The Family Approach at Each Moment

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Introduction

In this paper I wish to enter the fray over the role of family medicine in the care of the whole family. While family medicine has articulated and formulated an approach to the whole person which transcends the disease model, we have been struggling among ourselves over an approach to the whole family. Some argue that it cannot be done;[1,2] some that it is already being done;[3–5] and some that it must be done.[6,7] Debate about the family as the unit of care has filled much of the first volume of the new journal, *Family Systems Medicine*.[7–10] We have been confused by the multiplicity of dogmatic schools of thought about the family emerging from the gangly growth of the field of family therapy. No one school seems to have the "right" approach for generalist physicians. Paradoxically, social workers and psychologists coming out of training have the expectation of doing family work despite relatively little clinical experience, while experienced family physicians with a long history of clinical involvement with families find the idea of the family approach awesomely overwhelming. Some family physicians, committed to the care of families, have come to regard therapeutic work with families as the province of yet another specialist, the family therapist.[2] *

On the other hand, many family physicians see the family approach as the logical extension of the kind of thinking that led us to care for the whole person. In fact, the problems set forth by Stephens in his classic article, "The Intellectual Basis of Family Practice,"[12] are not so different from the problems being proposed as amenable to family treatment today. Stephens specified the "types of clinical problems and conditions which require a therapeutic relationship with the physician" as part of the process of defining the discipline of family medicine. (See Table I). Ten years later, these conditions are conceptualized as family problems rather than problems of individuals. Table II, drawn from the work of Ransom and Grace,[13] is a list of problems for which family or marital treatment is indicated. This list is composed of the families of the kind of patients outlined by Stephens, as well as those with openly acknowledged family problems. Most recently, Schmidt has listed the conditions for which research evidence exists that a family approach would be useful;[14] his list overlaps extensively with that of Ransom and Grace (Table III). Thus the kinds of problems of individuals which originally defined the content of family practice are being redefined as problems of families.

While agreement exists about what comprises family problems, confusion abounds regarding what skills the family physician should possess to address these problems. There is a general acceptance of the family system concept,[4,7,10,15,16] but no such consensus prevails with regard to a method of

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***Meanwhile the older literature of family therapy portrays the doctor as helpless in the face of severe psychosomatic symptoms and exacerbations of chronic disease.[11] In desperation, the physician is shown referring the patient to family therapy where the symptom turns out to "make sense" and the disease to go into remission with treatment of the whole family. The physician is characterized as the standard bearer of the disease model even at the same time that family medicine is loudly and self-consciously attempting to distinguish itself in the care of wholes rather than parts. It may emerge that family therapists are more comfortable working with a specialty model of medicine which will delegate responsibility for the whole family to the therapist rather than working with the family physicians who may want to share the therapeutic approach to the family. The resolution of this conflict over the role of the doctor will depend on the success of family medicine in developing a systematic approach to the whole family and the willingness of family therapy to desist in making the doctor the "straw person" of the disease model.**

TABLE I

Conditions requiring the unique skills of a "wise and compassionate physician." From Stephens.[12]

1. **Complaints which are obscure, vague, or undifferentiated.**
2. **Complaints which arise from life-threatening disease.**
3. **Complaints which seem out of proportion to physical or laboratory findings.**
4. **Complaints which are unusual, bizarre, non-physiologic, or non-anatomical.**
5. **Complaints which are persistent and disabling.**
6. **Complaints associated with marked anxiety or mood change.**
7. **Complaints which result from life change, conflict, or stress.**
8. **Complaints which may require risky diagnostic and therapeutic procedures.**
9. **Complaints arising from conditions which may be managed electively.**
10. **Conditions which are incurable.**
11. **Conditions involving habits and the life-style of the patient.**
12. **Conditions which require moral or ethical decisions.**

TABLE II

Conditions for which family treatment is indicated. From Ransom and Grace.[13]

