balint himself is described

as a person with great curiosity and open to new influences, always willing to try new ways, but he was also rather authoritarian and had a great charisma [71]. The Balint movement resembles in some ways a religious movement with the subsequent risks of fundamentalism.

Literature on Balint groups

The internationally published literature is limited on the training effects of Balint groups [81]. In "A Study of Doctors" Balint let the leaders, all psychoanalysts, assess each member's progress in the groups. Half of them were judged to have improved their skills [77]. Several attempts have been made to do controlled studies on the effect of Balint group participation both including residents and specialist, but they have the weakness of short time intervention of less than one year [82-84]. In a controlled study Turner showed a group of family doctor residents (n=6) significantly improved their abilities in behavioural medicine after nine months Balint group participation, compared with residents (n=8) who did not participate, measured with the Psychological Medicine Inventory [85]. The British literature uses a narrative case description technique focussing on the process in the physician-patient relation, continuing the tradition of Michael Balint [10, 43, 67, 86]

Lately some interesting articles on leader techniques and process in Balint groups have been published in the USA [87-89]. A whole issue of *The American Journal of Psychoanalysis* in 2002 was about Michael Balint, mostly from a psychoanalytic point of view [71].

Musham and Brock tested and interviewed frequent and infrequent Balint group-attending residents and found that intuition was more pronounced among the frequent attenders. The interviews gave the impression that there are two sorts of residents, those who benefit from and thrive and develop quickly in Balint groups and those who do not, and the proportion is about 50/50. They also questioned whether the latter could be hurt by attending and not feeling successful in the group [90]. Johnson et al did extensive psychological testing of family practice residents in order to detect differences between residents who continued Balint groups for two years and those who chose to finish after six months. The two-year attendees were with statistical significance more intuitive, but no other differences were found [91].

There have for many years been Balint groups in Israel, which has lead to publications about themes and developments in the groups [92, 93].

An interesting research project has been carried out in London on Balint groups with general practice residents. An anthropologist was invited to study the groups. This approach revealed unexpected and to some extent negative aspects, but the report has not been published yet [94].

The interest in doing research into Balint groups is growing judged by the works presented at the international meetings. This includes a willingness to study the group processes with fewer prejudices, and there are evident signs

of a development towards more critical and less fundamentalist attitudes in this research.

Obligatory groups

... in America everybody does it with resident groups, and so, everybody knows all the resistance or dropout tricks. For dropouts who are sitting around the table. They will read charts, they will go up and down. They will come in fifteen minutes before it's over. They will ask all kinds of very engaging but diverting questions ... (leader)

Obligatory Balint groups are sometimes used as a part of the education of young physician. The frequency of this is unknown, but in the USA about half of the residencies in family practice conduct Balint groups. Of these 27% are voluntary and 65% are mandatory [74].

Obligatory attendance in groups where personal experiences are supposed to be discussed raises ethical questions[95]. The function and life of a group is strongly influenced by its initiators and their purpose for initiating the group. The members in the group will relate to the other members and group's tasks in accordance with their motivation of being there. As explained on page 26 the members of concocted groups may focus on satisfying the demands of the external forces that run the group [96]. The external forces are, in the case of obligatory Balint groups for resident family physicians, the faculty who at the same time has the power to reject the student. In situations of conflict between single or groups of students and the faculty, it will inevitably affect the work in the group. The leader may be regarded as a representative of the faculty and it may be hard to create a trusting and confident atmosphere in the group.

Balint groups can also be characterized as obligatory with the purpose of protecting the activity from the surroundings' claim on the young physicians. In these groups the attendance is not recorded to the faculty and it cannot be used as a means of pressure on the participant. Yet the obligatory status of the Balint group makes it possible for the young physicians to leave their clinics and attend the group. Thus the confidentiality in the group is protected and the single member makes the choice of participating.

Is it obligatory?

Yes. Obligatory in a rather undramatic way, because once a week they have a course on a variety of things, and they leave their work, because these groups are during work time. And so they meet the chief physician or head of some clinic who talks about something or other, and then sometimes it's me. (leader)

The group as a complex system subjected to psychodynamic forces

I will here present some theories on groups in general. They contribute to the understanding of Balint groups and how they work. The theories have different origins and help to enlighten the phenomenon of small groups from different angles. I find both psychoanalytic theory and complex system thinking useful and I venture to mix them in the following. Complex systems are systems that are neither rigidly ordered, nor highly disordered [96, 97]. The complexity of groups makes them individual and unpredictable phenomena; no two groups are totally alike and no two groups will develop in the same way.

Local, global and contextual dynamics

A group is constituted of local dynamics, of members using tools to do tasks, individuals with individual motives, competences and characteristics. The members give rise to and are constrained by global dynamics, processes in the group. The group and its members depend on and affect the surroundings, the contextual dynamics [96]. These dynamics are all influenced by on the one hand conscious and rational motives and wishes; and on the other hand hidden agendas and unconscious motives [98].

Initiating forces

The formation of a new group can take place in four fundamentally different ways. The formation forces can be external or internal, the process can be emergent or planned, as is illustrated in Fig 1.

The four different ways are: (1) *Circumstantial* groups start coincidentally and unplanned, initiated by environmental forces, like for instance survivors in a lifeboat after a shipwreck. (2) *Self-organised* groups are unplanned, but emerge out of peoples' personal motives and desire to do something together, like friendship clubs and many choirs. (3) External forces can be the initiating force in a planned action as in working teams and other organisational groups, and this is called *concocted* groups. Here the motive to form the group derives from the initiating organization and not primarily the members. They may therefore focus the work in the group on satisfying external demands from the organization. (4) Groups that are planned and started on the initiative of the future members are called *founded* groups and here the members will coordinate and integrate their own goals, intentions and expectations [96].

These initiating forces are important factors in the start and further development in the group, but the dynamics in the group will also be strongly dependent on how the members act. No group is formed if members do not make contact and behave as group members.

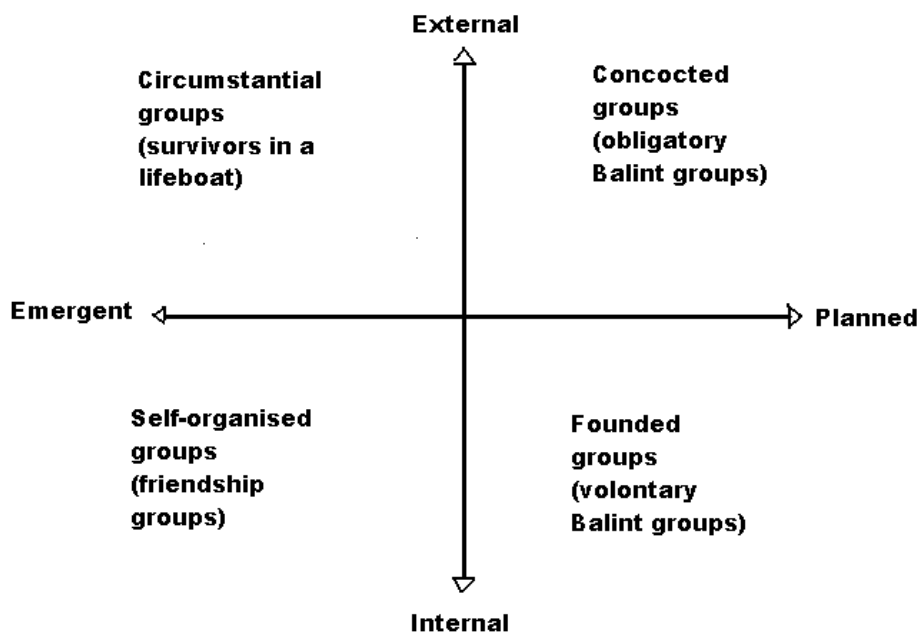


Figure 1. The four group-initiating forces and examples of groups emanating from them [96].

The ongoing group

The three dynamics of groups: the members, the group itself and the environment, have different aims and needs that the group is supposed to satisfy. The aim that should be easiest to define and clear to everyone is the work task. In the case of the Balint group it is to study and gain further understanding of the physician-patient relationship by means of the participants' own experiences. However, the group should also satisfy emotional needs and these are often diffuse, obscure and more or less unconscious. Mostly it is normal needs of good company and feeling warmth and sympathy in a group of fellows. But it may also be the organisation's need of pacifying troublesome staff members or a group member's need of being victimised.

The group will live its life under the influence of the multitude of needs and satisfy the demands more or less successfully, often undulating between focusing the work task and the emotional needs [98].

Working groups and basic assumptions

Willfred Bion(1897-1979) is well known for his theories on groups [99]. He defined "the working group" as characterized by its task, the assignment that is the reason for its existence. It can make use of the available resources, develop adequate structures, handle frames and develop tolerance and capa-

bility to contain insecurity and anxiety emerging from the group's work [98]. He also defined three different emotional processes that can occupy the group, the so-called basic assumptions. They are: (1) "The dependency group", whose existence is dependent on one person, most often the leader, who is unconditionally admired. (2) "The fight-flight group", constantly struggling against enemies for its existence, fighting or flying, tolerating sacrifices on the way. (3) "The pairing group", anticipating something wonderful being created in the future, often by two members in the group [100]. However, one important aspect of group dynamics has not been addressed by Bion, and that is the scapegoat mechanism.

Scapegoat

René Girard (born 1923) described theories of the mechanism of scapegoat as a fundamental human behaviour [101, 102]. In groups rivalry or conflicts between members can become organized into a unified aggression towards one member. From rivalry between everybody in a general chaos into a stable chaos in the group, where all but one are united against one, the scapegoat, who will be expelled from the group. The expelled member is a personification of the group's aggression and the group will for some time after this ritual feel relieved and comfortable. The scapegoat may be an ordinary member, but most often the person has some special attributes, gender, race, opinion or handicap. In a Balint group the "handicap" could be problems with empathetic ability leading to difficulties understanding what the method is all about and presenting "wrong" cases [90]. One characteristic feature about the scapegoat phenomenon is that it dissolves as soon it is recognized. Girard regards the scapegoat mechanism as universally fundamental in rites and much of his production focuses on religion and Christianity, but the basic mechanism is easy to recognize in many social situations in human life.

