Comparing a Christian Physicians' Support Group with the Balint Group

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The influence of religious beliefs on physicians' social attitudes and medical practices is not as yet adequately discussed in the literature. This paper describes a Christian physician support group and contrasts it with the more traditional Balint model support group. Issues of membership, leadership, and use of the group are discussed. The potential use and misuse of religiously oriented support groups are outlined.

Thirteen Christian physician members of a study group were given questionnaires regarding participation in and expectations of the group. They were asked to comment on the extent to which their religious convictions influenced their practice of medicine.

Participants discussed a wide range of issues both personal and professional. They benefited from the opportunity to share views with others who brought a spiritual perspective to patient care. Members stated that their spiritual beliefs influenced their attitudes toward social issues, such as abortion and divorce, and their practice of medicine, for example, by praying with and for their patients. The group provided a safe place to explore these beliefs. **J Fam Pract 1990; 30:65-68.**

Physicians of all specialties deal with similar moral and ethical challenges daily. All confront trying times with "difficult" patients and with their own limitations. For some, a commitment to a higher power is a source of support and guidance, and an aid to self-monitoring processes.[1] Although there has been some discussion in the literature regarding the use of physician support groups, notably groups organized within a Balint framework,[2] little has been written about physician groups utilizing a spiritual framework.

This paper describes a support group organized by Christian physicians and compares it with the more traditional Balint group. The similarities and differences between the groups are described. The potential use and misuse of religiously oriented support groups are also discussed.

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BALINT GROUP

Michael Balint, a Hungarian-British psychoanalyst, made an important contribution to family medicine by organizing seminars to help physicians acquire techniques for dealing with problem patients.[3,4] Balint seminars are not designed to be group therapy, but to encourage listening and interactive skills.[5] The physician-patient relationship is seen as a therapeutic tool. Physicians have benefited by better understanding their patients and themselves, thus enabling them to respond more effectively to complex needs.[6] Topics characteristically discussed in Balint groups include physicians' feelings about patients, treatment goals, problem clients, and ethical dilemmas.[7]

Balint emphasized "whole person" medicine,[7] which includes the combined impact of physical, mental, social, and spiritual well-being on health.[1] Spirituality, a cornerstone of the Christian physician support group, is described by Canda[8] as encompassing "human activities of moral decision making, searching for a sense of meaning and purpose in life, and striving for mutually fulfilling relationships among individuals, society, and ultimate reality, however conceptualized."

Organized religion is one form of accepted spirituality practiced in this culture.[9] According to Craigie et al,[10]

"religious commitment or practices have been shown to affect health status" in a positive sense. They cite several studies suggesting that people who are actively involved in their religion may experience a decreased morbidity in a variety of areas. They also note that "for many people, religion forms a basis of meaning and purpose in viewing life events."[10] Byrd[11] demonstrated the positive therapeutic effects of intercessory prayer in a population in a coronary care unit. Koenig et al[12] showed that the majority of 160 family physicians polled believe that religion has a positive effect on the physical and mental health of elderly patients.

CHRISTIAN PHYSICIAN GROUP

A group of four Christian physicians of different specialties began meeting on a weekly basis in 1985. By 1988 the group had expanded to 13 members. Any physicians who called themselves Christian were welcomed. Members were free to leave if they did not feel comfortable with the group's orientation. None did so. The group grew out of a need for fellowship and to discuss personal and professional issues from a spiritual perspective. The group utilized biblical principles in discussing ethical issues. When interpretations of the Bible conflicted, the group worked toward consensus in resolving these differences. The high level of medical expertise in the group acted as a safeguard against intrusions of theological bias into medical management.

The group met weekly in one physician's office for $1\frac{1}{2}$ hours. The meeting began with a structured time for prayer and study of a specific Bible passage. A study guide with weekly assignments was followed.[13] Leadership was divided between two of the original members. The group discussed the practical application of the study guide's questions to their daily lives. In this context issues surrounding professional ethical dilemmas, troublesome patients, and personal situations would emerge. The meeting would adjourn after another time for prayer.