1. **Marital and sexual adjustment problems which are presented as such in the office.**
2. **Family problems brought up in the office as needing attention: intense sibling rivalry, intergenerational conflicts, or serious disagreements about child rearing.**
3. **Any problem involving children that is greater than a self-limiting or common illness; adjustment reactions of childhood.**
4. **Serious problems of teenagers involving separation and the achievement of independence.**
5. **A crisis or chaos in the family that is not being well handled and may lead to further distress or symptomatic behavior.**
6. **When one person claims the problem is caused by another, for example excessive drinking or being house-bound.**
7. **When any memnber of the family shows signs of mental or emotional disturbance.**
8. **When any member develops a stress-related illness.**
9. **When intervention requires life-style changes affecting or involving members of the family, for example a radical change in someone's diet or daily life rhythm.**
10. **When a serious, chronic illness or disability in a member is not being handled well by the family.**
11. **When medical symptoms are present for which no organic basis can be found.**
12. **When other forms of treatment have failed.**

family assessment.[6,17–21] The STFM Task Force on Behavioral Science has proposed a curriculum including at least five different theoretical models of family therapy.[22] The literature is rife with "strategies for intervention" in the family,[23–25] yet there is scant reference to the approach to the whole family in day-to-day office practice of family medicine, and certainly no mention in the literature on health prevention.

I will make two points in debate over the family as a unit of care. First, I will argue that unless we consciously address the entire family in the provision of ordinary care we do not have anything different, and certainly not better, to offer than the best of our colleagues in the other primary care fields. Using pediatrics as an example of an important sister field, I will show that unless family medicine adopts a family approach in clinical instances, such as the well child visit, the episodic visit, and adolescent pregnancy, we have no greater claim to excellence than our colleagues in other specialties. I will also show that, contrary to the opinions of some contenders in the family as the unit of care debate,[2] an approach to the whole family can fit into ordinary office practice.

TABLE III

Conditions for which research indicates that family approach would be useful. From Schmidt.[14]

Pregnancy
Failure to thrive
Recurrent childhood poisoning
Preschool behavior problems
School behavior problems
Adolescent maladjustment
Major depression
Chronic illness
Diabetes
Arteriosclerotic heart disease, coronary bypass surgery
Poor adherence to medical regimen
High "inappropriate" use of health services
Terminal illness
Bereavement

Secondly, I will argue that the care we are already providing to individuals in families carries an implicit stance toward the family—that we are not neutral or uninvolved at the family level and, on the contrary, that we are taking an active, albeit unknowing, role in families by our primary work with symptom bearers. This role, while compassionate toward the individual, may serve to promote somatization, perpetuate symptoms, and exaggerate already troublesome family dynamics. Such problematic tendencies include the portrayal of the woman as weak and defective, the mother as overly bound up with a sick child, and the father as distant and excluded. (These characteristic portrayals appear in rigidified form over and over in the case histories of severe psychosomatic families which abound in family therapy literature.)[26–31] Unless family physicians look at how our work with individuals plays into ongoing dynamics in the family, we may find ourselves perpetuating exactly the symptoms we are attempting to alleviate. We must learn to see how our everyday work with patients assumes and promotes certain family constellations which may be creating symptoms in the first place.

Acknowledging our implicit stance toward families in our work with individuals, we have the opportunity to change. We can take an active role in the prevention of symptom formation through a conscious and consistent awareness of the entire family at any given moment in ordinary care. By ordinary care, I mean the uncelebrated work of providing preventive care to adults and children, treating common diseases of all family members, and accompanying families through their sometimes troubled and frequently unpredictable journey through the life cycle—in short, the care we provide without the expectation of consultation or catastrophe.

Are we really different?

