STUDENTS AND THEIR PATIENTS: EVALUATING THE IMPACT OF UCL MEDICAL STUDENT PSYCHOTHERAPY SCHEMES.

INTRODUCTION.

Medical students beginning their clinical studies go through an enormous psychological transition from being passive recipients of academic knowledge to engaging in active encounters with patients and illness and the clinical world of the hospital. For the first time they see people with life threatening illnesses, disability, disfigurement, and encounter death and dying. In our medical school, as in others, in their 1st clinical year, they now have special teaching on communication skills and ethical issues, and also have to follow up a cancer patient over many months in this 1st clinical year.

THE UCL STUDENT PSYCHOTHERAPY SCHEME.

53 years ago, in order to help students to gain a deeper understanding of the doctor patient relationship, Heinz Wolff, Dorothea Ball and Roger Tredgold began a scheme for carefully selected outpatients to be seen by the students for one year of supervised once
weekly psychodynamic psychotherapy (Ball and Wolff, 1963). This scheme has remained extremely popular with our students who found it helped them to learn to listen to their patients and to speak about difficult topics such as death and dying, to appreciate the value of continuity of care, and to recognise the significance of the patterns of dependency repeated by patients in therapy. Many have taken these skills into general practice and psychiatry.

Doing psychodynamic psychotherapy gives a student a unique experience of handling the dependency needs of a patient through the student's understanding of, interpretation of and working through of transference situations. This provides profound insights into the doctor-patient relationship. At the end of the psychotherapy students evaluate their work by writing a summary of the treatment. Here is an extract from the summary of a student's work with a patient with unexplained medical symptoms:

"We explored the significance of Jenny's symptoms and she remembered how anxious she had been as a child about not making it to the toilet on time before a class, fearing she might have an accident in the classroom; at home she had been taught that to use the toilet was dirty and never to be discussed. I tried to explore if there might be a link
between using the toilet and expressing certain feelings. Although she said she didn't understand, she interpreted new somatic symptoms in this light: as for example when trying to express her feelings about the ending of therapy she developed a cough which interrupted her, I interpreted how this might mean that she didn't want to tell me directly about how difficult it would be for her to loose me as her therapist."

In 2004 Jessica Yakeley, I and a statistician Austen Heady looked at the impact of participating in this scheme on subsequent career choice. We sent a questionnaire asking about career choice to 198 students from our medical school who had participated in the scheme between 1982 and 1992 and also 200 randomly selected students of the same period who did not participate. 77 of the 163 participants had not thought of doing psychiatry as a career before entering: of these 11 became psychiatrists (14.6%), compared with only 2 (1.6%) of the 128 controls (of 152 respondents) who had not considered psychiatry a career at the same stage. This difference was highly significant and implied that participating in this scheme encouraged medical students to choose psychiatry as a career. Many who did not specialise in psychiatry emphasised how this scheme had helped them understand the doctor-patient relationship. (Yakeley, Shoenberg and Heady 2004).

STUDENT BALINT GROUPS
Unfortunately because of the limitations on the number of suitable patients willing to see a student and the numbers of supervisors available we have only been able to take 10-15 students per year into this scheme. However in 2004 when we were faced with an increase in the medical school’s annual intake of clinical students from 180 to 360, Heather Suckling and I decided to offer the 1st year clinical students an alternative to our Student Psychotherapy Scheme by reintroducing Balint groups (originally tried out briefly by Michael Balint (Balint, Ball and Hare 1969) in a modified form (Shoenberg and Suckling, 2004): the students were invited to participate in a weekly Balint discussion group which was to last only 3 months. This experience with our 1st group very rewarding, even though it could not go as deeply as Michael Balint original groups did. This development has eventually allowed many more 1st clinical year students to benefit from a psychotherapeutic teaching approach than was previously possible. With the Vice Dean’s, help this was included on the curriculum as a Student Select Component: because of being a Student Selected Component it generated enough university funds to pay for 2 group leaders for each of 10 groups, one a Balint leader from General practise and one a medical psychotherapist from our department. At the end of 3 months the students are expected to write a reflective essay on their experience with a patient and how this has been
influenced by discussion in the Balint group. Nowadays up to 100 students participate a year in these 10 Balint groups running either in the Spring or the Summer terms or else in the UCL student psychotherapy scheme. So now up to 30% of the annual clinical intake gets one or other special psychotherapeutic teaching.

