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Collaborative engagement with colleagues may provide better care for 'heart-sink' patients

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WHAT IS ALREADY KNOWN IN THIS AREA

- Balint groups and similar reflective groups can open doctors' minds to the complexity of the patient–doctor relationship and help them to accept and deal with uncertainty in clinical practice. It makes the doctors more resilient and diminishes the risk of burnout.

WHAT THIS WORK ADDS

- Learning in a long-lasting reflective group boosts doctors' ability to deal with, and even embrace, the uncertainties of general practice and, in particular, their care of 'heart-sink' patients.
- Sustainability of a reflective group can be achieved through specific features of the group's structure and ways of working.

SUGGESTIONS FOR FUTURE RESEARCH

- Further studies to explore whether collaborative engagement with peers i) improves one's ability to deal with uncertainty in clinical practice and ii) leads to enhanced patient care.

Keywords: Balint group, general practice, practice-based small group learning, reflection, uncertainty

SUMMARY

Introduction

In this article we show how a group of general practitioners' (GPs') professionalism was enhanced through collaborative engagement. Complexity, uncertainty and so-called 'heart-sink' patients are naturally embedded in clinical practice. GPs need to deal with, and even embrace, uncertainty, enabling them to provide patient-centred care.

Methods

A relatively fixed group of Danish GPs have met regularly for more than 14 years, discussing difficult and complex cases. Their experiences were researched through two focus group interviews using semi-structured interviews comprising open and closed questions, which were audiotaped and transcribed. The qualitative findings were analysed employing grounded theory principles.

Results

Participation in the GP group was perceived to have had a positive impact on participants' personal and professional lives by reducing the number of 'heart-sink' patients, by strengthening their ability to reflect and deal with uncertainty, by boosting self-confidence by improved professional selfawareness, by providing them with a safe environment and by enhancing their working enjoyment and professional motivation. A number of features of the group's structure and ways of working, which appear to have

secured the long-lasting sustainability of the group, have been identified.

Discussion and conclusion

This group of Danish GPs experienced personal and professional growth through collaborative engagement. They have apparently learned to embrace and even value the fundamental uncertain and complex nature of primary care, which seems to benefit their 'heart-sink' patients. The features, which have ensured the long-lasting sustainability of this group, could perhaps inspire other younger GPs to work in such reflective groups.

INTRODUCTION

Clinical practice is never straightforward.[1] Doctors must learn to choose often between what is 'right' in some absolute sense and what is 'best' for individuals in their particular circumstances[2] and must learn to expect the unexpected.[3] Their practice is located in what Schön called 'the swampy lowlands', remote from the apparent certainties of science.[2] They address this complexity and uncertainty by developing their 'professional judgement'.[4,5]

Some GPs find ways to avoid or minimise the stresses this causes in their daily practice through a better work–life balance, develop 'outside interests', take a sabbatical, go 'part-time', or seek early retirement.[6]

Policymakers, too, attempt, especially in the current political climate, to reduce uncertainty through the imposition of protocols and guidelines, more it seems to reduce 'risk' than to help practitioners deal appropriately with the complexities of their own or other people's lives.[1] But GPs know that each patient encounter is different and that many cases are highly complex.[7] GPs understand the inappropriateness of these political initiatives yet can appear voiceless in arguing the case for embracing, rather than reducing, uncertainty as a necessity.[8] It is probably only doctors who fully understanding the uncertainty of people's needs that can offer the necessary support.[9] When the uncertainty embedded in these needs is not fully understood, appreciated, or acted upon, doctors may treat what some refer to as 'the disease' rather than attend to 'the illness' of the specific patient.[10]

The literature suggests that this uncertainty can be addressed successfully through 'collaborative engagement',[9,12,13] and that learning to practice as a professional requires 'the co-construction' of understanding, which best occurs through 'dialogue and discussion' within communities of practice,[11] and that 'learning to talk' is as important as 'learning from talk'.[12]

In postgraduate primary care education, collaborative engagement has enjoyed a long and honourable tradition, from the ground-breaking work of Balint in the 1950s through to the present day.[8,13] In a paper from 2006, Pinder *et al* report the experiences of London-based trainee GPs participating in reflective group learning.[14] In this comprehensive study they show that small groups provide the opportunity for doctors to examine their experience, the messiness of it, and their complex and contradictory reactions to it. It opens their minds to the complexity of the patient–doctor relationship. The authors argue that the group participants learn to accept and deal with uncertainty in clinical practice, which additionally makes them more resilient and diminishes the risk of burnout.[14] However, some group-based initiatives fail to survive more than a couple of years,[15] or they have a large turnover of members.[14]

In this article we follow a relatively stable group of Danish GPs who attempted to address the complexity and uncertainty embedding in their clinical practice by regularly meeting for more than 14 years, discussing difficult cases. Their experiences have been researched through a qualitative enquiry, which explores the impact on its members, and their observations about their patient care.