Balint groups do not exist as isolated phenomena; instead, they are part of a complex context, a fitness landscape.

Fitness landscape

The concept of the fitness landscape originates from theories of complex biological systems and has lately been applied to human organizations [96]. A landscape is here used as a metaphoric image of the environment of the group. Different areas of the landscape contain different opportunities to nourish or starve the group. The group must "fit" into the properties of the surroundings if it is to survive. When the landscape changes the group will have to fit into the new situation by changing and figuratively moving around to find adequate living conditions - or perish.

Applying this theory on Balint groups is interesting as it takes into account not only the near-surrounding organizational factors of the groups but

also the political and economic conditions of the society and the paradigm of the health care system.

In the Balint groups the work is guided by some psychodynamic concepts.

Psychodynamic concepts

Balint group work is originally based on psychoanalytic theories. Some concepts of importance will be defined briefly here. They are important as they are useful tools for the Balint group leader in helping the group members understand more about their own and their patients' reactions in their relationships. There is no teaching in Balint groups, only training, and the concepts are not taught in the groups; however they are sometimes briefly mentioned to help in making the understanding more concrete.

Object relation theory

This theory was introduced among others by Michael Balint and he developed the British Object Relation School of Psychoanalysis. A brief outline of parts of the theory is relevant here:

The object relationship of the infant to the primary object (most often the mother) is basically biologically and psychologically given, the aim of the infant is to be loved unconditionally. Sooner or later the infant will experience discrepancies between its needs and the physical and psychological care and affection of the primary object. This "basic fault" is conceptualized as a structural deficiency in the mind and we all have these deficiencies. If the infant's needs are extreme or the environment very insufficient in satisfying them, this will lead to severer deficiencies of the mind which are only partly reversible. The traces of these early experiences will remain and contribute to the person's constitution and determine how the person reacts to all illness as they will be repetitions of the basic fault (negative sensations outnumbering positive sensation). The person comes to the physician in a state of regression, like the desperate infant. In this state of regression the person is in contact with the basic needs of safety and is vulnerable. The physician can temporarily take the role of the primary object of the patient and has a unique possibility to nurture the patient's process of growing up [9, 71].

Defence mechanisms

Coping strategies are necessary as protection against anxiety and from being too conscious about and overwhelmed by external dangers or stress. This is why we all have defence mechanisms, which are unconscious and automatic. They moderate our reactions to emotional conflicts and internal or external stressors.

Defence mechanisms are classified into different levels on a scale from most mature to most primitive. The more mature, the more adaptive and

promoting of satisfaction and balance between conflicting desires. The more primitive, the more obstructing for the person, hindering interchange with others, e.g. active or passive aggressive behaviour. The latter is quite common in the consultation as the patient which is simultaneously complaining and rejecting help. Collapsed defence mechanisms can result in delusions and psychotic denials.

For the physician in the Balint group the concepts of defence mechanism are usable knowledge both in understanding the patients' behaviours in relation to their symptoms, and as they influence the physician's own reactions to the patient [103].

Transference - counter transference

These concepts were defined in the world of psychoanalysis, in the work and study of the unconscious, between the analyst and the analysand [104]. Michael Balint describes how they are also applicable in the Balint group as well as in all other relations between carer and care-taker [9, 105]. Transference can be defined as feelings, thoughts or behaviours from one person towards another which in fact belong somewhere else, meaning in other relations past or present. In the physician-patient relationship the term is used about feelings, thoughts and behaviour from the patient towards the physician. An example in clinical practice could be a young girl reacting towards the middle-aged female physician as if she were her mother.

Counter-transference is feelings, thoughts or behaviours emanating from the physician towards the patient. They can either derive from the physician's own experiences from relationships outside the actual relationship (illusory counter-transference), or be reactions to the patient's transference (syntonic counter-transference) [105].

Parallel process

The dynamic of the relationship between the physician and the patient may be mirrored in the relation between the physician and the Balint group. This is used to enlighten the physician-patient relationship. An example of this phenomenon:

In the group a physician presents a case of an unbearable patient. The group is compassionate towards the physician and criticizes the patient. Suddenly the physician takes the part of the patient and defends the more or less rational choices that the person has done, which the physician beforehand had rejected as stupid or counterproductive. The group now plays the role of the physician and cannot see any way out of the predicament. This is the time for the leader to demonstrate what happens and to point out the parallel process. This course of events gives the physician the possibility to understand the patient better and also to understand his/her own role in the relation. The group recognizes the mechanisms of the encounter and develops a greater understanding of them [105, 106].

When they are there [the parallel processes] and can be demonstrated in the group, they become relieving for all the members. That one suddenly can see that this is what it is! It provides a new dimension, a meta-level, and: "look, my God, here it is!" And then we all change. And suddenly one can see what happens in the physician-patient relationship and it is lifted up to a new dimension where one is changed and can look upon the patient in a new way. It is a great leap and very, very valuable. (leader)

Symbolization

This concept is not mentioned by Michael Balint in "The Doctor, his Patient and the Illness" [9], but it is based on psychoanalytic theory and I find it useful in the Balint group. The following explanation is very simplified. A symptom can be a sign from the body of something out of order, and it may be a physical disorder that needs biomedical treatment. However it may also be another sensation that has unconsciously gained its negative connotations from a coincidence in the past. A headache is interpreted as something wrong in the head until one understands that it has something to do with the mother-in-law paying a visit. If the patient can understand that the headache is a symbol of her feeling uncomfortable when her mother-in-law is visiting, then she will be able to abstain from physical explanations to it, but instead recognize its psychogenic origin. Understanding of symbolization is useful for the physician in relation to patients with psychosomatic symptoms, as they can help the patients in their process of symbolization. It can also help the physicians recognize their own unpleasant "symptoms" in encounters with patients and symbolize them to a higher level [107].

Groups as a means to improve professional competence

An often asked question is how to distinguish Balint groups from other groups. Small groups are widely used in competence development as they contribute special qualities to the learning process, apart from the simple aspect of saving time and efficiently making use of the teacher's salary. When the group climate is safe and open a free interchange of associations between the members can contribute to everyone's learning. The members learn from each other's experiences and thereby multiply the outcome. Sharing difficulties and feelings of insecurity with others is supportive and facilitates learning and well-being. The processes in the group may in themselves be instructive to the participators as they may learn to recognize them in other situations [108]. Support groups for young physicians can help them in their development into their new role of being physicians [109, 110].

Here follows a presentation of some other types of small group activity.

“FQ groups” in Sweden

So-called FQ groups (Fortbildnings- och Kvalitetsgrupp, “Continuous professional education and Quality group”) have existed in Sweden since 1993, where general practitioners meet and discuss medical issues [111]. The activity is supported by the Swedish Association of General Practice by means of so-called “study letters”, guides to group discussions on a multitude of topics, both medical and organizational. Sixty-four groups were active in 2004 according to an inquiry made by the Swedish Association of General Practice (Meta Wiborgh, personal information).

“12 man groups” in Denmark

For many years the so-called “Decentrale Gruppebaserede Efteruddannelse” (decentralized group-based continued medical education, in everyday speech called “12-man groups”) has been an established educational activity for general practitioners in Denmark. In 2002, 3130 general practitioners participated (88% of the work force) and 378 groups were registered. The groups met 8-10 times a year, the meetings lasted from 3 hours to two days. The activity is financially and organizationally supported by official means and free from industrial sponsoring. The groups are autonomous and stable. The subjects for discussions emanate from the everyday work, often authentic experiences, and the methods are based on problem based learning [112]. The issues are most often of medical character; sometimes an expert-specialist participates, but focus can also be the physician-patient relationship.

Consulting groups

Another type of educational group activity is “Consulting groups”, where general practitioners meet medical specialists and get advice on how to treat their patients, as a more or less continuing activity. This can substitute referral of the patients and at the same time educate the general practitioners in a dialogue with the specialist. The traditional power construction of the medical expert teaching the generalists, whose learning is implicitly on a lower level, may influence these kind of meetings [113]. The general practitioners seek advice from the expert, who has the final word and preferential right of interpretation, though the expert has often no experience of primary health care and the bio-psychosocial perspective. Michael Balint reflects over this relation between the general practitioner and the consultants and calls it “the perpetuation of the teacher-pupil relation” [9].

Supervision groups

When psychological rather than medical issues are focused and an expert leads the group, the activity will often be classified as supervision. Supervision groups are used in many professional connections, having supportive,

educational and advising purposes, e.g. for social workers and in psychiatric teams.

The supervision group resembles the Balint group in many ways. The principle in supervision groups is learning from reflection over concrete experience, as it is considered the base for new learning and reconsideration of knowledge and behaviour. The leader is a role model in his or her way of treating and replying to the members' needs and contributions; and in demonstrating ability to respond to and contain the material that is brought to the group. The processes in the professional-client relation are often replayed in the supervision group [108]. In the supervision group the leader has a teaching role towards the members and may consequently share with them the responsibility for the patients or clients that are discussed in the group. This contrasts to the principle of anonymous patient-cases in the Balint group.

Supervision is not common in Swedish health care except in psychiatry. When it occurs there is a tradition that physicians do not participate, which is an issue in itself. This may be due to psychological barriers in the corps, ideas of being superhuman and in no need for anything but instrumental skills taught in apprenticeship or lectures. Probably some shyness in the relation to other staff personal is involved; the physicians may have a leader's role in the team but not necessarily the competence to lead.

Methodology

The methodology of this thesis is influenced by my professional identity as a general practitioner. I have individualized the research methods to the character of the research questions. The investigated subject corresponds to the individual patient, whose needs should determine the treatment. In clinical work, one can often do the right thing in a number of different ways. The same flexibility is needed in research. This may sound trivial, especially to the scientific society, but the traditional positivist paradigm of health care prompts physicians to formulate research questions that can be answered with quantitative methods. The research design is then based on statistical laws, which require massive quantities of data, collected from many cases. Through this process they (the cases) lose their qualities of individuals with own experiences, as they are when we meet them in our daily work. These people's experiences can be studied with methods from human science, which we often call qualitative. Actually one can argue that it is the data which are qualitative or quantitative, and not the methods [114], but this terminology of quantitative and qualitative methods is commonly accepted and will be used in the following for simplicity. Versatility in methods is important, and the data in primary health care are often qualitative [115].