The experience of running a student Balint group has proved inspiring and moving, as the students are so enthusiastic, sensitive and imaginative. Sadly their encounters with their patients, apart from with their cancer patient, are extremely brief, mirroring both the new shorter stays of their patients on the wards, and their own rapid changes from one medical speciality to another. Often they only see a patient in groups of 2 or 3 students, so that individual patient encounters are less common nowadays.

BALINT LEADERS' EXPERIENCES.

The Balint groups provide the students with an opportunity to explore a number of themes. We found in our first Balint group that initially the students discussed several cases briefly in the early sessions and more time was spent on general issues, but as the students became more confident they began to discuss individual cases in greater depth. Often in the initial groups students speak about their
anxiety that they have no real role and of their concern that they are exploiting the patients in order to learn to become doctors. Later they begin to explore their communications with patients in a more positive way and begin to appreciate their value to their patients.

In one group a shy and usually silent student Arthur presented a middle-aged man with chronic obstructive airways disease, who had welcomed him, saying that he was glad to help students to learn something. He talked of his life before he had become ill: he was a keen sportsman and seemed to be coping with his illness with a positive attitude. Arthur, a keen footballer, who was wearing an Arsenal supporters’ shirt in our group, had clearly identified with him. Then, as he talked about his family, he burst into tears speaking of his son who had died at a young age. Arthur didn’t know how to handle this situation: he had been told that if a patient became very emotional, the student should not do anything to make the situation worse. He asked the group what they would have done, as he had felt reluctant to ask more questions for fear of spoiling the man’s positive attitude. Some students felt that he shouldn’t make the man more upset by probing into the story of the death: one said he couldn’t imagine what it would be like to experience the death of a child. 2 other students said that it might have been worth
asking this man if he wanted to talk about his son. They spoke of the pressure they were under to produce a good medical history as opposed to feeling they could spend time listening to the emotions of their patients.

Heather Suckling reviewed 3 groups she had conducted, recording 63 cases as having been discussed and identifying the following 10 commonest themes

1. The students’ role.
2. Confidentiality.
3. Consent.
4. The very ill patient.
5. Death and dying.
6. Revulsion towards patients.
7. History taking.
8. Professional boundaries.
10. The doctors’ behaviour.

The students in their feedback reported that

1. Participation in the group increased their confidence.
2. It improved their communication skills.
3. It encouraged whole patient medicine
4. It encouraged reflection
5. It provided support
6. It increased their enjoyment of their work (Suckling, 2005).

THE RANDOMISED CONTROL TRIAL.

In 2011 Jessica Yakeley and I conducted a randomised controlled trial (Yakeley et al 2011) which aimed to evaluate the effectiveness of the Student Psychotherapy Scheme (SPS) and participation in a Balint group in teaching students about doctor patient communication and the doctor patient relationship. These students had originally attended our annual introductory lecture about the 2 schemes and had then been interviewed to assess their suitability to see psychotherapy patients. 30 students were originally allocated to the study and were then randomly allocated to 3 groups each containing 10 students in: a Student Psychotherapy Group (SPS), a Balint group starting at the beginning of the trial and a Balint group starting at 3 months (so acting as a partial control) – they were then rated on a questionnaire testing their knowledge of emotional and psychodynamic aspects of the doctor patient relationship administered at the beginning, at three months and at one year.

We decided not to have a pure control group, as many of the students volunteering for the research had opted to do the SPS or a
Balint group for their SSC. Both Balint groups were run by the same two group leaders, to avoid any variation in the style of the group leaders which might have interfered with comparisons between groups 2 and 3.

The following questions were asked and the students’ responses were rated according to a guide.