METHODS

The GP group

In 1999 a small group of Danish GPs started to discuss their need to meet as peers to reflect on their professional challenges, difficult cases, and patient- and colleague-related problems. Ten trusted colleagues from different surgeries were invited to participate, and in early 2000 a discussion group was formed. There was from the start a strong and shared wish to create a forum to discuss problems in an open, honest, reassuring, comfortable, and 'safe' environment.

The group has met between four and eight times a year, with an additional annual weekend session to provide an opportunity to work more intensively. Early on it became clear that leadership was important, and the group has throughout the years appointed one of its members as leader. During the years only three members have retired from the group and three new younger GPs have been recruited.

The group from time to time has invited external 'experts' – people with a special interest – to take part in the weekend sessions in order to inspire future work in the group. The first such weekend involved one of the authors of this paper (CC) and this had a significant impact as it focused participants' minds on how they developed their professional judgement. At other times psychologists, psychiatrists, other GPs and a priest have attended meetings.

The working methods of the Danish group[16] differ slightly from a traditional Balint setup. At meetings, group members present one of their cases that has been significant in some way to their practice, for example because it was complex, challenging,

unexpected, worrying, or just 'difficult' – in short, a case causing them some uncertainty.[1] A group member interviews the case holder, interrupted at times by reflective discussions by the rest of the group, in order to explore the core of the presented case. The approach to discussion is a modified form of the so-called 'fish-bowl' technique. A detailed description of the group's working method is given in the Appendix.

The enquiry

Identifying or even measuring the impact the group's discussions had on the group members and their ability to deal with uncertainty is by definition difficult, if not impossible, within a traditional medical scientific paradigm.[14]

Therefore this enquiry is methodologically based on the assumption that the object of study – people's experience – is complex and multi-perspectival, and that group members will have created their own understanding of what the meetings have meant to them personally and what they as individuals have learnt through their participation in them.[17] This suggests a need to capture that experience through qualitative rather than quantitative methods.

Data collection included two successive focus group interviews with nine members each. One appointed member of the group conducted the first interview, using a semi-structured interview comprising open and closed questions. An external observer conducted the second interview, structured around findings from the first interview. Both interviews were audiotaped and transcribed.

The interview findings were explored following grounded theory principles.[18] First, two researchers, who also were group members, interrogated the interview transcripts, identified and classified 'meaning carrying units' and discussed emergent meanings. Nine categories were identified as shown in Box 1.

In the light of this initial analysis, the researchers further interrogated the data and the categories were merged into four themes. The third author, who was neither a group member nor a GP, commented on the classification of the data.

Box 1 The identified categories

- The problematic (or 'heart-sink') patient
- Impact on the doctor's professionalism
- The doctor's self-awareness
- Dealing with uncertainty
- Support and care of the doctor
- Feeling safe/having a secure space
- The role of humour in discussing difficult matters
- Asking why the group keeps on working
- The GP academic performance/handling the role as scholar during clinical work

This analysis demonstrated further data triangulation through relating the 'inter-subjectivity' of the researchers' interpretations, by looking for coherence and agreement/disagreement of interview statements amongst the interview participants, and by checking the coherence of the observed data with the relevant literature.

RESULTS

The themes and sub-themes emerging from the analysis are shown in Box 2.

Box 2 The themes and subthemes

Impact on participants' personal life
- Boosting personal self-confidence
- Having an easier (more fulfilling) life

Impact on participants' professional life
- Ability to deal with uncertainty
- Ability to reflect
- Boosting professional self-confidence
- Provide better communication and consultation skills
- Experiencing fewer 'heart-sink' patients
- Better professional robustness
- Improved professional self-awareness
- Boosted working enjoyment and professional motivation
- Recognising and dealing with the risk of collusions and 'back-slapping'

The supportive role of the group
- Safety
- Care taking
- Creating and maintaining a supportive environment

The sustainability of the group
- The group structure and processes
- Experimenting with methods, keeping an open mind
- Profound mutual professional and personal respect
- Recurrent external inspiration
- Use of respectful humour
- Deliberate selection of group members

Impact on participants' personal lives

All group participants experienced a positive impact on their private lives, as did their families. Group discussions made it easier to improve their work–life balance. Their personal self-confidence was boosted.