I have tried to give a rich description and shed light on my research area from several angles by means of different research methods. It is however

important to remember that all data in the following studies are originally qualitative, although some of them are converted into numbers.

Rigour in research

The trustworthiness of science can be discussed from different angles. To study a phenomenon with different methods will often give a more fulfilling picture than if only one is used. However there are some basic differences in the process depending on whether the approach is deductive (hypothesis-testing, quantitative) or inductive (descriptive, hypothesis-creating, qualitative) [116].

Quantitative methods, which often apply statistical calculations, have a well established system for judgment of trustworthiness that fit into the hypothetico-deductive model of research. This system includes internal *validity*, whether the test methods measure what they are supposed to measure, *reliability*, whether repeated testing could give same results and *generalizability* of the results to other settings. The *objectivity* of the researcher is important; in fact any qualified researcher should be able to repeat the study and should obtain the same results, because the researcher - as a person - should not influence the process.

One corresponding system of concepts of trustworthiness in qualitative methods includes *credibility*, *dependability*, *confirmability* and *transferability*. *Credibility* refers to the thoroughness in both data collection and analysis. *Dependability* as a concept of consistency, the process should be described so the readers can follow it and be adjusted to new material emerging during the study. *Confirmability* refers to the fact that the results should be shown to be grounded in the data. *Transferability* assures that the findings can be communicated to and understood by others, so that they can evaluate them as more or less relevant in their context [117].

Malterud argues that the researcher's *reflexivity* is an equally important criterion. The researcher's preconceptions affect all research, whether it is quantitative or qualitative. *Objectivity* of the researcher is not a realistic criterion, as research processes are full of moments where the researcher has to choose and interpret, inevitably guided by personal preferences and interests. The researcher's awareness of and willingness to reflect on these choices is the only way to secure the rigour in research [116].

Introduction to the Studies I-IV

The overall aim of this thesis is to study Balint groups and their effects on the general practitioner. Study I and III aim at demonstrating possible effects of Balint group participation on the general practitioners' experience of their working life both considering satisfaction and perceived competence in patient-relationships. I used a comparative study design in Study I for the pur-

pose of demonstrating effect with statistical means, whereas I in Study III went deeper into the participants' experiences by means of interviews. To critically scrutinize the Balint group method I searched actively for negative aspects and possible side-effects in Study IV, where I interviewed Balint group leaders and asked for their experiences of difficulties and dropouts. If Balint groups or other educational efforts lead to changes in the participants' comprehension of their role and task in their relation to patients, it is important to be able to measure these changes, and the instrument developed and described in Study II is an attempt to fulfil this need.

None of the participants in the studies were members in Balint groups lead by me.

4. Measuring effect of Balint groups (Study I)

The aim of this study was to determine whether and how general practitioners participating in Balint groups differ from other general practitioners with regard to satisfaction with their work situation and their perceived competence in handling patients with psychosomatic problems.

There were considerable methodological problems designing this study. The perfect design would include observation of patient encounters and also measure the long-term effect on the patients' health as the most convincing outcome in two groups of general practitioners, one of them attending Balint group.

Yet Balint groups are few and physicians who join a Balint group are motivated and have some prior interest in the physician-patient relationship. They are probably different from the physicians who choose not to join a Balint group. Thus a study design with a control group was impossible and a pragmatic and quasi-experimental design was used.

Method

The members of existing Balint groups were included together with a group of general practitioners from same region with similar conditions as a reference group. An existing questionnaire was modified to fit the purpose of the study.

Sampling

The Balint group leaders in the region of south-eastern Sweden were contacted and they were at the start of the study leading four Balint groups with general practitioners. All 26 Balint group members with at least 1 year of participation were recruited for the study. An equal number of general practitioners were recruited for the reference group. They were chosen intentionally to get a group resembling the study group concerning size of working place, rural/urban situation and ordinary working condition, meaning not too many vacancies and similar managing system (all participants were public employees). The physicians in the reference group had never had any possibility to join a Balint group.

Questionnaire

A questionnaire was made to suit the purpose based on a questionnaire used in a working environment study in the county of Jönköping in 1995 and 1997 by the local general practitioners' organisation [118]. A total of 30 of the items were used and 6 questions about psychosomatic issues and 13 about the doctor-patient relationship were added. The final questionnaire consisted of 49 questions sorted in 8 categories, *workload* (3 items), feeling of *control* of the working situation (11 items), *satisfaction* and stimulation with work (6 items), estimation of the *quality* of one's own work (4 items), *co-operation* and support (5 items), ongoing *training* and education (4 items), work-related *health* (10 items) and treating and dealing with *psychosomatic* patients (6 items). The terms in *italics* are used later as labels of the various categories.

The participants responded to each item in the questionnaire by rating their responses on a 10-point visual analogue scale (VAS) where 0 = least favourable, and 10 = most favourable. Differences between the groups' means were assessed with Students t-test for unpaired data considering the unequal variance when the groups differed in size. Statistically significant differences were assumed when $p < 0.05$.

Results

Of the 52 general practitioners allocated for the study 41 responded, 20 Balint group participants and 21 in the reference group. It was possible to validate the reference group by comparing their answers to the 30 borrowed items with the results from the above-mentioned working environment studies from 1995 and 1997. The reference group was thereafter considered representative of general practitioners in the region.

The Balint group participants were split into two subgroups depending on the duration of their participation, physicians with more than 1.5 years in Balint group were labelled experienced Balint group participants.

The experienced Balint group participants had significantly higher scores than the reference physicians in all categories except *Workload*, predominantly concerning feeling of *Control* in working situation, *Satisfaction* and dealing with *Psychosomatic* patients (see Figure 2). One specific item of interest where the experienced Balint group participants scored significantly higher than the reference groups, was: Do you sometimes refer patients or take "unnecessary" tests in order to terminate the consultation?

The means of the total results of the Balint group participants with long and short experience and the reference group are displayed in Figure 3.

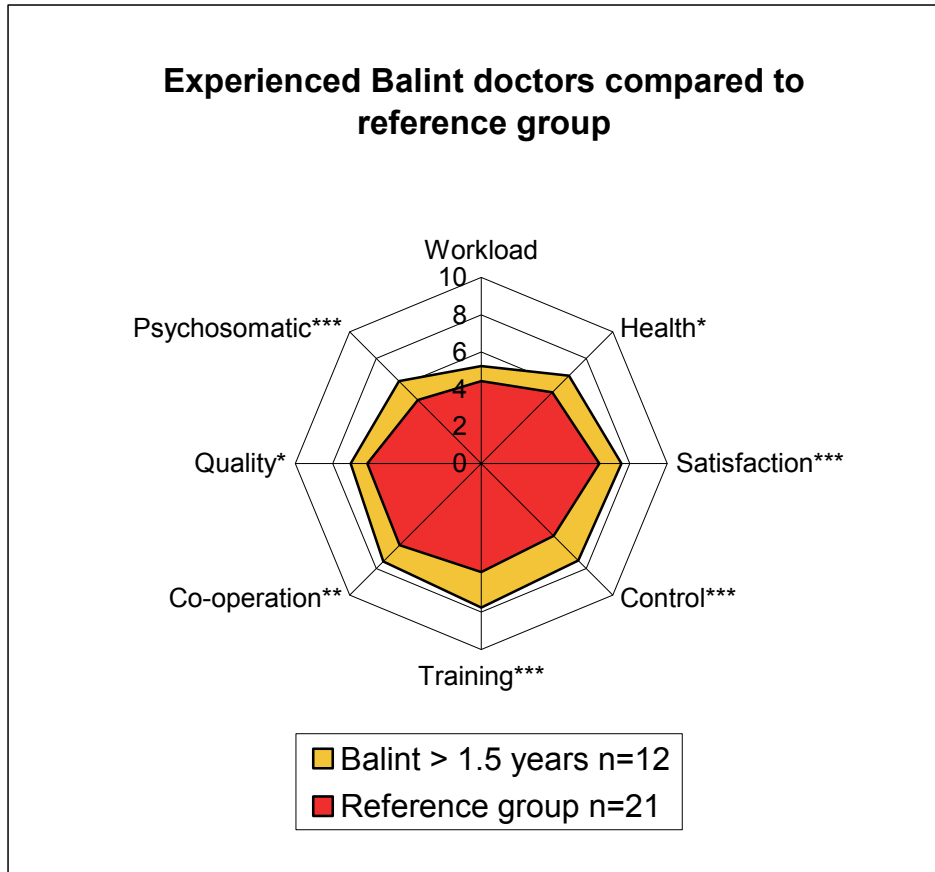


Figure 2: The mean results of the answers categorized in groups of the physicians with more than 1.5 years in Balint group compared to the reference group, showing the results of the t-tests. (*= $p < 0.05$, **= $p < 0.01$, ***= $p < 0.001$).

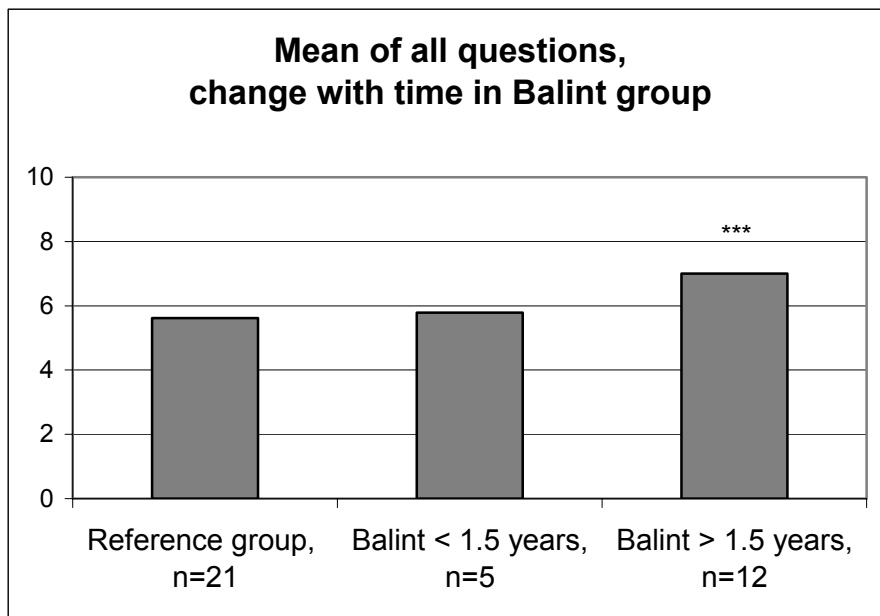


Figure 3. Mean total results of all the questions answered on the VAS scale, 0 least favourable, 10 most favourable, showing improvement, not significant in short time, but clearly after long participation in Balint group. (***= $p < 0.001$).

