A Visit to the Doctor: An Illustration of Implicit Meanings in the Doctor-Patient Relationship

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This article examines in detail how various aspects of the "art of medicine" may be illustrated through analysis of a single case. An apparently inexplicable problem, i.e., inconsistent and chaotic health-care-seeking behavior of a mother on behalf of her multiply handicapped daughter, and the resultant marital tension and conflict, is shown to have deep roots in the psychologies and families of origin of both parents. Further, it becomes clear that the physician's own emotional responses, in part related to his *family-of-origin issues, play a critical role in determining the evolution of the doctor-patient relationship. Through careful analysis of a "season" in the relationship between the physician and this family, as they are followed over a course of six weeks, the article attempts to illustrate how a physician in training can learn to recognize opportunities for pursuing psychological issues in the practice of medicine, learn how to elicit significant information from the patient-family, and be aware of the need to develop self-understanding in the process of promoting healing within the patient-family unit.*

Despite contemporary views of medicine as "health industry" (22) and medicine as technology (1), medicine as an art is still a compelling conceptualization. However, exactly what constitutes the art of medicine is challenging to define (7) and difficult to measure (8). It appears to be expressed through a patient-centered approach (13) that focuses on the implicit meanings (11) doctors and patients attach to specific encounters as well as on the compassion and caring (17) that should provide the context for such encounters. It generally is recognized that the doctor-patient relationship is the

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and reflect on actual behavior and events, as opposed to abstractions or summations of behaviors and events. While a case report can make no claims of generalizability, it does provide the closest available model for clinical behavior. The physician usually has no difficulty identifying with the setting described. It is almost always recognizable and familiar. The physician may or may not recognize the specific theoretical constructs and research results that inform the interactions of the case report. However, the physician will most certainly be able to relate to specific decisions and choices as reported in a specific case, and he can evaluate his own behavior by the standards set forth there. This type of learning approach actually leaves much less to chance than perusal of a research report, where it is usually up to the consumer to decide what relevance a finding might have in an actual practice context.

For these reasons the following case history is presented in some detail to illustrate the omnipresent reality of art-of-medicine dimensions in the medical encounter through a seemingly trivial patient-care issue. The case also offers a model of how such an issue may be explored to the benefit of the resident, the patient, the patient's family, and the doctor-patient relationship.

CASE STUDY

As behavioral-science director of a large family-medicine residency training program, I spend a portion of my time in direct observation and supervision of residents. One day during behavioral-science supervision I was approached by Dr. Smith, a third-year resident whom I knew fairly well, who had frequently discussed various aspects of patient management with me. Dr. Smith was concerned about persistent and problematic interactions he had with one of his patients regarding her seeking health care for her multiply-handicapped daughter and the resultant marital conflict in the family. He asked my help in assessing the situation and devising an intervention.

Janice and Tim Johnson were a couple in their mid-thirties. Dr. Smith had seen Mrs. Johnson frequently for a variety of complaints, including headaches, lower back pain, colds, fatigue, and vaginal infections. Mr. Johnson, on the other hand, had been seen only twice in the family-practice clinic during a three-year period, once for a fractured thumb and once for a gash on his forearm that had become infected. Both times he had seen a different resident. The Johnsons had been married approximately 12 years. Mr. Johnson was an independent contractor and Mrs. Johnson was a full-time homemaker. They had two children, Michael, three years old, and Rebecca, six. Michael was a normal, healthy, somewhat rambunctious toddler. Rebecca, however, had been born with spina bifida. She had had corrective surgery, resulting in a colostomy. She also had serious visual problems, allergies, as well as developmental retardation. Rebecca experienced many other medical difficulties on an ongoing basis, including repeated hospitalization for pneu-

most appropriate unit of analysis in which aspects of the art of medicine may be discovered.

Thinking of the practice of medicine as a form of art is problematic in many ways. It has been observed (17, 18) that even employing this nomenclature makes the practice of medicine appear inaccessible, mysterious, and unknowable. Medicine as science, on the other hand, suggests a reducible and understandable process. The distinction between art and science is in some sense fallacious, since art and science have much in common, notably discipline, perseverance, inspiration, commitment, and passion (15).

However, there may be a certain value in retaining the phrase, "the art of medicine." In fact, the interaction of physician and patient can significantly be illuminated by reference to professional artistry. Professional artistry has been defined (19) as the competence with which practitioners actually handle indeterminate zones of practice—those murky, ambiguous, unpredictable encounters that comprise much of a clinical practice. In this interpretation, the physician "designs" a "performance" characterized by certain aesthetically pleasing and emotionally moving qualities. What transpires between physician and patient thus appeals not only to intellectual curiosity but to the heart as well.