> My wife tells me that this group has made me more resilient, more focused, and much happier.

Impact on participants' professional lives

All group participants agreed that the years spent in the group had a significant impact on their professional life and performance. All said the group had improved their reflective ability and professional self-awareness. It also boosted their professional self-confidence and strengthened their professional robustness, which all helped them deal with uncertainty in patient care. Some also said the group discussions, especially with expert guests, improved their communication and consultation skills, by introducing a broader understanding of the nature of the patient encounter.

The result was that they experienced fewer 'heart-sink' patients – complex cases that prior to the group work some of the doctors dreaded seeing. As a result, group members felt able to offer both medical and psycho-social care more effectively. They also reported a boost in their enjoyment of work and increased professional motivation, which they felt was 'a cure against burn-out'.

A potential negative impact was also reported – the risk of 'collusion', and sometimes congratulatory 'back-slapping' was perhaps overly used to address difficult cases through friendly teasing and humour.

> It has helped me to understand and to accept, what kind of swampy lowland we are practicing in.

> The work with the group and associated reflections has given me an understanding that the issues I personally found very difficult are common to all GPs.

Supportive safe haven

All group members reported that meetings provided a highly valued, safe, caring and supportive environment – a forum where they could discuss not only any professional issues but also how particular professional events affected them on a personal level. The group helped several members through professional crises such as surgery 'splits' and severe staff problems, as well as significant problems some had experienced with their practice colleagues.

During group sessions they discussed the 'care vs cure dilemma' and recognised the importance of the 'care' element of the group work itself. However, they acknowledged that taking care of one's colleague whilst at the same time constructively supporting and challenging that colleague's development and self-awareness could be difficult. A fundamental basis of trust and mutual respect was a prerequisite for the development of the group but collusion is an inevitable risk that must be acknowledged.

> When it's getting difficult and tough in the consultation room, I begin to imagine this group is sitting behind me and listening, and that helps me act more wisely.

How to keep a reflective group together

Participants listed several reasons for the long-lasting success and sustainability of the group, including the selection of participants, a profound mutual professional respect, an agreed structure, external input, experimenting with different reflective methods, and respectful humour.

> We respect each other so much that we stick to the agreed timeframe, structure and method.

> The fact that we are not working in the same surgeries [as colleagues] gives us a significant amount of freedom and space where we can bring any kind of issue, and where there is room for humour and friendly banter.

In the second interview the initial data interpretation was confirmed by all group members. Participants then reflected on the impact of their group work on patient care. Group members found this hard to measure or even predict. However, they were convinced that collaborative participation had a positive impact on patient treatment because it supported:

- reflection about former complicated patients, resulting in more appropriate treatment of subsequent patients
- awareness and insight into one's own 'mental status and energy', which resulted in them being better able to deal with patient problems
- an ability to 'look behind' patients' emotions and anger, which previously prevented them focusing on the patients' fundamental problems
- now seeing patients who previously had been perceived as 'heart-sinks' more positively and caring for them more appropriately.

Furthermore, group members found that several of the positive effects resulted from an enhanced acceptance of uncertainty as part of clinical practice, and that collaborative engagement with colleagues provided ways to cope with this much more constructively and less stressfully than before.

One participant summarised the finial interview as follows:

> Taking part in the focus group interview, reading this initial paper, thinking about it and discussing it, has made me realise that this group has helped me to grow.

DISCUSSION

The group of doctors that form the basis of this enquiry have experienced personal and professional growth through collaborative engagement about the uncertainties of their practice. They have done so by establishing and maintaining a group, which includes:

- creating and sustaining a supportive and caring environment
- a non-directive, reflective approach that focuses on individual meaning-making rather than critique
- flexibility, experimentation, and open-mindedness
- respectful humour
- embracing, rather than merely acknowledging, uncertainty as a *sine qua non* of their professional practice, not to eliminate or to minimise it but to understand it as fully as possible, and to be able more confidently to live with it and to care for patients more appropriately through this.