Family practice and pediatrics share a value orientation and a set of assumptions about children which make our approaches similar. We overlap in caring for the newborn, infant, child, and adolescent patient. Both family medicine and pediatrics emerged historically as reform movements.[32–35] Both disciplines share an ideology of child advocacy. Both emphasize development, patient education, prevention, nutrition, and continuity. Unstated assumptions about a warm and caring, as opposed to authoritarian, style attract students interested in either field. Residents in the two fields get along well together in training programs where there is not competition for patients or for training sites. In fact, many teachers

and leaders in family medicine programs gained their initial training in pediatrics. Interactions between residents and between residents and faculty members are portrayed as more supportive and less competitive in both pediatrics and family medicine compared to other specialties. The constellation of all these similarities make both disciplines appealing to those students, frequently women, who experience varying degrees of dissaffection from other specialties during medical school. Finally, family medicine and pediatrics may attract a different personality type from other specialties portrayed as more aggressive, more com petitive, more intellectual, or more lucrative.[36–38]

Similarly, the content of the approach to the pediatric patient overlaps greatly between the family physician and the pediatrician. The history, the physical exam, the anticipatory guidance, the nutrition and prevention education—all would be remarkably similar, if not identical, when provided by an experienced clinician of either discipline.[39] Some family physicians may object at this point, saying, "But I delivered the baby," or "But I take care of the mother, too." And the psychosomatically inclined generalist would add, "But I don't start out by ruling out organic disease."

How has the family medicine approach differed in practice? We probably do ask the mother how she is doing. Whether we do this more often than pediatricians is not known. Whether we do anything different with her answer is also unclear. Perhaps we are more likely to ask about other family members or ongoing problems in the family. Maybe we encourage another appointment to address the other problems that surface. As physician to the parent we do have the capacity to see the parent as a person in his/her own right with needs and priorities potentially conflicting with those of the child or children. Conveying this recognition may be more characteristic of family physicians. On the other hand, pediatricians and child psychiatrists have been active in pursuing the area of infant temperament and style,[40,41] suggesting that some children are easier and others more difficult. Underlying this research is the assumption that the way an infant acts is not totally a result of what parents do, but rather a combination of inborn predisposition with parental reaction. The recognition that the infant has an autonomous personality from the start parallels an appreciation of the parent as a person who has to deal with the infant. Physicians who have children of their own appreciate how demanding is the role of parent, and are likely to convey that awareness to patients. In our customary approach to the child in the family, pediatrics and family medicine are quite congruent.

In some areas, this congruence works against a comprehensive approach to the family. No discipline is so attentive to the importance of rapid clinical change as pediatrics. Stories abound in pediatric training about how rapidly an infant can "go bad." Pediatric residents learn early in training about the importance of the parents' recognition of clinical change. A mother who can successfully identify deterioration in a child's status and bring it to the doctor's attention is a "Good Mom." A mother who can cope with persistent symptoms (fever, cough, congestion, diarrhea, wheezing) as long as they do not become severe and can continue following the medical regime is a "Good Mom." The opposite, though mostly unstated, is usually assumed—that parents who can't cope or don't comply must be "bad" or at best "at the end of their rope," exhausted.*

Family practice residents in training in pediatric settings rapidly pick up the concept of the importance of parental clinical observation. Unfortunately, the "Good Mom" vocabulary is also adopted as well. Physicians must become aware from the outset that parents are excruciatingly sensitive to the judgments of doctors and nurses. Parents already feel culpable for the child's illness; further hints to this effect can only lead to parental anger and defensiveness. Parents who go from one emergency room to another with an unimproving symptom have unaddressed concerns, as likely to be dismissed by family physicians as by pediatricians. Both disciplines would do well to reevaluate the underlying judgmental posture of the doctor toward the parent. In family medicine, where the mother and father are patients of the doctor, the potential exists to set aside judgment and to redefine the parents' behavior as making sense. Whether they have reached the limit of tolerance of the symptom, or have unspoken fears about the meaning of the symptom, or their behavior reflects disagreements within the family itself, it is the physician's role to tease out the explanation for their behavior and initiate change. Performing the physical exam and offering reassurance are not enough. In family medicine we have the potential to construe the family response to illness as a result of complex forces at work in the family. If we realize this potential, we will truly have something to offer our pediatric colleagues.

In the next section I would like to describe what I will call "an approach to the whole family at each moment" in the office practice of well child care, episodic care, and care for pregnant adolescents. While pediatrics can certainly come to adopt this appoach, I maintain that it is what should come to distinguish the care of children in families by family doctors.

