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A Reflective Account: Understanding the Psychological Challenges of Medical Practice

Balint Society Essay Prize 2020 Joint Winner - Student

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Reflection is a critical component of the continuous professional development which is required in the medical field. Balint groups provide an informal but protected environment in which affecting patient encounters can be explored, analysed and examined collaboratively. They not only provide an opportunity to gain a deeper appreciation for the complexities of the medical student-patient relationship, they also provide a medium in which thoughts and feelings can be discussed openly and honestly. This essay focuses on an encounter I had during a home visit with a general practitioner (GP) which was particularly difficult. It will explore the challenges I experienced during and after the interaction, the discussion the encounter stimulated within the Balint group, what I have learnt about myself and what I will take forward with me after this experience.

My case involved a 54-year-old gentleman, who was morbidly obese, a smoker and had an amputated leg. The patient was suffering from chronic obstructive pulmonary disorder (COPD), high blood pressure and had been recently admitted to hospital due to difficulties breathing and haemoptysis. His chest x-ray revealed a large pleural effusion, due to a suspected malignancy, and he was referred onto the two-week suspected cancer pathway by the hospital doctors and discharged. However, the patient had not been informed in the hospital what the referral was for nor the suspicion of lung cancer. Thus, the GP had to elicit what the patient understood, break the bad news to him as well as take a brief history and examine him.

On entering the patient's room, there was a strong smell of cigarettes. The patient, laying in his bed, appeared apathetic. I immediately felt nauseous and uncomfortable as I have always found the smell of cigarettes intolerable. Already, I established there was a barrier between the patient and myself. I could not focus

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on anything other than the smell of tobacco and found the experience quite overwhelming. On deeper reflection, I realised the response may be in part due to members of my own family who smoke regularly. My family members are aware of how sick I feel when I smell cigarettes thus they do not smoke around me. However, despite multiple attempts to encourage and support them in quitting, for various reasons they return to their smoking habit, which I find extremely challenging to accept as a medical student, due to the damage I know they are causing to themselves.

On reflection, I appreciate that the visceral reaction and feeling of repulsion and nausea may not just have been due to the smell itself, but at least partially evoked by my own personal aversion to my family's consumption of tobacco. It reminds me of a scenario in which I have not been able to use the knowledge I have to change damaging health behaviours within my own family. Not only has this made me conscious of a personal bias, it has also taught me that while a clinician has the unique opportunity of impacting the health of patients positively, this does not necessarily mean they will always have the same success within their own family. This disparity between me as a medical student and me as a person is both interesting and challenging, with often the line between the two becoming blurred. It has highlighted to me that being a medical student comes with certain responsibilities and privileges, which I as a family member do not have.

A significant proportion of the consultation involved the patient expressing anger about the care received from doctors, blaming them for the condition he found himself in. The GP later confirmed that on numerous occasions, she and the healthcare team had tried to support him in quitting smoking, but he had never been receptive to the support. The patient was diagnosed with COPD fifteen years ago and was made well aware of the strong link between smoking and lung cancer. I found it frustrating that he chose blame, rather than gratitude as a response to

healthcare professionals who were trying to help and absolved himself of responsibility for his plight.

Frustration is not an emotion I have experienced often during clinical contact, however, on reflection I have realised it was not the patient's dissatisfaction with his care that I found difficult to witness, but rather the manner in which the doctors were discussed. Transitioning from pre-clinical to clinical medicine has exposed me to the admirable work-ethic of doctors and seeing them belittled by this patient evoked an almost child-like defensive response, where I felt the need to not only defend but to remind the patient of how fortunate we are to receive such care. However, I was able to put aside rather than voice these feelings to the patient because I did not want to affect how I behaved with the patient clinically.

This stimulated much discussion in the group and an interesting point raised was that perhaps the patient's shame and embarrassment with himself and how far his health had spiralled out of control was manifesting as anger towards the doctors. This interesting viewpoint made me consider the possibility that blaming the doctors could be a coping mechanism for the patient, and rather than being frustrated by the response, a clinician should provide an opportunity for patients to voice such thoughts, as vocalising them may be somewhat therapeutic for the patient. Moreover, as a future doctor, I should encourage and be receptive to direct feedback from patients, even if it reflects who they are as a person as much as it does the professionals working with them, as this is key to improving the medical profession and maintaining the sacred trust that exists between the public and doctors. However, criticism should be given in a constructive manner, which does not demean or denigrate the character of particular healthcare professionals.

