Capacity of the Teachers to Recognize the "Warning Lights" And Develop the "Drug Function" For the Benefit of the Patient

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Abstract

An important aspect of the doctor-patient relationship is the emotional and psychological assumptions of the physician. In their book "Médicos com Emoções", Salinsky and Sackin studied the defenses of doctors during consultations. These defense mechanisms, when inadequate, can cause damage to the professional or the professional interaction with the patient. Thus they defined warning lights as the set of perceptions that point to the organization of counterproductive defense mechanisms. The Pontifical Catholic University of Goiás (PUC Goiás) has introduced in its medical school curriculum the study of the Balintian theory, confirming the value of the bond between doctor and patient. Professors should be responsible for uniting Balintian theory with medical practices, reinforcing the academics aspects of a good doctor-patient relationship. This study aims to evaluate the ability of faculty experts of 7th semester of medical course to recognize the warning lights, serving as a "drug" benfit to the patient.

Key words: Doctor-patient relationship, Balint, Medical Education

1. Introduction

An important aspect of the physician-patient relationship is the emotional and psychological assumptions of the physician. In their book "Médicos com Emoções", Salinsky and Sackin[1] studied the defenses of doctors during consultations. The authors noted that the defense mechanisms, even though essential for the emotional protection of the physicians, when inadequate they can cause damage to the professional or the professional interaction with the patient. Thus they defined *warning lights* as the set of perceptions that point to the organization of counterproductive defense mechanisms. They concluded that for the doctor it is important to identify these warning signs which once recognized in time, the *warning lights* will be used to generate reflections and modify the defenses making them less destructive.

The Pontifical Catholic University of Goiás (PUC Goiás) has introduced in its medical school curriculum the study of the Balintian theory thus confirming the value of the bond between doctor and patient[2]. Module VII (7º academic semester) has been shown to be a step in conflict because of the theoretical content, covering specialties such as Cardiology, Nephrology, Pulmonology, Oncology, Hematology and Forensic Medicine, with a deep emotional appeal due to close contact with aspects of death. In this environment, Balintian categories[3] are important tools in situations that require the development of defense mechanisms. The teachers of various specialties should be responsible for uniting Balintian theory with medical practices in clinics and wards, reinforcing the academics relevant aspects of a good doctor-patient relationship.

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This study aims to evaluate the ability of faculty experts of Module VII to recognize the *warning lights* and to serve as a "drug" benfit to the patient, being able to correlate theory and practice in the teaching and learning of the students.

Theoretical Assumptions about the Doctor-Patient Relationship:

The clinical encounter is now rich, dense, full of feelings and emotions, and these characteristics require the physician's knowledge, skills and attitudes in order to treat their patients adequately[4]. The doctor must also learn to know himself well enough to prevent their own preconceptions, personal problems and identifications with the patient from disturbing the development of an adequate physician-patient relationship[1].

Michael Balint was a pioneer in developing a theory about the relationship between a doctor and a patient. Since 1950, Balint organized, in the Tavistock Clinic in London, seminars with a group of family doctors in the NHS (National Health Service). In these seminars, the experiences, sorrows, successes and failures of the clinical practices of physicians were discussed, which led to the publication of the book "The Doctor, his Patient and the Illness". This booked marked the beginning of the paradigm shift in medical care, since that in it Balint described in detail the *categories* that guide his theory: *the doctor as a drug, the organization and the offer of the disease, the collusion of anonymity and the apostolic function.* [3]

The main category of the Balintian theory is the *doctor as a drug*. According to the perception of Balint, the doctor, when prescribing a drug, put in the prescription drug to much of himself and the relationship established with his patient, so as to extend or not the effect of the medicine prescribed by him. [6]

The following two categories correlate and complement each other. These are the *organization and the offer of the illness*. According to Balint, the patient from his suffering, anguish and pain, organizes a disease, an organic state of suffering which he can complain about. After *organizing* the disease, the patient *offers* it to the doctor, who can accept it or reject it. It is worth rejecting the correlation of these concepts with the category the *doctor as a drug*. The main adverse effect of the doctor in his role as a "drug" is the way he reacts in relation to the offers of the patient.

The *collusion of anonymity* is related to the doctor's ability to assume or not his liability before the patient. According to Balint, some doctors, faced with cases that leave them unsure, refer patients to several experts who examine the diseased organs, but do not assume responsibility for patient care. The patient is at the mercy of various professionals without, however, having a doctor that actually treats the case.