For more details, please see Study I

5. Estimating patient-centredness (Study II)

The aim of this study was to describe a new method to determine physicians' own understanding of their patient-relationship with regard to patient-centredness.

An essential part of the theoretical framework of the Balint group is patient-centredness and physicians with this attitude could be expected to join this kind of activity. In addition the work in the Balint group could be expected to strengthen a patient-centred way of being a general practitioner. Thus Balint group participants could be expected to be more patient-centred than general practitioners that did not participate in Balint groups.

Methods

The general practitioner informants from Study 1 (page 36) provided with the material for this study by answering a second attached part of the questionnaire.

This affix consisted of two parts:

First the participants were asked to answer the three following questions in writing:

1. What is the core of the meeting with the patient?
2. What is difficult in the meeting with the patient?
3. When have you been successful in the meeting with the patient?

These three questions are derived from Gloria Dall'Alba [119] who used the first two. The third question was added later and the three questions have been used by several authors [120, 121].

Next the participants were asked to choose between 28 roles that the general practitioner may assume in their relationship with the patients.

For details on the procedures in evaluation and categorization of the answers, please see Study II.

The agreement between the two parts of the instrument was tested using the weighted kappa coefficient; the difference between the groups regarding each part of the instrument by Wilcoxon's two-sampled test.

Points	Role-choice	Balint Participants	Reference group	Difference
3	Tutor	13	6	7
2	Mother/father	5	0	5
3	Container	13	9	4
2	Social welfare officer	12	9	3
2	Maker of limits	8	5	3
2	Fixer	7	4	3
1	Wastepaper basket	4	2	2
1	Judge	2	0	2
3	Medical consultant	13	12	1
2	Clergyman	6	5	1
2	Daughter/son	1	0	1
1	Prisoner	1	0	1
2	Confidant	11	11	0
2	Comforter	14	14	0
1	Signer of taxi bills	1	1	0
3	Co-worker	9	9	0
2	Psychologist	10	11	-1
1	Contra-worker	0	1	-1
3	Partner in conversation	15	16	-1
2	Teacher	6	7	-1
1	Writer of certificates	13	15	-2
1	Repairman	2	4	-2
2	Medical “treater”	16	19	-3
2	Medical investigator	15	18	-3
1	Writer of referrals	10	13	-3
1	Administrator	7	10	-3
2	Friend	4	8	-4
1	Writer of prescriptions	10	16	-6

Table 2. The roles, the scores, and the choices by the two groups of general practitioners. The roles are sorted in order of difference between the two groups' choices.

Results

The role choices are displayed in Table 2. Examples of patient-centred and non-patient-centred answers to the three questions are displayed in Box 1 and 2. The combined results of the two parts of the questionnaires are shown in Table 3.

A statistically significant larger number of the Balint group participants had a patient-centred attitude than the physicians in the reference group. The instrument separated the groups significantly and there was a significant correlation between the two parts of the instrument. The instrument can separate a group of patient-centred physicians from one with a non-patient-centred approach, but it has to be validated further before it can be applied on an individual level.

- | |
|---|
| <ol style="list-style-type: none">1. The dialogue. The contact, including the physical. The touch. The interpretation – the answer. The presence.2. Understanding. Making the right interpretation.3. When we have talked through the patient's conception, own beliefs. When we have reached a consensus around reason and treatment.
<ol style="list-style-type: none">1. Just the encounter, that when the encounter has ended we have understood each other. That I have understood what the patient really wants and that the patient has understood what I mean and my intentions.2. To experience a real encounter.
To manage the encounter when the time is short or I feel that the problem is bigger than the patient wants to say.3. When the patient has understood what I mean, that we can reach a conclusion, that I have understood what the patient wanted from the encounter.
<ol style="list-style-type: none">1. Contact, understand what human being I have in front of me. Understand the patient's problem and how he or she experiences it.2. Not to be able to cure.3. When we agree on diagnosis, appropriate - if any - examinations, treatment. When the patient has increased his knowledge about his problem. |
|---|

Box 1. Three patient-centred answers to the three questions: 1. What is the core of the meeting with the patient? 2. What is difficult in the meeting with the patient? 3. When have you been successful in the meeting with the patient?

1. To solve plainly medical problems.
 2. To place the right diagnosis.
 3. Both patient and I are content.
-
1. Help fellow people with medical problems.
 2. Diffuse and unclear complaints.
 3. Often.
-
1. If possible cure ill health, in any case relieve ill health.
 2. Patients who before the consultation already know and demand specific actions. This before I have had time to get into the problems.
 3. If we both are content when we end the consultation.

Box 2. Three non-patient-centred answers to the three questions: 1. What is the core of the meeting with the patient? 2. What is difficult in the meeting with the patient? 3. When have you been successful in the meeting with the patient?

		<u>Roles</u>		
		Patient-centred BP / RP Total	Intermediary BP / RP Total	Non-patient-centred BP / RP Total
<u>3 ques- tions</u>	Patient-centred BP / RP Total	9 / 2 11	1 / 1 2	1 / 0 1
	Intermediary BP / RP Total	1 / 1 2	4 / 2 6	2 / 2 4
	Non-patient-centred BP / RP Total	0 / 1 1	0 / 1 1	1 / 6 7

Table 3. The distribution of physicians according to their choices in the two parts of the questionnaire (BP=Balint participants n=20; RP=Reference physicians n=21; one BP and five RPs did not answer the three questions).

For more details, please see Study II

6. When Balint groups work well (Study III)

The aim of Study III was to study Balint group-participating general practitioners' experience of the influence their Balint group participation has had on their working life.

Lived experiences are best studied using methods for qualitative data, and I chose to interview the participants.

Method

A purposeful sampling [116] of informants was done by contacting the known Balint groups in southern Sweden to collect names of participating general practitioners with more than two years of Balint group experience and nine informants were interviewed. Efforts were made to get a varied sample concerning gender (four women, five men), age (43-60 years), professional experience and geographical setting. They participated in six different Balint groups led by six different leaders. Eight informants were Swedish; one was first generation immigrant from the Middle East. They had permanent employment and at least three years experience as specialized general practitioners. Their Balint group experience varied from 3 to 15 years.

They were interviewed by me at their workplace after work hours. The interviews were carried out in a relaxed atmosphere with a flowing dialogue. The interviews were audio taped and written out verbatim. I had never met any of the informants, but they knew I was a colleague with my own Balint group experience.

The method of analysis

The methods developed from the philosophy of phenomenology are useful when seeking descriptions of human experiences [116].

Phenomenology

Phenomenology originates from the philosophy of Edmund Husserl and has later been adapted into research methods [122-124]. It is not necessary to be a philosopher to conduct phenomenological research, but it is necessary to know the philosophical underpinnings of the methodology [64, 125]. Husserl

sought the essence of phenomena by reducing disturbing particularities derived from the naïve perceptions of the surrounding world.

In a Husserlian sense the essence of the phenomenon of Balint group participation was sought [123], but the researcher's understanding of the text is not free from presuppositions arising from the linguistic, cultural horizon from which one cannot move [116, 124]. These presuppositions are held back, put into "brackets" during the process of reduction.

The Empirical Phenomenological Psychological (EPP) method [124] was chosen. This method is useful when seeking the meaning the phenomenon has to the informants. It has similarities to Giorgi's descriptive phenomenological method [122] in its stepwise procedure, but allows more interpretation. The researcher traces out the meaning of the texts and judges the relevance to the description of the phenomenon in question, while actively holding back own preconceptions.

The steps of the EPP method:

- Step 1: All the interviews were read through repeatedly to get a good grasp of the whole.
- Step 2: The text was divided into meaning units (MUs). A MU starts when the meaning shifts as recognized by the researcher's empathetic understanding.
- Step 3: Each MU was examined closely and the language of the informants were changed into the language of the researcher by means of the researcher's interpretative understanding.
- Step 4: The transformed MUs were reformulated into themes and sub-themes.
- Step 5: The themes were related to each other in a general structure of the studied phenomenon.

Results

The interviewees expressed willingness to reflect over their own role and personal share in the physician-patient relationship and expressed commitment to do well for their patients.

They emphasized the importance of their Balint group for their working life. They described their Balint group participation as beneficial and essential to their working life as general practitioners.

The general structure of the interviewed general practitioners' experience of their Balint group participation's influence on their working life can be described as follows:

A means of endurance and satisfaction, rediscovering the joy of being a doctor. A continuous parallel process between the patient-physician relationship and the physician-Balint group relationship in which the general practitioner develops increased competence, professional identity and sense of security, making the good aspects outnumber the bad and the general practitioner able to endure in the job.

The themes constituting this structure were *competence, professional identity, sense of security, parallel process* and *endurance and satisfaction*.

The relation of the themes in the general structure is illustrated in Figure 4.