1. What effect can the relationship between a doctor/student and patient have on the patient’s overall care?
2. How may a doctor's/student’s feelings be affected by a patient?
3. How may a doctor/student use those feelings in relation to the patient?
4. How do you cope with your anxiety and uncertainty in your work with patients?
5. Do you feel that the relationship between the doctor/student and the patient should be an equal one? If not, why?
6. Why is it important to understand the nature of the patient’s attachment to the doctor/student?
7. How do you recognise emotion in a patient when it is not verbalised?
8. Please comment on your experience in this project.

These are examples of our guide for marking the responses: An ‘ideal’ answer was to include reference to all of the following ideas for each question.

1. What effect can the relationship between a doctor/student and
patient have on the patient’s overall care?

A good relationship can promote trust between the doctor/student and patient which will

(a) Allow the patient to confide and so give a fuller history,
(b) Help patient to comply with treatment,
(c) May help the patient to recover from their illness,

If the relationship is a poor one, it can have a very negative effect on patient care.

4. How do you cope with your anxiety and uncertainty in your work with patients?

(a) Acknowledge that I can sometimes feel anxious or uncertain
(b) By trying to reflect on why I am anxious or uncertain
(c) By discussing these feelings with a senior colleague.

5. Do you feel that the relationship between the doctor/student and the patient should be an equal one? If not, why?

(a) Although a doctor should respect the ideas and views of the patient, the relationship between doctor and patient cannot be an equal relationship.
(b) A doctor/student cannot impose his own difficulties on the patient.
(c) A doctor/student can expect that many patients will develop a dependence on their doctor/student.

(d) The reverse may also happen in that a student/doctor may come to depend upon the patient.

**Results:**

Shortly after the research started, two students dropped out of Group 1, one due to illness, and the other as she decided she could not commit to participating in the SPS after all leaving 8 students in Group 1, 10 in Group 2 and 10 in Group 3. At time 1) 25 of 28 students returned completed questionnaires, at time 2) this had dropped to 14 of 28, but by time 3) i.e. at one year, we achieved a return rate of 22 of 28.

We took the mean score of the three raters for each student, and from this calculated the mean score (and standard deviation) for each group at each measurement time.

**Table 1**

<table>
<thead>
<tr>
<th>Group</th>
<th>Time 1</th>
<th>Time 2</th>
<th>Time 3</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>(3 months)</td>
<td>(1 year)</td>
<td></td>
</tr>
<tr>
<td>SPS</td>
<td>6.7 (3.0) (n=8)</td>
<td>7.7 (1.4) (n=4)</td>
<td>8.0 (3.1) (n=8)</td>
</tr>
<tr>
<td>Balint Group 1</td>
<td>6.8 (1.2) (n=8)</td>
<td>7.6 (1.7) (n=5)</td>
<td>8.3 (1.8) (n=7)</td>
</tr>
<tr>
<td>Balint Group 2</td>
<td>6.0 (2.2) (n=9)</td>
<td>5.4 (1.7) (n=5)</td>
<td>7.4 (0.8) (n=7)</td>
</tr>
</tbody>
</table>

Standard deviation is in brackets.
n = the number of students who filled in the questionnaire.

At 3 months the mean difference in scores between the SPS and Balint Group 1 was negligible (adjusted difference in means 0.1, 95%CI -2.5 to 2.6, p=0.96). However the difference in scores between the SPS group and the partial control Balint group 2 approached statistical significance at the 5% level (adjusted difference in means -2.2, 95%CI -4.8 to 0.4, p=0.083). Similarly, the difference in scores between Balint group 1 and the partial control Balint group 2 was approaching significance (adjusted difference in means -2.2, 95%CI -4.6 to 0.3, p=0.076). However, this was based on only 14 students at this time.