The Well Child Visit

Despite our best efforts to involve fathers in prenatal care, labor and delivery, and well child

***The conflict between exhausted parents, who are looking for some way for others to care for their sick child, and overtired residents, who see each admission as an additional burden postponing sleep or family life, rarely surfaces for discussion in training programs. If trainees were not pitted against patients during residency, perhaps the judgmental postures described above would be adopted less often. Ransom[42] describes a similar antagonistic posture of family therapists against families; family medicine will need to work hard to maintain a stance in favor of the family.**

care, mothers shoulder the vast responsibility for bringing children in for routine visits. Grandmothers may occasionally come to an office visit in late pregnancy or accompany the new mother, but later on they play a more invisible role. Yet all of the family members are active in the intergenerational challenge of rearing a new baby. How many times have we asked a young mother what she was feeding her two-month old, only to learn that she was overfeeding the child with cereals, fruits, vegetables, and meats, as well as juice or formula. Very noncritically, we attempt to "educate" her about what is the proper nutritional balance for an infant of this age. Our lecture falls on deaf ears. I will always be indebted to the colleague of mine who pointed this out to me when we were residents. Cryptically, he quipped, "You can't fight Grandma." He knew intuitively that what young mothers feed their children has more to do with what people say in their family than with any recommendations that doctors offer. If we tell the young mother not to feed the child meats yet, and this is what her mother-in-law has been telling her, we have suddenly lined up against her in the family battleground. If we know what various parties have been advocating before throwing in our advice, at least we know what we are doing. My more general inquiry into infant feeding now goes like this: "What does your mother say about feeding the baby? Your mother-in-law? What did your sister do? What do you think is right? What do you think I'm going to say? How are you going to decide?" In the example above, a successful maneuver might be:

> "Well, different people in your family have a piece of the truth. You are right to want to offer your baby a balanced diet. Your mother-in-law is right that we usually wait until six months to start meats. Different generations of mothers learn different ways to feed their babies. Even different generations of doctors have said different things. Given what all the people in your family think, how could we work out a plan for the next two months that will keep everyone happy?"

This offering lets the young mother know that we are aware of how she sometimes feels caught between family members in her struggle to learn to feed her child. At the same time, we are offering our understanding that all infant care, but especially food, is a family affair. Thus the well baby visit becomes an exploration of the family system, not just an infant checkup.

When both parents come for the baby visits, which is encouraged in our practice, the opportunity occurs to acknowledge our awareness of the father's involvement with the child. This offsets the tendency for the physician to have an alliance with the mother against the father and other family members based on the frequency of contact. (I will discuss this concept of alliance more extensively in the next section.) When the father does not or cannot attend, the mother can still be asked, "What are the baby's father's concerns right now?" or "Is there anything about the baby your husband is worrying about at this point?" Should these questions turn up important concerns, I ask the mother to have the father call or stop in after the visit, rather than using her as a relay messenger. When the father does come in for well child visits it is always important to ask him directly if he has any concerns of his own about the baby. When young parents come in together I might also ask, "Do you ever argue about how to raise the baby?" After the giggling and sheepishness are over, some important, previously unvoiced questions emerge. This approach of taking each member seriously, whether present or absent, conveys our respect for them as individuals and our recognition that although they are bound together in a family they experience conflictual demands and obligations. We are also showing that for the family to function together as a whole, individual differences must be recognized and negotiated, not ignored or ablated. This understanding about individuals in families may appear basic but nevertheless is rarely conveyed as part of well child care.