Perhaps the most pertinent and practical finding is a universal outcome for all of the group's participants that they now experience fewer so-called 'heart-sink' patients and they have less annoyance with these patients. It seems as if they can appreciate more and more the contribution of these patients' 'heart-sinkness' to a better understanding by the GP of what their problems actually are and what they can do to support them, and if possible offer them better care. If this is so, it perhaps indirectly explains why the GPs found the group work prevented burnout.[6]

This study has major limitations regarding generalisability. The findings are based on only one Danish GP group and comprise participants' self-perceived experiences. Two of the researchers were group members and the data are therefore primarily a kind of insider evaluation, and not an external independent observation. We performed no individual interviews but only group discussions. These research conditions can lead to collusion both in data collection and data interpretation. We tried to compensate by a deliberate focus on applied reflexivity by the authors in the process, and by letting the second interview be moderated by an external observer. Nevertheless, we cannot generalise the findings to other Danish GPs nor to GPs in other countries. Our findings therefore must be interpreted alongside the relevant literature and experiences from other GP groups before wider conclusions can be made.

Our data concur with that from similar studies elsewhere. As reported above, doctors in the UK experienced a similar positive impact on their professionalism. Swedish data support our findings concerning burnout prevention,[19] and a Belgian study shows that GPs benefit from participation in Balint groups.[20]

There is an interesting difference in Michael Balint's description of the expected outcome of group learning compared with our data, where he states that doctors learn to accept that there are deemed hopeless cases with poor prognoses,[13] yet GPs in our study described actually seeing fewer 'heart-sink' patients. We cannot, however, tell whether this finding suggests some form of direct causality or is due to the long-lasting longitudinal small-group discussions, with this largely constant and trusted group of fellow GPs.

We deliberately set out to explore in this study whether collaborative engagement could be shown to help GPs handle uncertainty in this specific group of Danes, and the participants themselves said it did. However, to what extent the perceived benefits are caused by a better ability to deal with uncertainty in clinical practice must await further research. Having said this, the GPs in this study hint that by embracing the uncertainty in their practice they have developed personal strategies to identify more fully what a particular patient's problem *really* is, why the patient has *actually* come to see them, and what the full extent *truly* is of the issues they are facing.

WHERE TO GO NEXT?

A question remains as to how much collaborative engagement leads to enhanced patient care. The present study does not offer clear support for this, nor does it claim to demonstrate any such outcomes.

Research is therefore needed to explore others' experiences of similar projects to explore whether collaborative engagement actually benefits the patients they seek to help, so as to address more directly the fundamental question asked recently by Sommers and Launer, 'In what arenas could collaborative engagement be linked to specific clinician practice changes that in turn connect to improved patient outcomes?'[8]

Ethical approval

This was carried out as an evaluation and ethical approval was not required.

Conflicting interests

None.

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Appendix

THE METHODS OF THE DANISH GP REFLECTION GROUP

At meetings, group members present one of their cases that has been significant in some way to their practice, for example because it was complex, challenging, creating a surprise of some sort, worrying, or just 'difficult': in short a case causing them some uncertainty.

Although all cases have always been in some ways similar, each has brought new issues and new understandings, including:

- how to handle uncertainty in patient care
- how to handle emotionally caused bias in patient treatment
- how to adjust expectations between GP and patient and between GP and colleagues
- how to handle situations when one's professional integrity is attacked by patients or colleagues
- how to handle frustrations over lack of collaboration with hospitals.

The approach to discussion is a modified form of the so-called 'fish-bowl' technique. Before the meeting, the person presenting the case – known as 'the case-holder' – writes some notes about what to say. Then at the meeting the case-holder is 'interviewed' by another member whose role is, non-directively and without recourse to any analytical structures, to facilitate reflection by the case-holder in narrating the story. The emphasis at this point is descriptive clarity. The 'interviewer' uses phrases such as 'Say a little more about that' or 'What else?' There is no critique of the case at this point.

Once the story has been told, a reflecting group of three people comments on their thoughts generated by the story and its telling. The timing of this repeated discussion is lead by an appointed time-keeper. The purpose of this phase is also to encourage further reflection by the interviewer and presenter by colleagues who have been 'outside' the initial 'interview' and who often bring a new perspective.

Interviewer and case-holder then continue to discuss the case. The emphasis now is again not to critique the case but to consider what the 'case' is 'a case of', since frequently the cases presented become cases of many different things.

Following further discussion between the presenter and the case-holder, the remaining members of the

group, who have been listening and observing the discussions, have the opportunity to comment, particularly on what the presented case is, for them, a case of. At no time does anyone say 'If I were you I would have ... !' or 'What you should have done is ... !'.

Finally, the case-holder has the opportunity to voice any 'take home messages', though it is clearly recognised by all that every case is 'work in progress', so avoiding any 'conclusions' or 'closure'. What is often clear, however, is that during a session 'the problem' re-defines itself several times, frequently leading to a deeper understanding on the part of the case-holder and others in the group'.

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