METHODS

A questionnaire was designed to gain information about membership and specific views of the purpose and utility of the group experience.

Twelve of the thirteen questionnaires were returned. (One 72-year-old male general surgeon in practice for 45 years did not complete the questionnaire.) Responding group members ranged in age from 30 to 52 years. There were eight men and four women distributed among the following specialties: family practice (3), internal medicine (2), neurosurgery (1), general surgery (1), pediatrics (3), obstetrics-gynecology (1), and orthopedic surgery (1). The number of years in practice ranged from 2.5 to 18. Although all members regarded themselves as Christians, religious preferences included Methodist, Episcopal, born-again Jew, Roman Catholic, Evangelical Fundamentalist, and Christian. All but one woman were married.

RESULTS

Motivation for Joining the Group

Spiritual reasons given for joining the group are summarized as the desire to learn, discuss, study, and share issues with other physicians of like faith. The members benefited from the group by receiving encouragement, fellowship, and emotional support, and by discussing patients and medical issues, as well as having a referral source with physicians of like values.

Topics Discussed

Participants reported discussing the following topics at meetings: terminal patient care, abortion, malpractice issues, the medical profession as a mission field, time demands of professional life and how it erodes family life, and how medicine and spiritual issues interrelate.

Questions were asked about how participation in this group affected the treatment approach to patients (1) with terminal illnesses, (2) considering abortion, (3) subject to drug and (4) alcohol abuse, (5) having clinical anxiety or depression, (6) suffering with chronic illness, (7) coping with family problems related to divorce, and (8) involved with sexual abuse.

Three physicians said that the group directly and indirectly encouraged them to share their faith with terminally ill patients; three felt that their treatment approach was not influenced; one felt that because of the group, death was not so personally threatening; one felt that it was easier to be calm with the family and patient, which led naturally to a discussion of spiritual matters.

Physicians' responses regarding the abortion issue indicated agreement that the group strengthened individual members' conviction that abortion was ethically unacceptable. Discussion of alternatives to abortion and potential referrals to community resources was helpful. Responses to dealing with drug and alcohol abuse ranged from no change to the comment by several that the group gave support for recommending spiritual guidance.

Physicians varied in their responses about the treat-

ment of patients with anxiety or depression. Some said the group had no effect on their approaches. Others felt that the group supported the possibility of suggesting religion as an answer. One member reported giving scripture readings about anxiety to patients for study.

Some group members gave comforting scripture readings to persons with chronic illnesses. Others stated that the group did not influence their treatment protocol. Similar answers were given to questions about dealing with patients with family problems related to divorce.

In dealing with patients with problems related to sexual abuse, one physician reported the group encouraged her to still love the perpetrator despite a deep hatred for the action. Another physician confided that she had trouble dealing with the problem and that she prays for guidance and the ability to forgive and not judge. Another physician referred such patients to his pastor.

The majority of physicians said they prayed either silently for their patients or with them, if appropriate. When asked if they talked about God with their patients, most physicians affirmed that they did so if the patient brought up the subject, or when they sensed a need, or if an opening presented itself. Responses to the question "When should the physician encourage the patient to go to church?" included, "if I see a need"; "if patients are looking for spiritual strengthening"; "if they have gone to church in the past"; "at times of stress or loss."

Group members used the group meetings to discuss difficult problem patients. Patients with leukemia, a child with a brain tumor, a mother considering an abortion, emotionally draining patients, very dependent patients, and alcoholics, all were mentioned as examples. One half of the physicians mentioned patients to pray about in the group. Most physicians felt that prayers either sometimes or always helped the medical outcome.