Episodic Care

The episodic visit is even less likely to be situated within the family context. Here the medical model reigns unchallenged. As with adults, it is only after multiple visits for the same unremitting but undiagnosable symptom that the possibility of "something going on in the family" is raised. When acute illness provokes episodic visits, neither the family nor the doctor puts the family context squarely in the center of the transaction. Yet this is exactly when I would argue that every interaction with every individual in every family should be informed by the family approach. Critics will retort here, "What about the simple sore throat?" Of course, as Freud is reputed to have said, "Sometimes a cigar is just a cigar." But more importantly, in our work when is a cigar not a cigar? Or when is a "simple sore throat" the inconspicuous entryway into the huge cavern of the family system? In our practice of low-income multigenerational families, if a mother brings a child with a sore throat she may be acting at the instigation of multiple agendas. Yes, we take a history, examine the child, do a throat culture (if cost-effective!), negotiate treatment, and do patient education. We may even ask the mother what she thought this sore throat was and what she expected of us. We have come to consider it commonplace to ask about the meaning of symptoms in the context of the whole person. We may learn that she was worried about strep or recent exposure to scarlet fever. On the other hand, she may also bring the child because if she doesn't and the child gets sicker she will be criticized by her mother or sister or mother-in-law for not acting sooner—for not being a "good mother." Or, if her husband comes home from work and the child is sick, he may get impatient and angry and insist on taking the child to the emergency room, with the resultant delays and frustrations. So the mother may bring the child with the sore throat to fend off the pressures of her larger family. This agenda is rarely, if ever, articulated by patients without prodding on our part. We can elicit this agenda simply and non-threateningly by

asking, "What do other people in your family say about this or want done about this?"

When we begin to recognize parental interaction in the health care of their children, we can begin to untangle the reasons behind any given episodic visit. Parents, or mothers and grandmothers, as another example, have talked to each other before heading for the emergency room. This fact is acknowledged by the many anthropologically minded researchers who point out the various lay resources that a patient or family might have "consulted" before entering the medical care system.[43,44] Lacking in this analysis, however, is that the decision-making process itself reflects certain family dynamics which the physician could recognize but more often ignores. To be specific:

> What to do about a child's fever? The young mother calls her mother, who tells her to give the child baby aspirin. The child remains fussy and febrile. The father tells the mother to call the doctor, who arranges to meet them in the emergency room. There the doctor diagnoses an ear infection, gives an antibiotic, and switches the child to acetaminophen. The father concludes that the grandmother was wrong and feels vindicated in insisting that the mother call the doctor. The mother feels uncomfortable with the wedge that has been further driven between her husband and her mother, and feels stuck in the middle. Later mother and father fight over issues tangentially related to the grandmother.
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> Alternatively, the physician asks the couple in the emergency room, "What have you tried so far?" The mother replies, "My mother told me to give baby aspirin." The doctor could say, "That was the right thing to do. You have managed this problem just right up till now. Now we need to add something to what you are already doing." Result: the existing tensions in the family are not exacerbated and maybe potentially lessened by contact with the doctor.

Some readers will respond, "Those are the same questions I'm already asking!" and that is precisely my point. The "family approach at any given moment" does not necessarily require more time but rather a different focus of the questions and a different understanding of the patient's responses. This is the application in episodic care of what it means to "think family."[45]

Adolescent Pregnancy

As individuals, teenagers represent a special challenge and offer unique rewards to clinicians who decide to become involved with them. Despite the growing literature[46] in this area and the emergence of "adolescent medicine" as a new subspecialty, responses of individual physicians, be they family physicians or pediatricians, to individual adolescents are still more likely to be determined by the personality of the people involved. It is difficult to set aside our personal feelings about smoking, drinking, drug use, unprotected intercourse, and running away from home, to mention only a few problematic behaviors, from our interaction with a given adolescent. We may preach acceptance and limit setting but are just as liable as parents to be critical, judgmental, and rejecting. We have a long way to go and probably need another way of viewing adolescents to make headway in this terrain. Pregnant adolescents represent a particularly difficult but rewarding challenge because of the unique setting of the event at the intergenerational crossroads.

What I mean by "intergenerational crossroads" is that adolescent pregnancy is the moment when the new generation is formed: the child becomes the parent, and the parent the grandparent. However bitter and recriminating, or loving and accepting, or infantilizing and fantasy-ridden this process may be, the intergenerational meaning is inevitable. Interactions with an individual anywhere in the family have immediate reverberations throughout the family. The family system is in so much flux that each moment is highly charged with family meanings. The family physician, and indeed any clinician choosing to work with pregnant adolescents and their families, must carefully pick their way across an obstacle course strewn with boulders of stubbornness and potholes of family legacy. Each pathway is unique; the care of a thirteen-year-old who is pregnant is the creation of a different set of alliances from the care of a pregnant seventeen-year-old.