The feeling of frustration also arose from how preventable the lung cancer was. Interacting with a patient with a challenging diagnosis like lung cancer, I was acutely aware of the possible alternative outcome if this patient had stopped smoking. I think all clinicians find the myriad of 'what ifs' challenging. The group

explored our natural tendency as medical students to look for self-imposed damaging health behaviours, which are risk factors for the diagnosis the patient is presenting with. On closer reflection, I have realised an inclination in me to try and elucidate the cause of a condition and contributory risk-factors, due to the manner in which pathology has been taught to me. There is a strange kind of comfort in thinking that life is not completely unfair, rather patients have contributed to their own pathological states. The group also discussed how we are pre-disposed to absolve the doctor of responsibility and shift the blame onto the patient for their condition. It was fascinating to observe the blame being shifted between doctor and patient, by each party to the other respectively. It highlighted to me the complexities of medical practice and how the manner in which pathology has been taught to me has had an integral impact on the way in which I view patients.

A poignant moment during the history was when the patient said, 'I might stop smoking now', creating a sudden change in atmosphere. Being aware that the diagnosis of lung cancer was almost certain, and that the patient's life expectancy was no more than a year, this moment evoked both sadness and cynicism in me. The cynicism resulted from both the timing of his desire to quit smoking, when it would have very little impact on his condition, and doubting whether the patient would actually quit this time. The patient's candid admission exposed a vulnerability which I found saddening and touching. The look in the patient's eyes and disappointment with himself in his voice as he spoke about quitting lead me to realise both how hopeless and helpless this man truly was. One member in the group remarked that perhaps admitting he needed to stop smoking was an open confession to himself and the doctor that something was seriously wrong. This has taught me the value of non-verbal communication and how there are two concurrent streams of communication running between a doctor and a patient: the first being verbal communication, and the second being an unspoken dialogue, which neither party is truly conscious of, in which raw emotions are being

expressed. Being able to differentiate between the two but to also acknowledge both streams of communication leads to greater patient satisfaction and allows a fuller appreciation for the psychosocial issues surrounding a patient.

As mentioned previously, this patient was morbidly obese. This created an immediate connection between me and the patient because I was overweight for the majority of my high-school years and obese during sixth form. Although, now I maintain a healthy weight, I have a unique appreciation for the manner in which obese people are demonised by society. There is a widely held belief in society that obesity is a self-created problem and the simple 'eat less, move more' motto is the solution. From my own personal experience, I know this simplistic view of obesity to be incorrect. It is a chronically underappreciated fact that obesity is as much a psychological condition as it is a physical state. Interestingly, group members stated that describing the patient as obese contributed to a negative image of the patient and perhaps made it more difficult for them to empathise with the patient due to his weight. This further reinforced to me how poorly obesity is understood on a psychological and emotional level by clinicians and society as a whole, as well as highlighting to me the negative connotations surrounding obesity.

The negative image arises from the idea that obesity is self-inflicted, thus patients are not entitled to the empathy and considerations a person in the 'sick role' normally receives. For me, as opposed to acting as a barrier to empathising with the patient, his weight engendered empathy and a deeper understanding of an aspect of his life. I have realised due to this, that my own personal struggle with my weight will be a positive tool that I can use to build rapport with and help both patients and fellow clinicians. On further reflection, I found it interesting to see how my approach to the patient's obesity was in complete contrast to how I thought of his smoking habit. This exemplified to me my biases and made me reflect on the reasons patients smoke and the difficulties faced when attempting to quit.

Reflection has given me a greater level of consciousness of my personal biases and I believe this will prove hugely beneficial to me as a future clinician.

Throughout the consultation, I felt a multitude of emotions, but I explained to the group that it would be unprofessional to express certain feelings. This stimulated discussion amongst group members regarding what thoughts and feelings are appropriate to share with a patient. There was a consensus that doctors are performers and certain thoughts should be kept to oneself. Further exploring this, group members expressed that having a façade made them feel more comfortable during patient care and how the ability to 'perform' was beneficial for both patients and doctors. This led me to reflect on my own personal understanding of the nature of my current role and future role as a clinician. I have always viewed medicine as both an art and a science and I have found that whilst interacting with patients, I am playing the role of a medical student. Being able to have a barrier both helps me to deal with the level of suffering I am exposed to on a regular basis and also to cope with what I experience internally whilst fulfilling the demands of my role.

