Getting the Frame Straight

To the Editor:

I was energized to see the publication of the recent commentary “Reframing Balint.” Such a commentary serves to further discussion on an essential topic for family medicine education. I agree with many of the points of the commentary, e.g., the importance of the leader empathizing with the developmental stage/need/moment of the group and the difference between the original Balint groups composed of GPs in England and Balint groups in US residency training programs.

I also agree with what I take to be a central thesis of the commentary: since there is no one right way to conduct a Balint group, what gets interpreted as a “deviation” or “presumed error” may actually not be. Although I agree that there is no one right way to conduct a Balint group, there continues to be enormous value in maintaining Balint’s original frame of the doctor-patient relationship as an anchor for a Balint group’s work, whatever the members’ level of clinical experience.

Any residency group experience should not automatically be called Balint. To call a bifurcated group as described in the commentary a “hybrid” Balint group is misleading, confusing, and potentially splitting.

For optimum educational experience, residency programs should provide a variety of ongoing group experiences, each with a clearly understood frame. There are distinct differences among the three most prevalent group experiences: Balint groups, personal and professional development (or support) groups, and case conferences. To grossly oversimplify, case conferences have a case presentation format and focus on how to better deal with the patient and situation presented. Personal and professional development groups do not set out to present cases or patients; the focus of these groups is the stressful experiences of the participants.

Balint groups have a case presentation format and focus on the empathic understanding of the doctor, the patient, and the doctor-patient relationship. Within the framework of each of these groups, there is room for great variation. Often, the most interesting challenges and growth for both the leaders and participants come from groups that push the edges of the frame. However, it is important to hold a conscious and cohesive frame, particularly in the residency setting. This is not to advocate a “rigid orthodoxy” of method as necessary (or even desirable). However, clarity of purpose and method may be both desirable and necessary. When a frame is not held with consciousness and purpose, the ability of the group to develop, grow as a group, and achieve its purpose over time is at risk.

In today’s climate of medical practice, continuing reflective group work with one’s colleagues throughout one’s medical career becomes even more crucial to ensure a satisfying, engaged, and stimulating professional existence. The foundation and skills for a commitment to group work begins in residency training.

There must be room for interpretative discourse on the various residency group experiences. These and other thorny issues are routinely discussed during the American Balint Society’s leadership trainings, collegial Balint weekends, in publications, and on the membership list serve. The American Balint Society looks forward to continuing dialogue with all individuals who are participating in, leading, or doing research on groups in medical settings.

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space to conduct the three distinct group experiences Dr. Addison describes. In the world in which I work, the “hybrid” groups are the only way I have found to do justice to the lived reality of family medicine interns, residents, and faculty and to the spirit of Michael Balint (which includes but is not limited to the doctor-patient relationship). Dr. Addison’s disclaimer notwithstanding, he defends a clinical orthodoxy in the metaphor of preserving a frame. “Getting the frame straight” implies that I’ve got the frame wrong. I demur. At issue is not only content but timing.

In my (historical) experience, insistence on the purity of the (original) frame has led to group rebellion against the content of the frame. Sometimes deviation from the original frame is the only way to eventually reach it. In my Family Medicine paper, and in a much longer one, I have argued paradoxically that in some groups, on some occasions, one can “hold a conscious and cohesive frame” (the original Balint discourse) only by first reframing the group process and honoring the family medicine interns, residents, and faculty where they are right now and not forcing a frame on them. Sometimes, at the time of the gathering of the group, a physician-patient case does not have the emotional valency or urgency of a residency or departmental issue. Sometimes a doctor-patient case can be addressed only after more pressing emotional needs are addressed. Put differently, one may eventually arrive at a discussion of a doctor-patient relationship but not necessarily begin the group with it. In sum, I believe that attention to the experience of the group honors rather than violates the memory and work of Michael Balint.

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Comment

Medical Education Reform in Iran

To the Editor:

Our team of medical educators was invited to Iran in December 2002 by the Iranian Ministry of Health and Medical Education and the World Health Organization. In addition to presenting papers at the 5th National Congress on Medical Education in Shiraz, we reviewed and made recommendations on plans to create a system for accreditation of undergraduate and graduate medical education, on the role of educational development centers, and on plans for curriculum reform. To accomplish our mission, we met with faculty, students, and administrators at four medical schools and with staff from various offices in the ministry and with Minister of Health Dr. Pezeshkian.

Iran is a nation of 67 million people with 65% of the population under 25 years of age. Following the Islamic Revolution of 1979, the government initiated a series of health reforms. The number of medical schools was increased from 10 to 40, with a corresponding increase in student enrollment. The health care system was reorganized with a strong emphasis on primary health care and integration of health services with medical education. Health statistics demonstrate remarkable progress. Since the revolution, life expectancy has increased from 52 to 70 years, the infant mortality rate has decreased from 110 to 26 per 1,000 live births, the maternal mortality rate has decreased from 237 to 37 per 100,000 births, immunization coverage has increased from 20% to 95%, and the population growth rate has declined remarkably from 3.2% to 1.3% per year (personal communication from Hamid Reza Jamshidi, vice deputy for health, Ministry of Health and Medical Education, Islamic Republic of Iran).

Our team was warmly greeted by everyone. We felt entirely safe and welcome everywhere we went. We visited several of the many rich cultural heritage sites, from the ancient royal city of Persepolis to the modern palaces of former shahs. Most impressive of all was the genuine warmth of friendship, enthusiasm for interaction, and commitment to excellence in medical education we encountered with our professional colleagues in Iranian medical schools.

The plans we reviewed for accreditation standards were state of the art. Educational development centers at each university organize faculty development workshops, supervise CME, manage teacher evaluations, and plan curriculum change. The curriculum reform plans produced by these centers would create a well-integrated, student-centered curriculum that emphasizes self-directed learning and competency-based assessment. We hope our visit will help move these plans to full implementation.

The profession of medicine transcends politics. Medical educators and physicians in Iran and the United States share the same goals, namely, to provide the best possible education to their medical students so that they might better serve the needs of the population. Despite its relative isolation, Iran has made remarkable progress in improving health care delivery and medical education. Iranian medical educators recognize the serious need to reform their medical education and are interested and willing to interact with colleagues abroad. Our hope is that health care and medical education will be enriched in

REFERENCE