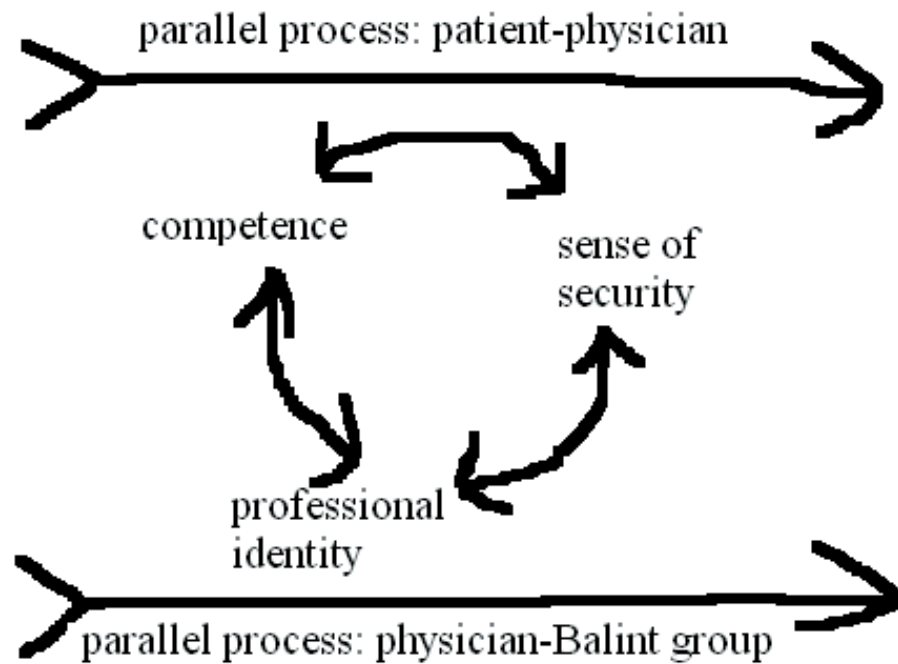


Figure 4. The general structure of the phenomenon of Balint group participation's influence on the working life of the general practitioners.

Competence

It's knowledge of yourself that it's mostly about. If you know yourself you can understand half the problem – if we see the whole as patient-doctor, so it's very important to have a reasonably clear picture of yourself and how you react in the encounter (participant)

Professional identity

You get it strengthened somewhat, what primary care should be, that you see the person more than the illness; this is strengthened within the Balint group, I think. (participant)

Sense of security

So that I felt that I become more confident and stronger in the patient encounters [...] I feel that I dare go closer to the limits of what could lead to agitation but that I feel is constructive in the consultation. Just the fact that I can take a difficult consultation to the Balint group makes me feel safer when I go into the encounter. That means that if I didn't know that the Balint group was there in the future as tool, then I would become worse in my job, simple as that! (participant)

Endurance and satisfaction

Can you imagine what your life as a general practitioner would have been like without the Balint group?

I might have been charged for misconduct – for prescribing too much medicine, maybe. Or I would have had too many patients and been burned-out. I would not have been able to handle the burden and I would have been more sensitive to criticism and when patients get angry for some reason.

There are those who think that Balint, that's something you do for a couple of years, and then you have learned it, but that's not the way it is. We work with people and all the time new difficulties turn up, new emotions, that is, unless you become a zombie. (participant)

After a meeting in the Balint group, how do you feel?

Well, it can be – most often it is elevating or how shall I put it, a little relieved or how to say? You've got something, how shall I say, positive. It feels good, ha-ha. Pretty much like you've done something a little different, you have been at the hairdresser or something, or done something to your body, had a shower or something like that, ha-ha. Some pleasant feeling.

Refreshing?

Refreshing, yeah exactly! (participant)

For more details, please see Study III

7. When Balint groups work less well (Study IV)

The aim of Study IV was to study possible negative aspects of Balint groups by exploring Balint group leaders' experiences of difficulties and dropouts in their groups.

The background for this study was the questions of why there are so few Balint groups and why some members terminate their participation. The strategy of interviewing Balint group leaders was chosen because it was difficult to search for answers to questions about negative aspects of Balint groups. You cannot ask people why they did not join an activity and expect interesting answers. Asking members who have left the Balint groups would be the right strategy, but demands a prospective design with many groups, and this was not within the possibilities of this thesis. Even with that design it would probably be difficult to recruit informants among those that were really hurt, as they might be reluctant to talk about it.

Dropouts may be due to dysfunctions in the Balint groups but not all dysfunctions lead to dropouts. It was interesting to look at dropouts and other difficulties in the groups as they might explain the scarcity of Balint groups. The leaders of the Balint groups experience these difficulties and could be expected to reflect over them. I had for a long time wanted to do interviews with Balint group leaders, but my engagement in the national Balint organization made it difficult to recruit enough leaders that I did not know personally. The 14th International Balint Congress in Stockholm August 2005 made it possible to include leaders from outside of Sweden.

The magnitude of the phenomenon of dropouts was unknown as well. The congress provided an opportunity to get some information on this question as many Balint group leaders were gathered.

Method

The questionnaire

The delegates at the Balint Congress, who were Balint group leaders, were asked to fill in a questionnaire about their experiences of leadership, dropouts and their opinion of the reason for the dropouts.

The interviews

Eight Balint group leaders were contacted by e-mail and asked if they would participate in an interview and they all accepted. Efforts were made to make a varied sample concerning gender, age, profession and nationality [116]. The informants were four women and four men, age 50 to 77 years (mean 61.4). Their professions were general practitioners (four), psychiatrists (two), psychologists (two); five were also psychotherapists and one psychoanalyst. They were from Sweden, Israel, United Kingdom, Denmark and the United States. Their experience as Balint group leaders were 2 to 33 years (mean 17.3), one had only led one group and one had led more than one hundred groups (mean 10.4 groups). Four were involved in educating Balint group leaders. An interview guide was used covering the following areas: the informants' development into Balint group leaders, their strategies and techniques in the groups, experiences of difficulties and dropouts (examples were specifically asked for), and if they had reflected on possible risks from Balint group participation. The interviews lasted 40 to 70 minutes, were audio recorded and written out verbatim.

The method of analysis

I had planned to use the EPP method [124] in the analysis of this material as I had done in Study III, and I started out doing it. However, here the method limited the analysis in a way that was dissatisfying. In step 3 (see page 45) the language is changed from the informer's into the researcher's and all particularities disappear before categorization is done. This means that narratives are reduced to short descriptions of the meaning of the story to the informer. In this study I looked for the stories about what had happened in a Balint group that had resulted in a member leaving the group. Thus the narrative of the course of events was important. I looked for other methods and found that in Malterud's systematic text condensation method [126] the categorization is done before the condensation of the text. I found this method more useful in the analysis of this material.

I used the following steps:

- Step 1: The interview texts were read though several times in order to get a good grasp of the whole. Previous conceptions were actively held back.
- Step 2: The parts concerning difficulties and dropouts were chosen for further analysis. Here preliminary themes were noted.
- Step 3: The text was divided into meaning units (MU), a new started when there was a shift in meaning.
- Step 4: The MUs were grouped according to the themes they belonged to. New themes emerged during this step.

- Step 5: The text of the MUs was interpreted, translated and condensed into the language of the researcher. In this step generalized themes emerged out of particularities.
- Step 6: The themes were grouped and main themes and systems emerged.

Results

In total, 51 congress delegates filled out the questionnaire making it possible to estimate the occurrence of dropouts to 10%. They ranked the dropout reasons, seven preset options, as displayed in Table 4.

Rank	Assumed reason for dropout
1	Practical reasons (retirement, moving away, economy)
2	Personal psychological reasons (fear, resistance)
3	Cannot work in group, don't fit in
4	Too little progress (they were bored)
5	Group-leadership problems (keeping frames and focus)
6	Hurt feelings from some intervention
7	Conflicts in the group

Table 4. The leaders' assumed reason for participants dropping out of group, ranked in order of the weighting in the questionnaire. N=51.

A general impression from the interviews was, that the leaders were empathetic to the working conditions of the general practitioners, they were dedicated to the task of creating a safe milieu in the groups, and that the goals and methods of their leadership were alike independent of nationality.

Three main themes emerged from the analysis: (1) *the individual member*, (2) *the group including the leader*, and (3) *the surroundings of the group*. The themes and sub themes that emerged from the analysis of the interviews were arranged around a triangle with the three main themes at the corners and the sub themes on the axes between them (figure 5).

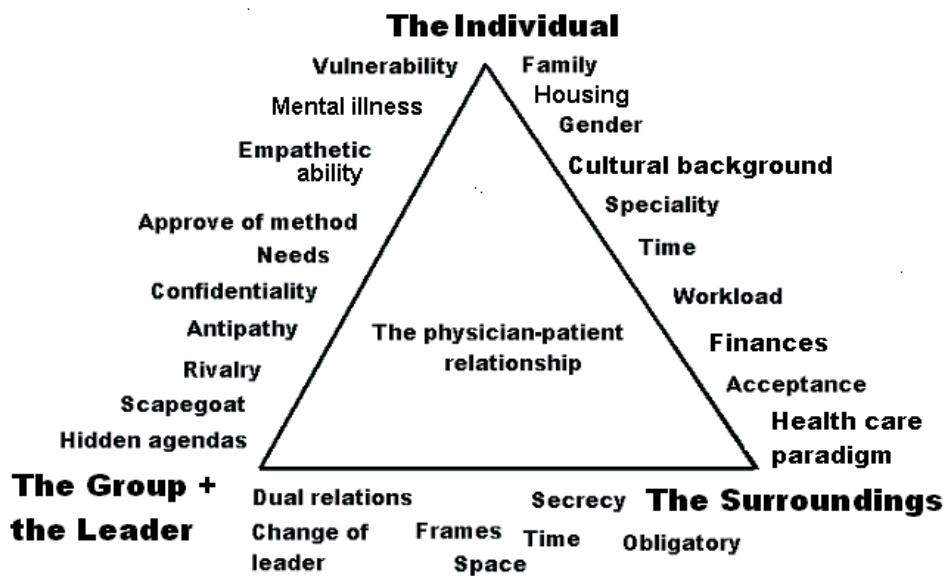


Figure 5. The findings from the analysis of the interviews with eight Balint group leaders on their experiences of difficulties and dropouts in Balint groups. The three main themes are arranged in relation to the sub themes.

The individual participant

The participant is part of a complex psychosocial system that in a multitude of ways interferes with Balint group participation. These range from practicalities such as abode and work hours of the spouse to more or less severe personal problems or disabilities. In times of the participants' own illness or other traumas the personal vulnerability to issues arising in the group was increased. It was also clear that people dropped out because they simply did not like the method, they were looking for other ways of learning.

