NOTES BALINT GROUP 2
11/22/99

Patient presented was a 27 yo Latina female in good health except for chronic but changing abdominal pain. Resident's (female/Iranian) frustration was that patient's symptoms kept changing. Pt had been treated successfully for pid, but continued to return for additional complaints. Resident also frustrated that she was working through an interpreter. Patient denied any other life problems, claimed she was happy, and was in a stable relationship with a boyfriend. She had no children and did not want children. She worked as a secretary. Resident had no other information about patient. On questioning, resident commented that although pt denied depression (resident had evaluated her for this problem), she observed poor eye contact and flat affect.

Suggestions included the following: One resident commented on peculiarity of Latina female not wanting/liking children. She speculated about the possibility of hx of sexual abuse or sexual molestation as a child. She recommended further psychosocial interviewing, especially in the area of sexual history. The issue of using a male interpreter was also raised (this had occurred twice in the past), with the suggestion that a female interpreter would be preferable.

Another resident suggested allowing the patient to focus on only one complaint per session and to extend the interval between the patient's follow-up visits.

Another resident suggested inviting the boyfriend to attend an appointment and get his perspective about the pelvic pain, especially in relation to their sex life. A variant on this idea was suggested: ie, if the boyfriend could not come in, the patient could be asked about his perceptions of her pain.

A related suggestion was made that the patient could be asked what she thought might be wrong with her (resident reported she had done so, and patient simply replied she didn't know). Resident was encouraged to pursue this line of questioning, to elicit the patient's concerns, as well as the opinions of significant others (mother, sisters, friends etc.) who might have suggested a possible explanation.

Another resident suggested scheduling a counseling clinic, where the patient could speak in Spanish, and where she could have more time to probe psychosocial issues. We discussed the pros and cons of using the already established (but language-impaired) doctor-patient relationship vs. making a referral to another physician. The resident expressed significant concern about her ability to communicate adequately with the patient. It was suggested that the resident ask the patient how much of a problem she thought language differences were, and whether she would feel more comfortable speaking with a physician in Spanish. A discussion ensued about doctor-patient matching vs. looking for common denominators between disparate pairings.

Another resident suggested pt keep a symptom diary to clarify nature/frequency/duration of symptoms.

After the session, another resident (Egyptian-male) came up to say he also was frustrated by an uncontrolled diabetic female pt in her 50s who was compliant with clinic visits but did not fill her medication prescription and/or did not take her medication. She also did not test her sugars, and was noncompliant with diet and exercise. Resident was frustrated that he met with her regularly, but felt it was more of a social visit, and that he was not "helping" her medically. Pt was divorced, had no friends, no family in area, and appeared to enjoy her contacts with the physician. Different strategies were explored, including direct expression of physician frustration; careful investigation for barriers to following medical advice (these did not seem to be economic - medications were covered by MSI insurance); asking patient to explain to doctor why medications were important; and having patient focus on one area where she might make a behavioral change, and then plan it carefully. We speculated about whether an improvement in control might represent a threat to the patient in potential loss of contact with resident. It also emerged patient was asymptomatic, so that taking medications might not be seen as useful in the present. We also discussed possible sexual innuendos to the relationship, but with the exception about 9 months ago of a single episode where the pt accused resident of "breaking her rib" when he did a breast exam (based on her reported visit to a chiropractor, the latter taking an xray, and making this suggestion - no documentation for any of this), resident felt patient always behaved appropriately. We discussed importance of fulfilling social needs while never relinquishing search for strategies that might effectively engage the patient in management of her diabetes.