> In the situation of a thirteen-year-old, the physician must first work through for him/herself, the girl's and the family's choice about keeping the pregnancy or terminating it, if that is an option. If the family physician is seen as championing an option that the family cannot tolerate, the family will be forced to go elsewhere. This is equally true of abortion as it is of the choice of keeping the pregnancy. (At a later moment, the same is true about the choice of releasing a baby for adoption *v.* keeping the child.) In the situation where a thirteen-year-old chooses, within the context of her family, to keep a pregnancy, the relationship of the doctor to the girl and to the family is crucial. Given the early stage of differentiation of a girl this age from her family, and her ongoing needs for schooling, peer relationships, and growth as an individual, the project of caring for her involves building an allegiance with the adults in her family who will realistically be caring for the infant a significant amount of the time. These adults must be engaged in the task of permitting the girl to grow up even as she carries out a task they (and the physician) associate with adulthood. The doctor's relationship with these adults (be they parents, aunts, grandparents) is, therefore, central, along with the steady consistency of the relationship with the girl herself.
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> The care of the pregnant seventeen-year-old, on the other hand, occurs at a different stage of separation from the family. At this stage the young woman demands to be seen as an individual in her own right with the right to make relationships and choose her own course in life separate from the wishes of her family. Where there is overt conflict between the young woman and her family, the family physician must convey his/her respect for the adolescent and allegiance to her developing autonomy, at the same time translating this process for parents who may be deeply angry and rejecting toward their daughter. Some adolescents may need to see a different clinician from their previous family doctor in order to demonstrate their independence from their family of origin. In this case, the clinician must still situate the young woman's actions within the context of her family. Other pregnant adolescents may be able to continue attending the same family doctor, choosing the consistency of a known parental figure at a time when their relationship with their own parents is tumultuous.

Caring for the child becoming parent to the child is not only one of the most challenging tasks in family medicine, it also exemplifies exactly what is

crucial about the approach to the whole family at each moment. Alliance to any one generation or individual against another, more than on a momentary basis, will spell failure in the exercise and may create unnecessary expulsion of family members, including the family physician him/herself. Success can be measured by the satisfactory evolution of the young woman into motherhood, her ability to develop an adult-to-adult relationship with the baby's father or other partner, her parents' growth into their identity as grandparents, and the entire family's ability to accept the infant as a new person in the family with a stature of his/her own. While the early part of this process is marked by rejection and conflict, the later stages are frequently characterized by reconciliation of the young woman with her mother or both parents, reacceptance in the parental home, and support in the labor, delivery, and postpartum experience. The following example demonstrates how satisfactory negotiation of transitions for each generation resulted in a new, less-symptomatic family equilibrium:

> The oldest daughter in a Puerto Rican family headed by a single mother becomes pregnant at 17. The mother is widely regarded in the extended family as incompetent because of a seizure disorder. The pregnant daughter, oldest of many cousins, has been a mother figure in the whole family, and is now gaining her autonomy through starting a family of her own. Her mother's episodes of "ataques" worsen.[47,48] The doctor, somewhat helplessly, sees the grandmother-to-be worsen at the same time that the mother-to-be is demonstrating her competency to be a mother by coming to all her prenatal appointments, learning about pregnancy, delivery, and baby care in the teen pregnancy program, and in general becoming a model teen mother. At the time of delivery, the daughter chooses to be accompanied by her mother in the delivery room rather than by the baby's father. After the baby is delivered, the doctor hands the grandmother the scissors to cut the cord as part of the customary natural childbirth routine. The grandmother accomplishes the task and gladly greets the arrival of her first grandson. Later on the grandmother boasts her new competency as a person who knows about babies because of her important role at the birth. She becomes active in the care of her grandson while her daughter finishes school. In the first few years of the teenager's marriage, her daughter is able to return home for support when the young father becomes abusive. As the marriage stabilizes and both grandmothers support the young mother's ultimatum about no physical abuse, the daughter is able to aid her mother financially. Office visits for the grandmother lessen remarkably as do complaints about seizures and nerves.