Some of those who dropped out, it is only a handful, some of them wanted more about "elephants and how to hunt them", that means practical advice on communication. And that has been part of the criticism against the Balint method, that "we are not told how to do things, and we need that".

(leader)

The group and the leader

The leaders' central role was emphasized as the keeper of the frames and rules, of which confidentiality was one of the most important. Some leaders who had obligatory Balint group for residents experienced difficulties with the processes in the groups, particularly when there were conflicts in the

relationship between the resident and the faculty. The Balint group was demonstrated as susceptible to the same mechanism as other groups, and described above in Chapter 3. Stories of rivalry, hidden agendas and scape-goats were told.

I know some terrible dropouts! There was one years ago who was really insulted by aggressive members of the group and we leaders didn't protect him. He complained and he was right and then he didn't show up again.
(leader)

The surroundings

The Balint group as a complex system in a misfit landscape

The relation between the group and the surroundings can be illustrated in terms of a “fitness landscape” [96] as mentioned in Chapter 3 (see page 28). There is a mutual exchange of influences, but the findings indicated that the Balint group was the weaker part. The society's total economic, cultural and political state together with the health care paradigm constituted important parts of the “fitness landscape” of the Balint group.

The world of health care is subjected to the same economic limitations as the rest of the society and the biomedical paradigm is firmly established. Although the psychosocial aspects of illness and health and communication in the consultation are getting more attention in the literature [35, 40, 41] it is hard to see radical changes toward a more human and patient-centred view of the physician-patient relationship in real life. Hence it is not surprising that there are so few Balint groups, but that there are Balint groups at all.

... they [the general practitioners] feel maybe right, that there are so many other agendas and they have so little time [to participate in Balint groups] and with the crisis we keep hearing about in government's agenda and so on and so forth, and they are probably right.
(leader)

For more details, please see Study IV

8. Discussion of methods

Different methods may be used to study different aspects of a phenomenon.

The impact of figures and statistics is considerable in the tradition of medical science. Moreover, indeed it is important to be able to demonstrate with statistical significance that treatment A is better than treatment B as the consequence of “trial and error” would be disastrous for the patients. The demands on validity and reliability in this kind of research are considerable: clearly defined and measurable outcomes, many participants, and in order to demonstrate an effect of an intervention the randomized double-blind design is necessary. Studying effects of educational and supportive intervention and patient-centredness, it is difficult to live up to these demands. Balint groups are scarce in Sweden, a double-blind design impossible and the topics difficult to grasp. In this thesis I have nonetheless tried to grasp them, by means of several approaches, using both numbers and words, analyzing the material with both statistical and text analyzing methods.

Self-report research has limitations, both concerning the stability of the reported attitudes and social desirability bias [41]. On the whole, the use of statistical methods when studying non-numerical data is problematic in all science, but has nevertheless a long tradition in for instance psychology and sociology [108, 127]. One can also question the applicability of Student’s t-test on the VAS scale in Study I, as it is not certain that this is a numeral scale and not an ordinate, but it is still widely used e.g. for evaluation of pain-treatment [128]. While using the VAS scale the interpretation from symptoms or feelings into numbers is done by the informant. The transformation of verbal statements into grades and classes in Study II is disputable too. Here one can apply the same sort of worries about the reliability as in the text analyzing methods in Study III and IV, as transformation of verbal utterances always includes interpretation, here done by the researcher(s).

Rigour in studies of qualitative data is ensured by the transparency of the research methods and the reflexivity of the researcher, both of which must be declared in detail [116, 129]. The researcher’s preconceptions impinge on interpretations. One way to counterbalance this is to do the analyzing procedures in group, so I have let other researcher scrutinize the results in order to gain a negotiated consensus.

The problem with the researcher’s preconceptions in this thesis needs extra attention. I am a physician doing research on physicians, a general practitioner doing research on general practitioners, a Balint group-participant

doing research on Balint group-participants, a Balint group leader doing research on Balint group leaders. What a list of bias! Risks and advantages must be discussed. This is an essential part of the researcher's reflexivity [116]. In sharing experiences with the informants there are risks of common "blind spots" and implications, hindering a full illumination of the phenomenon [130]. I have asked for clarifications, examples and negative aspects as an attempt to face up to this. The tutors and the multi-professional peer group of researchers at the Department of Health Sciences Research have persistently raised the question of my preconceptions during the whole process, never letting me relax on this point.

The advantages of my experiences as a physician and Balint group leader are on the other hand also important to mention. Getting access to the world of physicians is not easy, the fear of "external" judgement considerable. It is a common belief among physicians that their profession is very special and cannot be understood by others. They tend to look with suspicion at people who want to study their work, especially when this concerns negative aspects. There is reason to doubt that the informants would have been as honest and willing to participate without this mutual understanding of a colleague [130, 131]. The interviews have more the character of collegial dialogues than formal interviews and the informants share in a very creditable way their experiences from their professional life as general practitioners and Balint group leaders, including difficulties, worries and mishaps.

Another aspect to be considered is the question of the characteristics of physicians in Balint groups. It is most likely that general practitioners who initiate or join Balint groups have a special interest in patient-centredness and the physician-patient relationship. This was already observed by Michael Balint [77], and limits the generalizability of the results of Balint group participation.

Ethical considerations

According to the Swedish law (2003:460) approval from ethics committee is needed for research that implies physical or psychological influence on the participants. This means that approval is not needed for the studies presented in this thesis. Nevertheless it is important to keep good ethical practice in all research and this has been conducted throughout this work. Verbal and written information have been presented to the informants. This includes assurance of confidentiality and of the possibility of withdrawing from the study at any time without explanation. Informed consents have been signed. Great efforts have been put into guaranteeing that informants cannot be recognized in published material. However, Study III was approved by the Ethics Committee at the Faculty of Medicine, Uppsala University.

9. Discussion of results

The results of the studies in summary:

- Study I: Compared to the reference physicians, the Balint group participants were more satisfied and reported higher feeling of control in their working situation. They considered themselves competent in dealing with patients with psychosomatic problems to a higher degree than did the reference group. There seemed to be a time-effect of Balint group participation as the difference increased with time in Balint group.
- Study II: The presented instrument named “How patient-centred am I?” could separate a group of patient-centred physicians from a group of non-patient-centred and can thus be useful in evaluation of training programs. It is not validated enough to test the individual physicians, but can be used by them in private or as a tool in joint reflections on the physician-patient relationship or to detect early signs of burnout.
- Study III: The interviewed general practitioners described their Balint group participation as beneficial and essential to their working life in several ways. Not only did it increase their competence in the patient encounter but it also strengthened their professional identity and enabled them to endure in their job and find joy and challenge in their patient relations.
- Study IV: Roughly 10% of the members dropped out of the Balint groups. According to the findings in the interviews with the Balint group leaders, the reasons for this were either practical or connected to processes in the groups. Some left because they were discontent with the method as such, wanting more straightforward teaching, others as a result of events in the group that were sometimes destructive. Whether these persons were hurt is not known because the follow-up of these cases was insufficient. Obligatory groups seemed to differ profoundly from classic voluntary Balint groups for specialists.

In this chapter these results will be discussed in relation to the aims of the thesis and related to theories and concepts presented in Chapter 3. First the

Balint group's positive influence on these general practitioners' experience of their work life and their patient-relationship as pointed out in Study I and III. A discussion follows of the task of the general practitioner focussed on the difficulties of estimating patient-centredness, difficulties which the instrument presented in Study II seems to contribute to solve. Then follow three chapters on Balint groups in which I make use of the theories of the small group as a complex system as well as the results of Study I, III and IV. First the health care system constituting the context of the Balint groups is considered in a discussion of whether Balint groups are an effective contribution to general practitioners' continuous professional development. Then the issue of obligatory groups and groups for young physicians is examined representing the global aspect of the group. Finally the local aspect is examined in a discussion of the risks for the individuals in Balint groups. In these last two chapters I connect to psychodynamic concepts described in Chapter 3.

The general practitioner's working life

The role of the general practitioner is that of being between the patients and the specialized health care at the hospitals. This may be a complicated position, being gatekeeper against the public's demands on specialized and limited resources and at the same time defending the patients' rights to the same [5]. The relation to the specialists is complicated and often marked by feelings of inferiority and resentment. Michael Balint described it as "The perpetuation of the Teacher-Pupil relationship" [9, 113]. It is a common saying among general practitioners that they are the trashcan, and that their obligation is defined by others as - doing whatever nobody else can or will do.

For a competent generalist it is difficult to limit ones obligations towards the patients' diversified and sometimes not strictly health related problems and it is easy to get caught in the trap of omnipotence. The physicians interviewed in Study III seem to have found ways to define and limit their obligations towards their patients' needs and they have at the same time improved their patient relations. To step down from the pedestal of omnipotence and define what they actually can do well is crucial to the general practitioners, if they want to positively define their professional identity.

In Study I the Balint group participants described the same workload as the reference physicians but seemed to have developed an ability to control their working hours better, both in terms of contents and time spending. This was confirmed by the informants in Study III. They related that they have learned to encounter the patients in a way that was open to the patients' agenda without fearing of losing control of the frames of the encounter. Study I and III indicate that the Balint group participation had given the general practitioners the ability to define and keep the limits of their obligations.

Could the explanation for these positive reports from the Balint group participators be that they have unburdened themselves of their difficult patients? It does not seem so. On the contrary, they express that these patients are difficult but challenging, and they score higher in their self-estimated ability to handle patients with psychosomatic diseases. They are more willing to accept the patients' reason for seeking help from the health care system and they state that they do not take unnecessary tests or refer the patients to get rid of them to the same extent as reported by the reference physicians. In the interviews the physicians say that their discomfort in difficult encounters has decreased because of what they have learned in the Balint group. Thus, they could be expected to endure and maintain continuous relationships even to patients with vaguely defined or intractable conditions. This is an important aspect as these patients otherwise run considerable risks of being referred and exposed to unnecessary, expensive and hazardous diagnostic and "therapeutic" procedures, as was stated already by Michael Balint [9]. This should be an advantage not only for the patients but also for health care economy [60].

