Balint groups in undergraduate medical education: A systematic review using narrative synthesis

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AM is the guarantor. All authors contributed to review design. AM and DH drafted the review protocol. HC provided expertise on psychiatry and medical education. DH provided expertise in systematic review processes. AM developed the selection and data extraction criteria. All authors read, provided feedback, and approved this protocol.

This study is not funded or sponsored.

1. Introduction

1.1 Balint groups and the patient-centred approach

In the 1950s, psychoanalysts Michael and Enid Balint began to lead group discussions with general practitioners (GPs) to explore the emotional content and difficult aspects of the doctor-patient relationship (1,2). The format has since expanded to other specialties, as well as allied and para-medical professionals (2,3). In the UK, participation in Balint groups is now compulsory within postgraduate psychiatry training, and is included in the curriculum for training in general practice (3). Of the 33 undergraduate medical schools, there are two
which currently offer Balint groups as optional components of the curriculum, one will begin offering groups in 2017, and a further six are expressing interest (3–5).

Balint groups consist of six to twelve members plus either one or two group leaders. A member is invited to present a case involving emotional difficulty in relation to a patient (2). Once finished there is time for questions from the remaining participants (1). The presenter then pushes back their chair from the group, to remove themselves from discussion, as other group members reflect on the case from the perspective of both patient and doctor (1). The presenter then re-joins the group for final discussion before time is up (1). Groups typically meet on a weekly to monthly basis, and run anywhere from a few weeks to several years (1,2,6).

Balint groups are believed to be useful at a range of stages of medical education for addressing psychosocial phenomena including resilience, burnout, empathy, compassion fatigue and communication skills (7–10). Here we focus on the overarching concept of patient-centredness, characterised as a necessary attribute of newly qualifying doctors in the UK General Medical Council’s Outcomes for Graduates (11). Patient-centredness means providing care that is individualised, respectful and empowering (12,13). For patients, such an approach is associated with increased satisfaction, improved quality of care and health outcomes (13–15). For doctors, it is associated with fewer malpractice complaints (16). The patient-centred approach is addressed in UK curricula using a combination of communication skills training, teaching about general practice and health promotion, and clinical exposure to patients (5,17,18). There is a well-documented decline in students’ attitudes, empathy and patient-centredness throughout medical school, particularly once regular clinical experience has begun (14,19–21). Given scarcity of resources, there is insufficient evidence to justify
medical schools’ routine commissioning of Balint groups. We plan to undertake a synthesis of the literature to understand whether and how Balint groups might help medical students to become more patient-centred in their approach. This will address the questions “Does participation in Balint groups help medical students to become more patient-centred?”, and, “By what mechanisms might Balint groups help medical students to become more patient-centred?”

2. Methods

2.1. Theoretical approach

This review will be approached from a pragmatic epistemological viewpoint (22,23): it will be more concerned with the “conceivable practical consequences” of taking various courses of action than with the building or testing of social science theory (24).

2.2 Eligibility criteria

This systematic review will include published Randomised Controlled Trials (RCTs), observational studies and case series with any or no comparison arm, as well as qualitative research/ multi-methods studies. Participants must be studying for a degree in medicine; groups including non-medical student participants will be excluded. Interventions must be labelled as Balint groups; papers will be excluded if they combine Balint group work with other methods. Due to resource constraints we will accept only full-text articles available in the English language.

2.3 Information sources

We will search EMBASE, MEDLINE and PsycINFO (all through Ovid), and the Cochrane Central Register of Controlled Trials from database origin until 25/08/2016. The Journal of the Balint Society will be hand-searched from its conception (1971) until 25/08/2016.
2.4 Search strategy

Example Search strategies are presented (Tables 1-3). Online searches will be combined with searching the bibliographies of key papers.

Table 1: PsycINFO (results 1806 to 25/08/2016) search strategy

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<td>4</td>
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<td>5</td>
<td>exp Medical Education/</td>
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<tr>
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</tr>
<tr>
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<td>809</td>
</tr>
<tr>
<td>8</td>
<td>6 and 7</td>
<td>89</td>
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Table 2: MEDLINE (results 1946 to 25/08/2016) search strategy

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<tr>
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<td>Education, Medical, Undergraduate/ or Education, Medical/</td>
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<tr>
<td>5</td>
<td>undergraduate?.mp.</td>
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<tr>
<td>6</td>
<td>1 or 2 or 3 or 4 or 5</td>
<td>108370</td>
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<tr>
<td>7</td>
<td>Balint$.mp.</td>
<td>688</td>
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<tr>
<td>8</td>
<td>6 and 7</td>
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</table>

Table 3: EMBASE (results 1974 to 25/08/2016) search strategy

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2.5 Study records:

2.5.1 Data management

The numbers of citations retrieved, included and excluded at each stage will be documented using Mendeley Desktop version 1.16.1, MS Excel will be used to identify duplicates and data will be entered directly into tables in MS Word.

2.5.2 Selection process

One reviewer will be responsible for selecting studies through the screening, eligibility and inclusion stages. The abstracts of all studies identified through online searching will be screened for eligibility, and either discarded or assessed at full-text for inclusion.

2.5.3 Data collection process

A single reviewer will carry out data collection, initially with a pilot extraction form which will be tested and modified for use in final data collection.

2.6 Data items

Data items will include study characteristics (study design, year of publication, sample size, country, setting and study length), Balint group characteristics (number of participants per group, frequency of groups, number of group leaders and durations of meetings), participant’s characteristics (year of study, age, gender) outcomes (all reported) and any reported results of association between intervention and outcome.

2.7 Outcomes and prioritisation

Primary outcomes will be any instruments that seek to demonstrate, or themes that illuminate some aspect of patient-centredness, or a change to students’ internal characteristics. Secondary outcomes will be instruments that seek to demonstrate, or themes that illuminate the appropriateness and acceptability of Balint groups.
2.8 Risk of bias in individual studies

Risk of bias will be assessed using: the Cochrane tool for RCTs (25), ROBINS-I for observational studies (26); the Institute of Health Economics checklist for case series (27). The Joanna Briggs Institute’s Quality Assessment and Review Instrument (JBI QARI) will be used to assess studies with primarily qualitative methods (28). Quality assessment will not be used to exclude any study from analysis, but to inform confidence in the findings of each (29).

2.9 Data synthesis:

We anticipate that heterogeneity of methodology and outcome measures will mean that quantitative synthesis is not possible. Instead, we will use a framework for narrative synthesis (30,31).

2.9.1 Narrative synthesis stages 1 and 2: Developing a preliminary synthesis and exploring relationships in the data

A preliminary synthesis will be established through pilot data extraction, where main findings from included studies will be tabulated, grouped and thematically analysed. This synthesis will provide an organised framework of study findings. Relationships in the data will be explored via vote-counting of themes across studies to determine differences in emphasis across the included studies.

2.9.2 Narrative synthesis stage 3: Developing a theoretical model of how the intervention works and why

We will devise a treatment theory to hypothesise linkages between ingredients (observable actions), mechanisms (processes by which they induce change), and outcomes (aspects of the recipient’s functioning) (32).
2.9.3 Narrative synthesis stage 4: Assessing the robustness of the synthesis product

We will reflect critically on the review process using appropriate frameworks for quantitative (33) and qualitative research (34).

References


PROTOCOL: Balint groups in undergraduate medical education: A systematic review using narrative synthesis – Monk A, Hind D, Crimlisk H

Available from: http://www.annfammed.org/cgi/doi/10.1370/afm.813


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