The last category proposed by Balint is the *apostolic function*. It is about opinions, advice and medical guidance that carry aspects of the personality of the professional. The doctor in such situations turns out to coin in his conduct that he believes much of the advising and somewhat "imposing" on the patient what he thinks is right, usually based on common sense.[3]

In an English study with family doctors in Balint groups, Salinsky and Sackin evaluated the ability of doctors to share emotions with their patients. The result of this study was the book "*What are you feeling, Doctor*?"[5] published in 2000 and later translated into Portuguese as "Médicos com Emoções"[1]. In this book, the emotions and defenses of the doctors are exploited in order to recognize that a medical consultation can avoid failure if the doctor learns to balance his medical knowledge and his feelings (*the professional self and personal self*).

There are many queries that are problematic for both the physician and the patient. This fact occurs when the patient mobilizes the doctor disturbing feelings that are not recognized or understood properly (countertransference). When doctors can not deal with these feelings they often develop defense mechanisms, which are sometimes essential for personal and professional protection and sometimes are extremely excessive and present themselves as obstacles to a doctor-patient relationship that is empathic and problem-solving[1,5.]

The analysis of Salinsky and Sackin[1,5] showed that the discussion on the subject in Balint groups reveals the defenses used during the consultation and gives the doctor a better way to deal with their emotions. Discussing these defenses also allows the doctor to feel better prepared when engaging in similar cases, which is critical to his emotional balance. During the Balint groups, participating doctors noticed that some environmental signals during the consultation could indicate when a defense would be raised, and then called *warning lights*[1,5.]

Defined, therefore, as the *warning lights* these perceptions could provide precaution during the approach and installation of unnecessary and counterproductive defensive mechanisms, as well as those needed for a good doctor-patient relationship. They concluded that for any doctor it is extremely important to identify these warning signs that once recognized in time, will serve to slow down, generate ideas and modify the defenses making them less destructive.

The warning lights most discussed and categorized after the study are: Anxiety, Feeling irritable, Worried about time, Withdrawn and aloof, Cold and contemptuous, Angry, Careful not to offend, Overuse of the biomedical model, Apostolic behavior, Health education, Sticking firmly to practice policies and Too closely identified[1.]

The evocation of the mechanisms of defense against the warning signals correlates with the counter transference of the doctor. This is because the medical professional does not completely dissociate himself from his personal self - a being with intrinsic feelings, subject to boiling emotions. That's when the defense mechanisms become important and must be identified and reframed to avoid the disastrous abandonment or completion of the clinical encounter.

When the doctor is not able to see the warning lights, instead of acting as a good drug and receiving the offer of the disease in its entirety, he ends up avoiding approaching the real suffering of his patient, performing the *apostolic function* [1].

2. Methodology

It is the quantitative and qualitative research with the objective to analyze the perceptions of the teaching physicians of the warning lights and their subsequent performance as a beneficial drug to the patient. The *participant observation and semi-structured questionnaires* were used as instruments. *Participant observation* was carried out in order to recognize the warning lights perceived during the consultations, while the *semi-structured questionnaire* aimed to record the opinion of the doctor and patient after the same consultation. From this information it was possible to compare responses and assess whether there was a good *drug function* to the patient. The participants were the specialists professor doctors and the patients treated by them in the Holy House of Mercy and the Institute of Forensic Medicine in Goiânia-GO. The study was approved by the Ethics Committee in Research of the Holy House of Mercy in Goiânia (CEP / SCMG) under protocol n^{o} 023/10.

In the first moment, termed "pre-research phase," the researchers developed a student training to implement the instruments through two simulations of consultations in the mirror room of the Skills Laboratory at PUC. The simulated consultations were held with a student playing the role of a patient and two other academics of the medical school at PUC Goiás representing doctors (students in "*role*"). During those moments, the simulated application of the instruments of research was made by the researchers (participant observation and application of semi-structured questionnaires).

The same instruments were then applied during two real visits with teachers of the PUC Goiás medical course that did not fit as subjects of the study. Although such evaluations have not resulted in any data used in the research, they were able to develop better academic skills for going into the field.