Balint group participation seems to increase satisfaction in work according to the results of both Study I and III. The sense of community and sharing of experiences and worry combined with the feeling of better being able to meet the patients with empathy and competence make the physicians enjoy work more.

Conflicts of values and feeling of loss of control are two important factors leading to burnout [20, 21, 132]. According to the results of Study I and III, participating in Balint groups could be a means to achieve coping strategies for general practitioners rendering them less sensitive to stress. Moreover it may lead to improved physician-patient relationship and a patient-centred approach. In fact the patient centredness trained in Balint groups, by enhancing optimum contact between the physician and the patient, may satisfy the demands of values that the physician has for the job.

But my work at least, as the type of general practitioner I am, has improved considerably. I put down my job in a completely different way. I don't take it with me when I go for lunch. I don't bring it with me home. I sleep well at night. I don't feel stressed facing patient encounters that I knew before could be a little tough, I don't feel that way. (participant)

Thus the Balint group may in several ways improve the working conditions for the general practitioners, making them more capable of withstanding the pressure throughout their working life [28, 132].

The task of relationship

The difficulties mentioned above (see page 18) in doing research on the physician-patient relationship and patient-centredness may boil down to the fact that it is all about two persons meeting each other, both being parts of complex systems. No two people are alike and no two meetings are the same, not even two encounters between the same persons for the same reason on two occasions. Both persons bring with them their personal experiences and expectations into the encounter, the patient willing to relate parts of them to the physician. The physician with the learned professional discretion keeps them well hidden, but they will nevertheless affect the physician's way of being and acting in the encounter. In researching the dynamics in this encounter one can view it from psychodynamic, cognitive, system-theoretical or other angles and they can all be true to some extent, but the observations will still be volatile. Communication is acting, relationship is being. Communication is made out of observational and measurable attributes: e.g. discourse content, body language, timing in listening and talking etc. Relationship has to do with personal attributes: e.g. caring, concern, respect, presence, and immeasurable attributes: rhythm, melody, balance and synchronization – and what is not said [133].

Many scales and instruments to measure physicians' patient-centredness already exist [41]. As mentioned above the physician's emotions in the encounter may be of larger importance than recognized before. The doctor-as-person as a vital ingredient in the concept of patient-centredness has not had its own scale before. The instrument presented in Study II reveals patient-centredness from new angles because it explores the physicians' self-perception of their physician-patient relationship. By answering the open questions and choosing the roles the physicians express what is important to them and what difficulties they experience while relating to the patients. The instrument reveals the physicians' understanding of their part in the physician-patient relationship perceived from an internal perspective.

The instrument presented in Study II is very cheap and easy to administer. It combines qualitative and quantitative methods, and includes the fifth dimension of patient-centredness: the doctor-as-person [41, 42]. Patient-centredness is sensitive to context, because patients have different expectations of the encounter depending on their background and the reason for their visit [46]. The demands of flexibility of the physicians to meet each patient in the "right" way are considerable and the degrees to which they are fulfilled are difficult to measure. The open-ended questions exhibit what the physicians find important without the limitations of pre-set items, and the roles can be adjusted to culture and tradition, both qualities making the instrument flexible and feasible in many contexts. In choosing roles the physicians account for their perception of the part they play in long-term patient relations.

A key problem with self-report instruments concerns social desirability bias [41]. The significance of this problem depends on the consequences for the physicians of their answers to the questionnaire. Such a questionnaire should, in my view, not be used in accreditation procedures or in job interviews. Instead it can be used in privacy by the individual physician him- or herself to monitor changes in interactive capacity and patient-centredness as result of working conditions [4, 21] or training, and as basis for discussion and reflection in groups of colleagues. The instrument can also be used in groups of physicians and medical students to evaluate educational efforts.

On the meaningfulness of Balint groups

According to the theory of small groups as complex systems (see page 26) the group consists of dynamics on three levels: the contextual, the global and the local [96]. Regarding the Balint group as a complex system I choose to discuss the following aspects in relation to the results of Studies I, III and IV.

The surrounding system's view: Is Balint group activity effective?

Is any training in competence in the physician-patient relationship effective? Much money is put into educating physicians, but very little evidence exists about the effects [45, 134]. This may depend not only on unwillingness to declare negative results and get resources withdrawn, but also on methodological difficulties in doing research in this area. What should be regarded as outcome and how can it be evaluated? And is it possible to evaluate their cost-effectiveness?

Hulsman et al (1999) reviewed evaluation studies on training programmes in communication skills for clinically experienced physicians. The results were not impressive [45]. Neither the evaluation methods used, nor the effects of the training. It was striking that the few studies with sound methodology showed the least effect of the education programmes. The education programmes described were of short duration, the only one that lasted more than 2 months consisted of 18 x 2 hours during 6 months. These participants seemed to have gained skills that lasted and even developed further when they were tested again after 18 months [135].

The same methodological problems are evident in the few evaluation studies done on Balint groups [82-85, 93]. The studied programmes of Balint group participation are clearly shorter than the two-year span that Michael Balint put up himself from his theoretical viewpoint and experience [77].

Thus high quality research is scarce in the area of training physicians in how to behave in the encounter with the patient.

Michael Balint et al. had the group leaders (all psychoanalysts) evaluate the development of the individual participating physicians without asking the general practitioners themselves. They found that about half of the participants showed considerable positive development [77]. I took another point of departure by focusing on the participants' own experience. In Study I and III, I examined the general practitioners' various experiences of their Balint group participation, of their working conditions and of their relationship to patients. I found that they reported more positive feelings about their work in general and their relations to the patients in particular than the reference physicians, differences that increased with time in the Balint group (Study I), and they related this to what they had learned in the Balint group (Study III). They emphasized their increased feeling of satisfaction and control in their working situation. Considering the meagre evidence on communication education programmes, these results could in my opinion be taken as reasonably indicative that Balint group participation by those general practitioners, who appreciate the method, may render them more resistant to stressors in their working environment and thereby less susceptible to burnout [132].

The global process, the method: Balint groups or support groups – and should they be obligatory?

I don't run Balint groups for [...] the GP-trainees, for I feel "wow, the doctor-patient relationship is the key and very important!" Firstly I think the participants, the enforced participants, in the situation, they have to come to that realization themselves. I don't feel comfortable like a large part of the course is going to be about this, whether they like or not, and I am aware that they have a lot of other things they want to discuss. It is about what's their needs as well, and they should be allowed some "what's?" and some of those "what's?" reflect other needs. (leader)

According to Johnson et al. some Balint groups conducted in American residents programmes resemble support groups more than Balint groups [74]. There seems to be a growing understanding that Balint groups for young physicians during educational programmes, especially when obligatory, may differ profoundly from the original method, which aimed at voluntary and actively chosen participation by general practitioner with at least some experience of being a practicing specialist [89, 136]. In the classic Balint group there should be no teaching, no answers to questions, no praising, but limited anxiety is encouraged and constructive criticism allowed [9, 89]. What the average young physicians need is, in my view, support, safe role models and a place to discuss their development into their new professional role (see quote above). This is in the classic Balint group regarded as denial and avoiding the real issue, which is the often painful work of facing and feeling

the emotions in the encounter with suffering patients. In this process the members can detect mechanisms of symbolization and defence, which they were not aware of, and this is challenging and may be painful. To expose young and non-voluntary physicians to this could be unethical and counter-productive. The results in Study IV concerning the risks of Balint group participation support this statement.

It seems that the issue of whether Balint groups can be obligatory is more fundamental than was previously understood. The theory of the group's initiating forces may explain this [96]. The obligatory groups for young physicians are concocted groups, planned and organized by external forces (page 26). Thus these initiating organizations' motives to start the Balint groups become essential as well as the members' relation to these organizations, as described in Study IV. Conflicting demands by the faculty on the students will affect the Balint group [137]. Some leaders in Study IV report difficulties with truancy, resistance and inertia in obligatory groups, reflecting a feeling that the faculty with its disciplinary power is sitting in the room.

We once had a group with such residents in X and I had a feeling that they didn't want to talk because the director of the school, the professor, told them to talk and they had a feeling, "he can give us commands in every area but he cannot force us to talk about ourselves." [...] That may happen when it is obligatory.
(leader)

The local perspective: are Balint groups safe and worthwhile?

It seems as if the long-term commitment is important if a real and lasting change of understanding is to be achieved [64]. While revealing uncertainty and "changing personality" [9] the physician is vulnerable. Feeling confident is crucial to the process. The stable frames and safe milieu in the Balint group, maintained by the leader, can probably act as a greenhouse, facilitating the physician's growth. However, the findings from Study IV somehow contradict this. These findings suggest that Balint groups are not always idyllic and harmless.

Balint group leadership may be conducted in different styles [89], but it always aims at creating a safe environment for creative reflection on the physician-patient relationship while protecting the physician presenting the case [9, 88]. Safety is emphasized in the literature, but Balint groups are susceptible to potentially harmful group dynamics.

On the one hand Balint groups can be safe places where the general practitioners can expose their feelings of insecurity and frustrations, and learn how to interpret and make use of these feelings as described in Study I and III. On the other hand they can be risky places for vulnerable persons. Study IV demonstrated that harmful situations occur, leading to members leaving

the Balint groups. The possible damage inflicted on these persons is not known. Members were also reported leaving the groups because they did not learn enough.

Leading the Balint group seems to demand balancing between too much and too little. Between the extreme experiences that new understanding and change may sometimes be fascinating and sometimes very painful [51, 54]. The leader must let the group advance in a tact that satisfies the most inquisitive members and yet protects and encourages the most restrained. The interventions should lead forward without hurting anybody. This is obviously a difficult task and in the case of very heterogeneous groups – impossible. There will be dropouts [90].

The first group [I participated in] was a very uneven group, in that there were some very experienced general practitioners, and then there was me and another resident. So that, one felt ... that it was unequal, they had so much more experience, so that one did not do oneself justice like that.

