Tidsskriftet
DEN NORSKE LEGEFORENING

Reflecting groups for newly qualified doctors

DEBATT

LARS CHRISTIAN OPDAL

E-mail: l.c.opdal@analyserom.no
Lars Christian Opdal, psychiatrist and psychoanalyst, private consultant specialist in Oslo and psychotherapy supervisor (psychodynamic psychotherapy) at Akershus University Hospital's Division of Mental Health.
The author has completed the ICMJE form and declares no conflicts of interest.

LJUBICA GLUMAC

Ljubica Glumac, psychiatrist, psychotherapist and senior medical consultant at Akershus University Hospital's acute psychiatric unit.
The author has completed the ICMJE form and declares no conflicts of interest.

Young doctors soon find themselves in demanding interpersonal situations, despite not being particularly well trained in how to relate to their own emotions triggered by patient encounters. Reflecting groups may provide a forum for them to acknowledge and manage their own emotional reactions.

Emotional reactions arise in all encounters between doctors and patients, although the causality can often be vague (1). The patients' earlier relational experiences will influence how they express themselves, by way of transference (2). Doctors on the other hand, will be emotionally affected by their patients' form through counter-transference (3). Doctors are thus able to gain unique knowledge of their patients' relational repertoire and an insight into how they perceive their relationships with other people. This often triggers a strong urge to do something.

Similarly, doctors clearly bring their own relational baggage to the encounter with patients. It is necessary for doctors to reflect on this fact before they start an intervention. Failure to do so carries a higher risk of taking inappropriate action.

However, today's doctors are not encouraged to register their own emotional reactions to patient encounters. The trend is rather the opposite: examinations and treatments are presumed to be carried out on an objective basis through the completion of forms and checklists. As a result, subjective reactions are often ignored rather than acknowledged. Emotional reactions are triggered by the encounter, but they are not listened to. This means that important patient information may be missed, while doctors lose out on an opportunity to reflect on their own reactions.

The purpose of the reflecting group is to give participants a safe forum where they can talk about their own experience of patient encounters, followed by thinking out loud, in the

company of colleagues, about diagnostic understanding and treatments.

How to facilitate open reflection

Many have felt that this type of reflection is best developed in groups. Balint (4) found that when doctors were faced with difficult treatment pathways, it was useful for them to share their own reactions with colleagues. Andersen (5) worked with 'reflecting teams'. He found that reflecting on clinical gridlock situations could generate new opportunities of understanding for patients as well as doctors. Norman and Salomonsson (6) developed the 'weaving thoughts' method, which gives specific advice on setting up a group to foster open reflection.

Inspired by these findings, staff at Akershus University Hospital's acute psychiatric unit set up a weekly reflecting group for LIS1 doctors (formerly house officers). One of the participants start by telling the others about their perception of an encounter with a patient. It is considered important to report on any 'gut feeling' and subjective responses generated during the encounter – the sensations that affected the doctor.

Participants feel less burdened by pressures of work and better equipped to do their job when they understand that they are not alone in finding it difficult

The other participants proceed to reflect on the encounter, by 'thinking out loud together', while the person who opened the session listens. The group leader can often find it difficult to stop questions being asked of the person who shared his or her encounter. Doctors tend to ask questions and are not normally used to expressing their own emotions and associations in clinical discussions. Nevertheless, experience suggests that the participants soon understand the value of sharing their own reflections.

The person who opened the session by talking about their own perception of an encounter with a patient is given an opportunity to comment at the end. This is to allow this individual to put into words any thoughts that may have arisen during the reflecting session, should he or she wish to do so. There are no set answers.

Lessons learnt from reflecting groups for LIS1 doctors

Taking part in a reflecting group offers a good opportunity to share emotional experiences, openly and honestly. It is an important premise that the sessions are felt to be safe, peer-based, and empathetic. This may be particularly valuable at the start of a medical career, because newly qualified doctors often feel lacking in confidence.

A sense of safety is maintained within the group by ensuring that the person who has given an account of a patient encounter is shielded from any questioning and criticism. The participants are free to think out loud together, based on what they have heard, but those who open a session, will not have to defend their course of action.

When they were medical students, the participants will often have been taught that doctors need to switch off their own feelings in order to make critical and correct decisions as quickly as possible. A common experience within the group is that participants feel less burdened by pressures of work and better equipped to do their job when they understand that they are not alone in finding it difficult. It becomes easier to act appropriately vis-à-vis patients when the doctor realises that their own emotional reactions are understandable and recognisable across a group of colleagues.

There are also many examples to suggest that reflection improves the doctor's understanding not only of their own difficulties, but those of their patients. The doctor may well perceive a certain response to be a personal failing at first, but may on reflection realise that it echoes the patient's sense of despair and powerlessness.

Our experiences suggest that it may be useful for LIS1 doctors to take part in reflecting groups while working in an acute psychiatric unit. It is highly likely that this is the case for

more experienced doctors as well.

REFERENCES:

1. Vaglum P. Irrasjonelle faktorer i lege-pasient-forholdet. Tidsskr Nor Lægeforen 2002; 122: 1906–9. [PubMed]

2. Freud S. The dynamics of transference. SE 1911; 12: 99–108.

3. Sandler J. Counter-transference and role-responsiveness. Int R Psychoanal 1976; 3: 43–7.

4. Balint E. The History of Training and Research in Balint Groups. Psychoanal Psychother 1985; 1: 1–9. [CrossRef]

5. Andersen T. Reflekterende processer. København: Dansk psykologisk forlag, 1994.

6. Norman J, Salomonsson B. 'Weaving thoughts'. A method for presenting and commenting psychoanalytic case material in a peer group. Int J Psychoanal 2005; 86: 1281–98. [PubMed][CrossRef]

Published: 17 October 2019. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.19.0547
Received 28.8.2019, first revision submitted 14.9.2019, accepted 18.9.2019.