A survey was administered to the academics who attended module VII of the graduation of Medicine of PUC Goiás by the end of 2010, to map areas of the greatest emotional appeal of this semester. Students graded from 0 to 10, in ascending order, the clinics saw as giving the highest emotional appeal. It was given a cutoff value of 7 (seven), in order to select the most striking clinics.

The researchers then discussed the professor doctors of the specialties that 50% +1 of the students regarded as the most impactful. According to the factors of inclusion and exclusion (see Table 01) a raffle for codification was performed, at random, for the doctors through the letter M followed by Arabic numerals (example: M1, M2 and so on) for later identification of the professionals when reading the data investigated.

Considering that the same doctor may have different reactions, behaviors and attitudes depending on the patient to be met, a *participant observation* was made by only one of the researchers, of three (3) medical consultations for each professor doctor selected.

Upon completion of the consultations, both researchers applied the *semi-structured questionnaires* with closed and open questions to the doctor and the patient he attended (selected according to the criteria of inclusion and exclusion - see Table 02), in order to understand if the doctor was able to recognize its warning lights to be a good drug to the patient, in the view of the physician and the patient.

Data analysis was made from a careful reading of the record of participant observations for all consultations seeking to highlight the bright spots, having as an epistemological base the Balintian theory. A survey was done of data from closed questions of the *semi-structured questionnaire*, seeking to understand the perception of the population studied as to their satisfaction during the consultation, and survey data obtained in open-ended questions seeking to categorize the responses obtained by the professor doctor and patients. Finally, we developed a dialogue between the data in order to understand if the teachers were able to recognize their warning lights and act as a beneficial drug to the patient.

3. Description and Data Analysis

From the survey made with the academics who attended the course module VII of Medicine, Catholic University of Goiás until the end of 2010, were chosen as a research field (areas of greatest emotional appeal) the following specialties: (a) Oncology, (b) Forensic and (c) Hematology.

Hematology was considered as a "lost" research, because the ambulatories were transferred to the Blood Bank in Goiânia, with a different profile of consultations and a new teacher, who fled the scope of this study.

As there was only one teacher in each specialty that met the criteria for inclusion in the study, they decided to analyze the ambulatory consultations with the professor doctors named M1 and M2, both female and aged 45-55 years. One had a superficial knowledge about the Balintian theory, the other a total stranger. None of the teachers surveyed had previously participated in Balint groups.

Asked about the influence of knowledge of academic Balintian theory in their medical practice, both said they were not influenced by them in their doctor-patient relationship. M1 justified in saying that she observed that in her ambulatory clinic the students avoided treating the patients, thus reinforcing the emotional impact that the selected specialties provoked in the academics.

From the observation of consultations of M1, the tone of the doctor's voice could be seen rising when one of the patients reported not bringing the additional supplementary examination required in the last consultation, showing, in his speech, the warning light of *irritability*:

> _____"Let's forget about the exam. What do you feel?" (Fragment of medical speech M1)

Also during the consultations of M1, the warning lights of *Health education* was perceived at the time the patient spoke emphatically about the prevention of postoperative complications. Thus, during consultations, M1 did not recognize her warning lights and could not put into practice any behavior or attitude in order to improve the relationship with her patient and overcome her irritability. However her patients did not realize her dissatisfaction in the medical clinical encounter, which turned out to protect them from an unfavorable relationship.

In answering the semi-structured questionnaires applied after the consultation, when asked how she felt after the first encounter with the patient, M1 said she considered the consultation bad, because the patient had forgotten the supplementary examination, which she thought was "the focus ". In contrast, the patient reported the opposite:

> ‘"The consultation was good, the doctor could explain why the test was so important, it made me relieved. I was nervous because I saw that the scan had changed "(Fragment of the patient's response after meeting the teacher M1)

Note that although the patient knew that the exam had an evident alteration and also did not bring the exam to the doctor to review, she felt more relieved only by the fact that she had been consulted, which shows the development of a good "drug role "by the doctor. It can also be seen that the focuses considered important were not the same for M1 and for the patient. After the consultation, the doctor felt disappointed, believing that the same would have happened with the patient, pointing to the fact that the teacher did not recognize their therapeutic potential by Balint called the "drug role".