(participant)

The difficulties in the Balint groups described in Study IV were not fully explained by means of the theories of Wilfred Bion (see page 27). One interesting finding in Study IV is that the leaders rarely investigate the motives of the dropouts, they guess. Moreover they tend to blame the dropout. This came forth both in the interviews and in the ranking of dropout reasons in the questionnaire (see page 50). Mostly leaders described the dropout member as not fitting in, as giving the group a hard time and that it was a relief when the member was finally expelled. The explanation of what happened was attributed to the person's personality or some quality or unfortunate development within the dropout or wondering whether this person had the qualities of a physician at all. These stories gave me associations of scapegoating, which Musham and Brock warned against (see pp. 24 and 28) [90, 101, 102].

Some of the Balint group members that drop out may be persons unable to function in groups or who have serious problems with empathy; however, they may also be physicians whose particular needs for gentle guiding and protection are ignored. Leaders are participants in groups and susceptible to intrinsic harmful course of events. The firm frames of the Balint group method should help in controlling these, but the frames are deranged as soon as there are hidden agendas or states of dependency in the group.

This risk of getting hurt is higher for psychologically fragile or ill persons, or during periods of turbulence in people's lives. This problem of temporary hypersensitivity of members was difficult to address for the leaders participating in Study IV, but should be considered.

Michael Balint introduced "mutual selection interviews" because of high dropout rates in the groups. The interview should provide the applicant with

a clear impression of what the method is like, and the group leader with a possibility to exclude physicians that in all probability would not benefit from the training or could be expected to drop out quickly. The interview procedure was evaluated and found worthwhile [77]. All the Balint group leaders interviewed in Study IV mentioned the possibility of individual interviews. They regarded it as a way to avoid letting in physicians with severe psychiatric disorders, for whom they thought Balint groups would be hurtful. However none of the leaders used the method of mutual selection interviews.

Contacts between the leader and the members outside the Balint group are not regarded beneficial for the process in the group and are supposed to protect the integrity of the group members. This principle of isolation of the group from the surroundings is probably grounded in the psychoanalytical origin of the method and may co-act with the leader's denial or failure to notice certain destructive processes in the group. This tradition may thus be questioned in some cases of dropout because it may leave expelled members hurt and prevent the leader from learning and further understanding of the process.

The physician, the task and the group

Working with this thesis I have come to see the physician as an actor in a complex system of circumstances and relations that influence each other in a multitude of ways. I have tried to show this system in Figure 6.

The small triangle in the middle is the foundation of biology, sociology and psychology upon which life rests.

The middle triangle shows the patient's system, being a person, having an illness and relating to the doctor. Here are also the components of Michael Balint's book where he first presented the groups that came to bear his name.

The outermost triangle is that of the physician. I think this applies to physicians in general, not only to general practitioners. Personal qualities and private experiences are crucial to the way the physician encounters the patient (in the middle triangle). The task of medical practice (and handling illnesses) is incorporated in organizational and paradigmatic circumstances that the physician is compelled to correlate to. The social and relational part is in the left corner. It is here the physician can look for support and together with colleagues reflect and develop new understanding, useful in the role as doctor for the patient. These needs are often unsatisfied and here the Balint group can be an important ingredient in the physician's life.

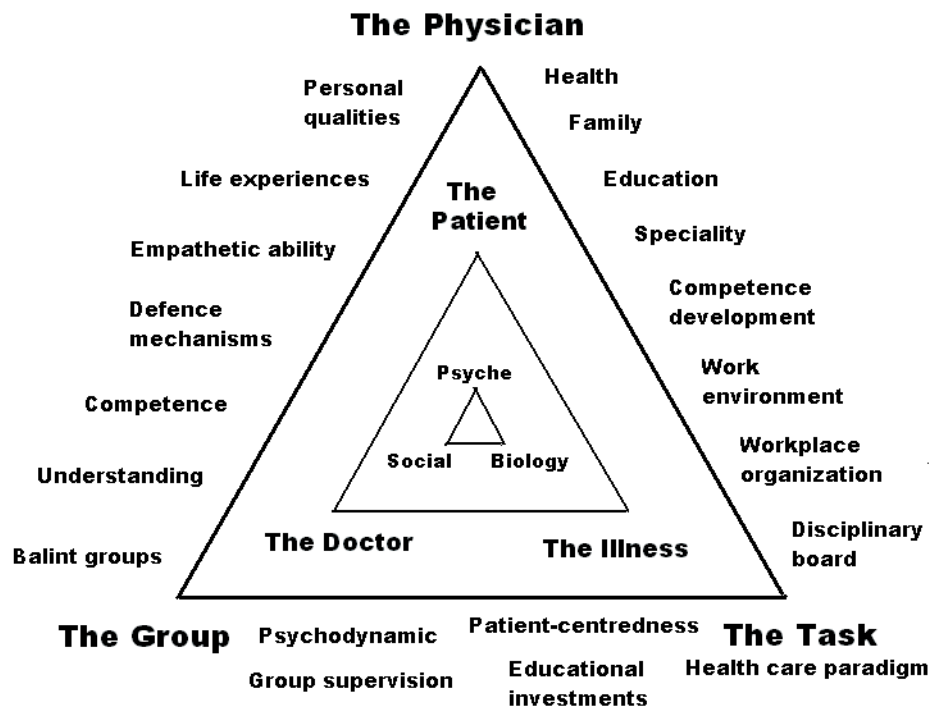


Figure 6. An illustration of my present conception of the physician's situation in a complex system, influencing and influenced by a multitude of factors and circumstances.

This complex system of the physician provides an abundance of fields that attract the curiosity of the researcher. I will mention some here.

Future research

- To study possible implications for the patients. Patients' experience of, satisfaction with and health care outcome from encounters with Balint group-participating general practitioners compared to general practitioners that do not participate in Balint group. Howie's "Patient enablement instrument" could be used [49].
- How do the Balint groups achieve their goals? By combining material from Study III and IV the working methods can be studied from the perspective of both the participants and the leaders.
- The development of Balint groups needs to be studied. How long should a Balint group continue? Do some members get satisfied and terminate after some years? What do old Balint groups look like and what purpose do they fill?
- The physician's self-reported patient-centredness in the instrument "How patient-centred am I?" should be compared to how the physi-

cian behaves in the consultations by means of consultation observation techniques.

- We need to study prospectively the process in Balint groups and the individual member's experiences, both good and bad. This could help in understanding which physicians can be expected to benefit from Balint group participation and might lead to more diversified educational models.
- Balint group participation may have different implications to female and male physicians. This is an important question to develop and may be included in several of the above-mentioned projects.

Overall conclusions

The results of this theses point at the Balint groups as a means for general practitioners to develop competence in the physician-patient relationship. The Balint group can provide a safe place for inter-collegial reflections over the task of general practice leading to a strengthened professional identity. The group discussions on emotional aspects of obscure or frustrating patient encounters can lead to new understanding of the relations. At the same time the group is a place to find support and means to gain control over the working situation. This may reduce the risk of burnout.

Not all physicians benefit from the Balint group method and there are also risks of bad group dynamics, which may be hurtful. Balint group leaders need to be highly aware of these processes and actively investigate into why members drop out of the groups and whether they are hurt. They should consider the possibility of "mutual selection interviews" more often, as participation of a member demands a stable psychological condition and an open mind. Physicians without these characteristics would probably benefit more from other methods, e.g. mentorship. This makes obligatory Balint groups an issue for discussion.

The thesis concludes that professionally conducted Balint groups are generally beneficial for general practitioners as a means to make the physicians endure, even thrive in their job. The method seems to be a gentle, efficient way to facilitate development of new understanding of the physician-patient relationship with possible positive effects for the patients as well.

You change [in the Balint group], but you are also changed by life itself, if you are in a good life, with good frames, and if you talk with a good friend or with your spouse or your children, then life is [...] development. And that can be facilitated in a Balint group in that it is refined.

Refined in the meaning that it can go a little faster, but with the same methods as life itself offers, when life is at its best and not offending.

(leader)

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11. Summary in Swedish

Distriktsläkaren har en central plats i sjukvårdssystemet, men kraven och belastningen på dem har ökat och det är tecken på utmattning i kåren. Ett patient-centrerad möte mellan läkaren och patienten är bra för patienten och sannolikt även för behandlingsresultatet. I Balintgrupper kan läkare uppnå ny och utökad förståelse för läkar-patient relationen genom att studera deltagarnas egna upplevelser av patientmöten.

Denna avhandling syftar till att studera effekter på distriktsläkares arbetsliv av Balintgrupp verksamhet. Distriktsläkare med och utan erfarenhet av Balintgrupp jämfördes med hjälp av en enkät och statistiska metoder och distriktsläkare med Balintgrupp erfarenhet intervjuades. Dessa båda studier visade positiva effekter av Balintgrupp deltagande på läkarnas arbetsliv beträffande upplevelse av kontroll och tillfredsställelse, och på deras relation till patienterna, i synnerhet patienter med komplex problematik.

Ett nytt instrument för självskattning av läkares grad av förmåga till patient-centrering har utvecklats och testats. Det kan användas i grupper av läkare till att utvärdera effekter av träningsprogram, och av individuella läkare till att spåra förändring i förmåga till patient-centrering som ett tidigt tecken på utbrändhet.

Balintgrupper granskas kritiskt genom att intervjua Balintgrupp ledare om svårigheter i grupperna och avhopp av medlemmar. Det förefaller som om Balintgrupper passar in i moderna teorier om små grupper som komplexa system, och att de är underkastade gruppdynamik som ibland är skadlig. Professionellt ledda Balintgrupper verkar vara en varsam, effektiv metod för läkares kompetensutveckling, men metoden har sina begränsningar. Deltagande kräver psykologisk stabilitet och mental öppenhet hos läkaren och obligatoriska Balintgrupper kan ifrågasättas.

Sammanfattningsvis kan man säga att Balintgrupper generellt sett är bra för distriktsläkares arbetsliv som ett medel för att hjälpa distriktsläkaren få kontroll över och trivas i sitt arbete. Metoden befrämjar utveckling av ny förståelse av läkar-patient relationen, som kan ha positiva effekter även för patienterna.

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