There was much dialogue about whether having a barrier causes authenticity to be lost in patient interactions. On reflection, I believe that my professional demeanour does not detract from the authenticity of the interaction. As human beings, albeit unconsciously, we behave differently with different people in our lives: our friends, family, work colleagues and patients. I have genuine conversations with patients, however, it is another aspect of my personality which I bring to the fore during these interactions. When faced with situations that are particularly meaningful to us, or hook childhood memories, the struggle is to remain in the moment as a professional. Moreover, the medical student-patient interaction is an honest but professional relationship and I think it is entirely appropriate to remain conscious of this during consultations. I am of the

view that professionalism and authenticity are not at odds, rather they are congruent with one another, each aiding the other in patient consultations.

This led to a wider discussion about how refreshing it is to see doctors talk openly with us. After the consultation concluded, I discussed with the doctor how emotionally challenging the experience was as well as how trivial yet poignant I found his admission that he would now like to quit smoking. The doctor echoed my thoughts and I found it almost relieving to know a practising clinician, with years of experience, felt emotions similar to my own. I found the honesty and openness of the interaction between us uplifting. My relief was a result of the realisation that doctors do, to a certain extent, perform in front of patients and that despite the doctor having years more experience than me we both shared a common human emotional response. It provided a degree of validation to my feelings and allowed me to relate to the doctor both in her role as a clinician and as a person with innate emotional responses. This has taught me the importance of engaging in open and frank conversations with my colleagues to work through feelings rather than keeping these to myself.

One of the reasons for accompanying the GP on this visit was to observe her breaking bad news. I was rather surprised by the subtlety with which the matter was discussed. The doctor elicited what the patient knew, and the patient remarked 'I know something is very wrong with my lungs'. She explained to the patient that he had a two-week referral and the need for further testing, however, at no point did she mention the word cancer. I was astonished at the hesitancy of the doctor to mention the word 'cancer', especially when there was a very high probability of this diagnosis. I discussed this with the doctor after the consultation, and she explained to me that there was not a lot that could be done anyway and thus she did not see any advantage to explaining the strong suspicion.

This hesitancy both in the hospital doctors and the GP to openly discuss their suspicion lead me to reflect. I felt as though each person was passing the buck

forward and did not want to be the one to use the word cancer. It exposed to me a more vulnerable side in the clinicians which I found humbling and deeply revealing. Their desire to not be the doctor who mentions the potential diagnosis seemed to be because they were fearful of the response this might elicit from the patient. Moreover, witnessing practising clinicians struggling with certain aspects of patient care helped to remove this image of doctors as perfect people who have no weaknesses. This helped instil confidence in me and also relieved the burden I have felt of trying to be the infallible medical student. In future, I will take into account the anxiety in giving a certain diagnosis due to fear of the patient's reaction, however, I will endeavour to place the patient's needs first and accept the bitter truth that sometimes you just need to have the courage and be the one to do it. It has also occurred to me, on reflection, that giving bad news to someone less directly may be the final opportunity for the individual to make a clear connection between their actions and their condition.

To conclude, reflection in the Balint groups has been hugely beneficial to me for a number of reasons. It has not only provided me with a safe forum in which to discuss and explore my own thoughts and feelings, it has facilitated honest and illuminating conversations with fellow medical students, which have enriched and broadened my perspectives on the cases presented. Reflection has given me a greater level of awareness about my own innate emotional responses to situations, and I strongly believe this consciousness will be useful in future patient interactions. In particular, the manner in which both the patient's smoking habit and obesity elicited strong yet opposing responses was both unexpected and thought-provoking. This has armed me with a greater understanding of how my own past and current life experiences have shaped the person I am and the clinician I will be. I have had the opportunity to gain a greater appreciation for medicine as an art and learnt that being a doctor requires elements of performance, however, the performance aspect need not detract from the authenticity of the interaction. I

have observed both individual strengths and weaknesses of clinicians which has aided me in abandoning this notion of doctors as flawless individuals, rather I have realised that we are all on a journey of continuous professional development.

In fact, lifelong learning, continuous development of our ability to interact with patients and a capability to acknowledge honestly our limitations are the very essence of the joy of studying and practising medicine. As I continue my journey through medicine, I am going to incorporate a greater degree of reflection into both my consultations with patients, as well as the thoughts and feelings the interactions provoked in me. Ultimately, I have realised that reflection is the foundation upon which lifelong professional development rests.