Thus, the doctor's approach resulted in measurable improvement in the grandmother's health through facilitation of her growth into her new role.

Implicit Involvement with the Family

Ransom and Grace have argued:

> Any kind of therapy is a way of intervening into a family. Whether one works with an individual or with multiple members of a family, from the family therapy point of view the reality of mutual interdependence still remains. The remaining question is whether one works directly with the family in an implicit or explicit manner.[13]

Traditionally, family physicians have worked primarily with individuals and only implicitly with the family as a whole. Even the recognition of this implicit stance has been slow in coming. The possibility that our involvement with individuals may in fact contribute to family distress and perpetuate family dysfunction is rarely considered. I will maintain that the organization of our work predominantly with symptom bearers, and with mothers as the primary caretakers of children, perpetuates existing family dynamics and promotes what Stephens has called "careers of illness."[49] Said in another way, the family physician may get "locked into binding coalitions"[13,26] by virtue of the individual approach toward the somatizing family member who makes extensive use of the medical care system.

The fact that women go to the doctor more frequently for themselves and with their children has the practical result that the physician has far more contact with mothers in young families and with women in general than with men. (The tendency for women to view themselves as defective[50,51] and their children's ills as their own fault may also predispose women to become the patients.) With regard to the care of the children, the doctor will typically tell the mother what is going on and what needs to be done and expect her to relay this information to the father. As a result, the father is excluded from the communication and may perceive the mother and the doctor in alliance with each other, sometimes against him.

Physicians must be particularly aware of alliances created by their gender. When mothers complain to the doctor about fatigue, anxiety, depression, and somatic symptoms, the empathic doctor, recognizing the reality of her stressful situation in the family, falls into alliance with the mother. This is exacerbated by both men and women doctors, but in different ways.

> The woman doctor, sensitive to what she sees as a women's issue, may underline the portrayal of the man as unfeeling, uncommunicative, and distant. The women thus line up against the man, who is further distanced from the important communications within the family by the doctor visit. Understandably, the father may later find it difficult to trust the woman doctor, whom he sees as being his wife's ally against him.*
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> If the physician is a man, the scenario is constructed where a woman patient tells all her troubles to and gets support from a man, who in contrast to her husband is depicted as warm, sympathetic, and understanding. Despite the absence of any sexual intimations, this opposite gender relationship has the same effect as above: the husband is excluded from the doctor-patient relationship, which is viewed, at best, as the province of the woman and children, and at worst, as a sexually threatening liaison.

Family physicians of both sexes must actively examine our stance of working primarily with women and work doubly hard to pull in the usually excluded father in a way which is respectful of his concerns. One way to do this is to have the father call the doctor after a given visit to elicit his concerns and to give him directly whatever medical information was conveyed. In a phone call to a family, both parents can be asked to get on the line, or each can be spoken with in turn. An active effort to include the father can work against the tendency for mothers to be viewed as primarily responsible

for the family's health and sickness. (This better serves the feminist goal of the woman's well-being by recongizing that children are a shared responsibility rather than hers alone.) Through active, systematic effort to include the father, the pitfall of exclusive alliances can be avoided.

Another way that family physicians become implicitly involved in coalitions in families is on behalf of the overtly more powerful forces. As doctors, we frequently operate by reacting to the squeakiest wheel:

> An alcoholic, single mother of three, sober for the past eighteen months, sends her fourteen-year-old daughter by herself to see the doctor for a problem of diarrhea of two months' duration. The doctor arranges some tests and talks with the girl. With her permission, the doctor calls the mother in front of her and reviews the plan. Three days later the tests are not yet back. The grandmother calls to say that the girl is at her house and that she is vomiting and in pain. The physician decides that hospitalization is indicated at this point and tells the grandmother and the girl on the phone. Then the doctor calls the mother and informs her of the new decision. She acquiesces. Behind the scenes, the grandmother calls the mother and admonishes: "You see, I told you, you haven't been taking care of her properly. If I hadn't called the doctor, she'd still be sick and in pain." Result: the doctor's intervention undermined the mother's struggle against her alcoholism and seemingly endorsed the grandmother's view of the mother's incompetence.