The final question was, "Assuming you had any of the following problems, how comfortable would you feel about discussing them in the group?" The physicians rated on a five-point scale ranging from very uncomfortable (5) to very comfortable (1). They were also asked to indicate those actually discussed. The problem list is displayed in Table 1.

In summary, participants felt free to discuss a range of issues, both personal and professional. Most benefited by sharing with like-minded individuals utilizing a spiritual orientation when addressing issues. Group members valued the support of being with a familiar, accepting group that met regularly over a long time. The physicians reported being influenced by their spiritual beliefs in their attitudes toward social issues and in their practice of medicine. The group provided a safe place to explore these beliefs.

TABLE 1. GROUP DISCUSSION ISSUES AND PARTICIPANTS' LEVEL OF DISCOMFORT

Issues	Mean Discomfort Score*
Sexual problems†	3.6
Marital problems	3.3
Drug abuse	3.0
Alcohol abuse	2.9
Psychiatric illness	2.7
Overinvolvement with patient	2.2
Family problems	2.0
Physical illness	1.6
Malpractice suits	1.6
Professional goals	1.6

*5 = very uncomfortable, 1 = very comfortable
†The only topic not actually discussed by the group

DISCUSSION

The findings in this paper indicate that individual members of a group of physicians benefited from being part of a self-selected support group holding common spiritual beliefs. Unlike the Balint group, this group provides a basis for resolution of dilemmas by relying on biblical principles. The potential finality of this standard limits the range of views and solutions. The Balint group, in contrast, may be more accepting of questions with less expectation of resolution. It encourages physicians to listen more carefully to patients and to see the world from the patients' view. Balint groups have traditionally been used by general practitioners and family physicians. This Christian support group included a variety of physicians representing different specialties. Eligibility for membership included only being a Christian and a physician. In both groups a range of issues are discussed, but the spiritually based group focuses more on moral and ethical dilemmas.

In the Balint group, participants acknowledge the need to talk over problems in the physician-patient relationship. In the spiritual support group studied, the agreed-upon goal was to have an opportunity to study the Bible and to apply its lessons to life. Neither group acknowledged using the group as a resource for exploring personal issues. Both such groups, however, probably function at least partially in this realm.

Leadership in Balint groups is typically arranged by formal appointment of a group facilitator who has background and training in the behavioral sciences. Leadership in the group studied was informally delegated to two of the founding members.

Finally, the spiritual group uses modes of support unique to a group with this orientation, including prayer, meditation, and applications of scripture study. In contrast, the Balint group primarily uses group discussion and

interaction as a means to understand problems and to provide support.

It is important to discuss possible dangers regarding the effect of this kind of group on individual members, patients, and the physician's ability to function in certain practice contexts. Individual members may feel pressured to accept the acknowledged group value. Challenging antiabortion sentiments, for instance, may be seen as too risky. The group may demand a level of such religious homogeneity that religions not considered Christian by the group will be discounted. Members may be influenced inappropriately to impose their beliefs and biases on patients and their families. Less receptivity to persons with dissimilar beliefs or other frameworks important to the understanding of human behavior potentially can adversely affect those patients seeking abortion or divorce or other patients who have serious psychological problems. In such instances the group's focus on a predominantly spiritual solution to problems may prove inadequate. Group members whose practice context includes practitioners with other value systems may experience isolation or conflict with their colleagues. The support group needs to be responsive to such issues.

In view of the above discussion, the authors urge those individuals considering the formation of a religious physician support group to define explicitly and anticipate potential pitfalls. For example, this support group tolerated a range of religious perspectives including a literalist-biblical approach. That reconciliation among various viewpoints was achieved was probably a reflection of the group allowing members to arrive at a basic agreement on a definition of Christianity. The group must develop rules for tolerating and managing theological disagreements and for effectively protecting medical diagnosis and management from extreme theological bias. The group may also need to develop ways of protecting an essential of effective care in family medicine, namely, openness to the uniqueness of individual patients and respect for their varied perspectives.

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