From the observation of M2 consultations, we could show long periods in which the doctor talked to patients without looking them in the eye, featuring the warning light of *withdrawal*. This signal is reinforced by the fact, when asked about how she felt after the consultation, M2 answer:

""I feel *normal!"* (Speaking of medical M2)

Also in relation to the *distance*, during the second consultation with the patient, the teacher M2 used few words, writing more than communicating verbally. On the other hand, in answering a semi-structured questionnaire, the second patient reported:

"I felt great, she answered me so good, she listened, paid attention to me."
(Excerpt of speech by medical patients from M2)

4. Conclusion

A good doctor-patient relationship is fundamental not only for therapeutic success in a clinical encounter, but also to protect the physical and mental health professional. By categorizing the decisions which involve the relationship with the patient, Michael Balint[3] provided tools for physicians to be able to establish appropriate links in the consultations. Salinsky and Sackin identified the "warning lights" [1,5] expressed by the professional when they are about to break the bonds required for remaining psychologically balanced, and to develop a good relationship with the patient. Thus, knowledge of the "warning lights" becomes important for the health of both those involved in doctor-patient binomial.

It was observed that while the medical patients evaluated in this study have left satisfied with the consultation, the medical teachers were not able to recognize their own "warning lights" during clinical encounters, feeling frustrated.

M1: "I was disappointed, I lost my time ..."
M2: "I feel normal!"

This data allows the perception that despite having developed a good "drug role" for patients, they were not able to use defense mechanisms appropriately.

It was observed that the contact of the professor doctors during module VII with the students, who are gifted with knowledge of the Balintian theory, did not influence them in their clinical practice. This fact demonstrates the difficulty of teaching in making the correlation between theory and practice of humanistic content studied by scholars during the course.

Thus, it becomes necessary to create strategies in order to provide teachers with knowledge about the Balintian theory, particularly on the warning lights developed by Salinsky and Sackin.

Table 01 – Factors of Inclusion and Exclusion of Medical Faculty

I) – Factors of Inclusion:
a. Be any age.
b. Being male or female.
c. Be a doctor.
d. Being a teacher of the Department of Medicine PUC-Goiás.
e. Being part of the medical specialties selected as the most striking.
f. Attending clinics in the Holy house of Mercy in Goiânia.
g. Not having any active academic participation at the time of participant observation.
h. Agree to participate in the study by signing an informed consent.
II) – Factors of Exclusion:
a. Work as an expert advisor of Course Completion (TCC) of other scholars of modules X,XI ou XII of the School of Medicine, PUC-Goiás, being aware of this issue by attenting teachers meetings.
b.To be a non-medical teacher.
c.To be a teacher who refuses to participate in the research.
d.To be a foreign teacher.

Table 02 – Factors of Inclusion and Exclusion of Patients

I) – Factors of Inclusion: (a). Patient attended by the pre-selected teachers at the first consultation or follow-up visit. (b). Patients aged > 20 anos. (c). People aged over 20 years old who accompanied the consultation of patients aged less than or equal to 20 years. (d). Male or female. II) – **Factors of Exclusion:** (a). Patient who was not served by the specialist teacher at the time of the survey. (b). Indigenous patients. (c). Inmate patient. (d). Patient of African descent. (e). Foreign patients. (f). Patients aged under 20 years..

5. References

Salinsky J. & Sackin P. Médicos com Emoções: Identificar e Evitar Comportamentos Defensivos na Consulta. Lisboa, Portugal: Grünenthal, 2004.

Taveira D. et al. Balint Groups in the Medical School of Pontifical Catholic University of Goiás: Report of an Educational Experience. Journal of the Balint Society 2010 vol. 38: 9-12

Balint, M. O Médico, seu Paciente e a Doença. São Paulo, SP: Atheneu, 2005.

Porto C.C., Branco R.F.G.R. & Oliveira A.M. Relação Médico-Paciente. Cap.2. In PORTO. Semiologia Médica 6ª ed. Rio de Janeiro: Guanabara Koogan, 2009

Salinsky, J. & Sackin, P. What Are You Feeling, Doctor? Identifying and avoiding defensive patterns in the consultation. England, UK: Radcliffe Medical Press Ltd, 2000.

Branco, R.F.G.R. A Contribuição de Balint à Relação entre o Clínico Geral e seu Paciente. Cap. 7. In BRANCO. A Relação com o Paciente: Teoria, Ensino e Prática. Rio de Janeiro, RJ: Guanabara Koogan, 2003.