In the family systems terminology, the mother was "triangulated" by the coalition between her mother and her daughter, now joined by the powerful force of the doctor. In medical terms, this adolescent was strongly suspected to be suffering from Crohn's disease, which had rapidly deteriorated before diagnosis and management could be accomplished as an outpatient. Only attention to the entire family at the moment of decision to hospitalize could have avoided the physician's unfortunate seeming alliance to the grandmother. Combatting the tendency to respond first and primarily to the person who appears in charge requires an actively watchful stance on the part of the doctor.

In families with seriously ill or chronically ill children, it is important to tread cautiously. Every effort must be made to say everything to both parents and to elicit opinions from each family member rather than dealing with one, usually the mother, as the main link to the family communication system. Otherwise, doctors tend to exacerbate the likelihood that the mother will become increasingly deadlocked in the care and responsibility for the sick child and unknowingly remove the father further from the child, despite the probability that he is just as worried as the mother about the child. Doctors themselves, through work with mothers, symptom bearers, and identified patients, have been active perpetrators of the unhealthy dynamic. The only remedy is active prevention in all families at all points of contact in sickness and in health.

***This trap is especially tricky for feminist clinicians who consciously recognize the oppression of their women patients but may not recognize the divisive effect their stance might have. The woman patient may be asking for support in remaining in an unbalanced, oppressive relationship, which conflicts with the doctor's own bias. The feminist doctor's stance may also, paradoxically, contribute to a mother's oppression in another way; if the doctor talks only to the mother, it overtly implies support for her heavy burden, but it covertly implies that ultimately she alone is responsible for her family. That position of sole responsibility is a crucial feature of her real oppression in the family unit. Thus, a seemingly feminist approach can unwittingly further compromise poor communications and further burden the woman alone with the task of raising her family.**

Prevention

Bloch has described the idea of family readiness for disease.[52] Families "needing" an ill member but not experiencing a major disease event may become psychosomatic families. In other "ready" families where an organic disease does occur, the chronicity of the disease process may be fostered.* In the identification of families who are "ready" for disease, the family physician has a possibility of exerting a preventive effect in the application of what I have been calling the family approach at each moment. We can identify potentially troublesome dynamics early in the family life cycle because of our countless contacts with families in the process of guiding routine health maintenance through pregnancy, delivery, and well child care. Prevention is implicit in the examples of conversations with families mentioned in the previous sections.

In the same way that family medicine has committed itself to caring for unselected patients with unselected conditions,[12] we are also committed to caring for unselected families. We do not know in advance what family dynamics we will encounter, nor how such dynamics will affect health and illness. As we come to know them, these families are engaged, however painfully, in the central tasks of the human condition: the establishment of loving relationships, the performance of meaningful work, the creation of children and the fostering of their growth to independence, the struggle with sickness and utlimately death, and the search for higher meaning in the human endeavor. Family physicians, engaged in these same tasks, may share our understandings about family relatedness through the demonstration of our approach to the entire family at each moment. Through this effort we not only have the possibility to exert a healing effect, we also create the potential to avert some of the suffering human beings experience as members of families.

Summary

In this paper I have demonstrated some of the skills involved in an approach to the entire family at each moment. I have focused on a family approach in well child care, episodic care for children, and

***On the other hand, families not in this state of readiness may handle sickness events in some other way. It is also possible that such families have fewer sickness events, or at least identify events less often. Dysfunction in these families would less often occur in relation to the medical care system, and is therefore less visible to physicians, although family therapists may have ample exposure to such families.**

adolescent pregnancy and have demonstrated how such an approach is essentially preventive. The traditional relationship of the family physician with individuals, usually women and mothers, creates an implicit alliance with the symptom bearer which may work contrary to the goals of treatment. Avoidance of hidden alliances and open communication with all members of the family permit the doctor to engage with families in a relationship which is both preventive and therapeutic.

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