

## BALINT GROUP 1

**SUMMARY:** 59 yo Afghani woman complains of low back pain and body aches. She has been tried on numerous NSAIDs and Tylenol with no relief. Whenever she makes a physician visit, she is found lying completely prone on the exam table. Although she and her physician both speak Farsi, she speaks a dialect that he cannot understand well. He feels helpless and frustrated. Recently, he feels very angry whenever he sees her name on his schedule, or sees her in person. The last time he saw her he was so angry he was "cursing her inside."

On questioning, his helplessness comes from two sources: 1) nothing seems to work, he can't make her better 2) there are language problems that make accurate communication difficult, with no back-up. The resident feels he is letting his patient down and not rendering good care to her because he cannot understand her. He feels isolated and alone in her treatment. It is this feeling of aloneness that differentiates this patients from other "frustrating" patients.

He articulated the patient pov as fairly positive. She likes him because he speaks Farsi and she thinks he understands her. She has expressed to her daughter positive regard for the physician, and seems cooperative and pleasant during their encounters.

Residents reflected the sense of frustration with patients with whom there is poor communication. One interesting facet of the case that was pointed out was the discrepancy between the patient's positive feelings for the doctor and the doctor's rage at the patient. The root of this rage seemed to be vulnerability - I can't really understand this patient as well as I pretend to, and so I might miss something, and I will be severely punished

There was some discussion of the role of "falsity" or "pretense" in the relationship - the patient assumed she was well-understood, and the doctor didn't want to disillusion her.

Further questioning elicited some sense of patient "blame" - if she spoke English (or Farsi) better, I would not have these feelings

Another residents asked if any of the patient's psychosocial issues had been explored. The resident responded in the negative, although he mentioned she had received a trial of Elavil without much noticeable change in any of her symptoms.

One resident suggested involving a family member as interpreter. Resident responded he had already done so, with positive results. A daughter spoke English well, and was able to inform him of her mother's vaginal bleeding, which the mother had not reported. This led to a further meeting with the patient, and patient questioning elicited the fact that the patient had not disclosed this symptom because she had had a very painful endometrial

biopsy earlier, and did not wish the procedure repeated. The physician was able to reassure her that he could provide better pain control, and persuaded the patient to undergo the procedure if necessary (it turned out not to be indicated).

Other suggestions included: 1) Becoming curious about the intense anger - what was it about the patient that provoked these feelings? Doing further investigation 2) Extending the system (counteracting his isolation) by involving the daughter more regularly in mother's care 3) Extending the system by consulting with additional specialists about the mother's symptoms 4) Making a point to see the patient in other contexts - in the waiting room, fully clothed; make a home visit to see interactions with family - to provide physician with a more complete, and less disabled view of the patient 5) The resident could be curious about the lying-down posture and question the patient about it - what does it mean? Is it r and r? is it a way of expressing her great distress? What is she trying to communicate? Once this is elicited, then the physician can better figure out how to come to terms with it. 6) The doctor needs to confront the issue of imperfect communication more honestly - admit to patient he doesn't always understand her, and focus on clarifying critical areas.

There was also some discussion of the common physician motivation of self-flagellation to improve performance. Facilitator distinguished between beating oneself up to produce desirable behaviors (ie., calling daughter, consulting with other doctors) vs. judging oneself so harshly that anger is directed at the patient. The imbalance between physician and patient perceptions suggested that the physician allow himself to acknowledge what he is doing right with this patient - that in an imperfect situation, he is doing a great deal to support and care for this patient

There was considerable normalizing of physician anger toward some patients. The question was raised whether anger can interfere with good care of the patient; and if so, how can it be "worked with" to promote a better relationship. Discussion of anger as a "cue" to change something in the relationship - rethink the relationship to draw better boundaries, reestablish control, confront pt's unacceptable behaviors, attempt to express more compassion for patient, think of a differ approach to the problem, ask the patient for help etc.