mation of the corpus luteum, which is essential for the symptoms of PMS. Dietary modification with high-carbohydrate diet, calcium supplementation,[6] and decreased caffeine could be helpful in preventing PMS. Depending on the type of PMS the patient has, appropriate therapy could be initiated.

The use of selective serotonin reuptake inhibitors (SSRIs) has been investigated in PMS treatment.[7-11] Tiemstra did not mention periodic and continuous therapy as an option. In our practice we find that PMS with aura can often be treated with a periodic use of SSRI about 10 days before the menstrual period or during the luteal phase. Patients with no aura can be cycled on the SSRI to coincide with the luteal phase. Continuous use of SSRI is warranted if depressive symptoms persist 4 days after onset of menstrual bleeding.

The patient can derive most benefit from appropriate use of diagnostic skills combined with individualized therapy.

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Reimbursement for Flexible Sigmoidoscopy

To the Editor: I am a family physician currently in practice in northeast Maryland. I enjoyed Dr. Rodney's editorial exploring the possible reasons why flexible sigmoidoscopy has not received widespread acceptance among physicians in general and family physicians in particular (Rodney WM. Will virtual reality simulators end the credentialing arms race in gastrointestinal endoscopy or the need for family physician faculty with endoscopic skills? J Am Board Fam Pract 1998;11:492-5). His reasoning is good, but he misses the major reason why we don't routinely perform the procedure—lack of reimbursement. These sigmoidoscopes are not inexpensive, and most insurers are unwilling to provide more than a pittance for performing a procedure that will take 45 minutes, including setup and cleaning. I do not own a sigmoidoscope; in the past I used the hospital equipment. I have since stopped, as managed care companies would rather I refer the patient to a gastroenterologist who does own the sigmoidoscope, thus avoiding a room charge at the hospital. In the time it would take me to perform the procedure, I can see 4 to 6 patients. I am not adverse to doing procedures; I perform skin biopsies and vasectomies in my office, and I have an active intensive care practice in the hospital.

At a recent managed care workshop it was noted that the behavior you reward is the behavior you get. Offering flexible sigmoidoscopy, as currently reimbursed, is a losing proposition and a poor business decision. I refer my patients to another physician for this procedure, at least those I can convince to pursue the test.

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Role of Balint Groups in Caring for Patients With Unexplained Symptoms

To the Editor: We wish to comment on "Understanding and Caring for the Distressed Patient With Multiple Medically Unexplained Symptoms" by Walker et al.[1] We agree with many of the concepts presented in the paper, and the way in which the P-P-P model is developed and related to clinical practice is excellent. Nevertheless, we find it unfortunate that the reference to the work of Michael Balint is limited to mentioning Balint groups as "an example of physician support groups."

Through his work with general practitioners in the United Kingdom, Michael Balint pioneered the investigation of how primary care providers effectively deal with patients who complain of unexplained somatic symptoms. Although based on observations gathered with physicians 40 years ago, Balint's seminal work *The Doctor, His Patient and the Illness*[2] introduces concepts that are echoed by Walker et al. These include the complex interaction between psychosocial factors and

somatic symptoms, the pitfalls of injudicious use of specialists, and the unconscious impact of other current and previous relationships on the relationship between the physician and the patient. The essential outcome of a successful Balint group is a reconceptualization of the physician-patient relationship that opens the door for new physician behavior. This new physician behavior, or manner of interacting with patients, is the primary product of Balint work.

Unfortunately, support is commonly misunderstood as the most important outcome of Balint groups. Brock and Stock[3] discovered in a national survey of family medicine residency programs that "provide support for residents" was defined as the most important objective for their Balint group activities. Perhaps this results from support being both a necessary ingredient and a byproduct of the Balint process. A supportive environment is necessary to foster sharing of difficult cases and to invite creative input from the group. In a specific Balint group session, support might result from a physician's realization that other physicians would have similar struggles in attempting to treat their patient. Finally, by enabling the physician to address the needs of patients more effectively, physician discomfort and stress are reduced.

In summary, we believe the benefits of Balint's methods extend far beyond support and continue to provide a method for opening a new depth of understanding of the physician-patient relationship.

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