At time 3, i.e. one year, there was no significant difference between any of the three groups, however the mean difference in scores (n=21) between the start of the project and one year was highly significant (mean difference =1.5, 95%CI 0.6 to 2.4, p=0.0023)**

The main findings were:

1. A significant improvement in the scores compared to baseline scores in all three groups at one-year, after the students had all participated in one of the two teaching methods, and
2. The finding at three months that the scores of the two groups who had participated in the SPS and Balint groups showed a trend that did not
quite reach significance, towards higher scores compared to the control group who had not participated in either intervention at that stage. These results supported our initial hypothesis in suggesting that the interventions were effective in increasing students’ knowledge of the doctor patient relationship as compared to students who did not receive such teaching experiences.

There were important limitations to our study:

1. There was no control group at 1 year so we do not know if the improvements seen might not have been accounted for by other factors such as the students’ encounters with physician patient interactions.

2. The numbers of students participating in the study were very small because we could not have a large sample for the Student Psychotherapy Scheme.

3. The questionnaire tested their knowledge at an intellectual level, and we do not know how much this acquired knowledge translated into actual improved communication skills.

4. Our ideal answers to the questionnaire may have assumed a greater potential in the students for learning about the doctor patient relationship than was possible with such a short exposure to these psychodynamic teaching approaches, which may explain why the changes in the 3 groups were relatively small.
5. The inter-rater reliability was not perfect, with the observers having different overall mean scores, and a less than ideal correlation between the scores.*

CONCLUSION

The results of our study suggest that both our psychotherapeutic methods of teaching can help medical students to learn about the doctor patient relationship and so are useful additions to the undergraduate curriculum. Whereas running a Student Psychotherapy Scheme requires considerable resources, as well as complex clinical governance and ethical issues, and can only be available to a small number of students, Balint group teaching, which also requires experienced group leaders, can accommodate many more students due to its shorter duration and its group approach. This also has the advantage that as a Student Selected Component it can be included in the Curriculum and as such generates university funds which pay for an adequate number of Balint leaders. Our student psychotherapy scheme has been developed in Bristol and Lausanne and with some modifications in Toronto. Student Balint groups have been used in Germany, Italy, Switzerland, South Africa, Poland, Finland and the USA (Sollner, Maurer, Mark-Sternberger and Wesiack 1992, Castiglioni and Bellini, 1982, Luban-Plozza, 1989 and 1995, Levenstein, 1980, Jugowar and Skommer, 2003, Torppa, Makkonen,

We see in the student psychotherapy scheme and in these groups how students begin to see themselves as future doctors with a responsibility for another person: in this process they change from feeling mere observers, of little use to their patients, to realising that their listening and caring skills are at a premium. So we believe that both types of experience help them to appreciate the significance of emotions in medical illness and with that to appreciate their true value as students for their patients.

Arthur the rather shy and silent student who was reluctant to explore the death of a patient’s son with him when this came up in his clerking wrote in his reflective essay:

“When the majority of the group seemed not necessarily to agree with what I had done I felt defensive feeling that if they had been in front of him they would have acted similarly, but then I saw my patient with respiratory diseases 2 days later. He joked with me ‘I’m invisible ,I’ve been discharged’ ;I realised there was a strong bond between us and thought of the comment by one of the Balint leaders that as a young man I might have connected with him as he might have seen me as having similarities to the son he had lost. This allowed me to interact with him in a more meaningful and personal level. I realised he was interested in my
education and my love of football. Now I think about my hesitation to speak about his loss when he got so upset. I can see that by simply asking whether a patient wishes to talk more about an issue means you give yourself the possibility of learning more about the patient on a more personal level while giving the patient the power to make the decision about where the consultation is going."

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Recorded scores at all three time points were pooled, giving 62 data points for which comparisons could be made between the three observers. The mean scores for all students at all time points were 6.8, 5.6 and 8.7 respectively, and the within-student standard deviation was 2.4. The correlations between scores of pairs of observers ranged from 0.49 to 0.65.

*If the observers had been blind, any biases should not have affected differences seen between groups at 3 months. Since only one observer commented that they were not blind when making assessments, the analysis was repeated with that observer’s results omitted. Results were essentially unchanged, with magnitudes of differences among groups being very similar to those reported. Indeed, the lack of reliability would have tended to mask true effects of the intervention, so we believe the
poorer performance for the control group at 3 months is likely to be real.

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