Thinking of physicians as artists as well as scientists challenges certain paradigmatic assumptions about the nature of the practice of medicine. The physician as scientist may strive for accurate observation, reliable data, replicable intervention. The physician as artist may more readily access tacit knowledge, take risks in intervention, and desire to be creative as well as accurate in practice. The distinction between art and science may not yet be outmoded, as both perspectives contribute important insights into comprehensive medical practice.

For family physicians, committed to encompassing not only a particular disease entity but the patient, the patient's family, and at least indirectly, the patient's community and cultural context, understanding and practicing the art of medicine is central to the successful rendering of health care (24). The art of medicine has been analyzed as a science (6, 8, 23), and it is indisputable, as has been argued, that we need more rigorous and systematic scientific investigation into this aspect of clinical practice (17). However, it is also true that the application of scientific inquiry to the art of medicine is still an endeavor in its infancy. As in any incipient research effort, formulation of testable hypotheses and controlled designs is dependent initially on a fundamental tool of the scientific method: accurate observation in the case-report format.

In these days of large-scale research designs and multicenter studies, the anecdotal case report is looked at somewhat askance. However, in many respects it continues to play an important role in the education of physicians. There are often large gaps between the niceties of theoretical constructs and research findings, and what actually occurs in a clinical setting between physician and patient. The case report provides the opportunity to analyze

monia and gastrointestinal infections. The child had a regular pediatrician and several other specialists involved in her care.

However, Dr. Smith saw a great deal of Rebecca because she often came along on her mother's frequent clinic visits. To Dr. Smith, it seemed as though Mrs. Johnson made appointments for herself as a means of "getting her foot in the door," so she could get his advice about her daughter. In addition, Dr. Smith had noticed that Mrs. Johnson frequently consulted him about procedures and medications suggested by Rebecca's other physicians. Mrs. Johnson also tended to call Dr. Smith to ask his advice whenever Rebecca had any symptoms of illness. Finally, Dr. Smith was aware that any illness episodes on Rebecca's part, whether mild or severe in nature, were the source of prolonged and serious conflict between the parents, which centered on disagreements about whether Rebecca needed to be seen by a physician. Typically, incidents of illness in Rebecca resulted in considerable maternal stress and anxiety, followed by a series of advice-seeking phone calls and finally taking Rebecca to a doctor, sometimes as an adjunct to the mother's visit with Dr. Smith, often on an emergency-room basis. Mr. Johnson consistently accused his wife of being hypochondriacal about their daughter's health, and he felt Rebecca spent far too much time in the doctor's office.

Luckily, on this particular day, not only was Dr. Smith scheduled for behavioral science, but Mr. Johnson happened to be driving his wife to her follow-up appointment for a vaginal infection. Therefore, Dr. Smith proposed we use the additional behavioral-science time to explore how the two parents might better handle the issue of Rebecca's doctor visits.

After Dr. Smith had completed his regular exam, he suggested to the Johnsons that he and I spend a few minutes with them discussing ways they might improve handling the decision-making process of when to seek medical help for Rebecca. Both parents agreed. Dr. Smith began by defining the problem as he saw it; namely, that Rebecca's signs of illness, and the decision-making process inherent in determining whether to take her to see a physician, appeared to result in a great deal of tension and acrimony between husband and wife. Both Mr. and Mrs. Johnson agreed with this statement and eagerly elaborated. Mrs. Johnson felt any symptom of illness, however mild, was a cue to rush Rebecca to the doctor. Mr. Johnson, on the other hand, tended to advocate more of a wait-and-see attitude, and he preferred things to "take their course." Rebecca's illnesses inevitably triggered heated and painful scenes between her parents.

The basic intervention strategy adopted by Dr. Smith in this first 20-minute session was a normalizing, "educational" approach. Although the parents appeared locked into adversarial roles, Dr. Smith attempted to validate both parental approaches to health care as potentially appropriate. He pointed out that both vigilance and tolerance of ambiguity were acceptable parenting responses in the face of childhood illness, and that both were

necessary in varying degrees to ensure Rebecca's well-being. At first the parents vehemently disagreed with his interpretation.

Mother: Don't you think it's wrong to sit around and wait while your own daughter's life might be at stake?

Father: Isn't it overreacting to treat every little sniffle and cough as though it were a life-or-death situation?

Dr. Smith again attempted to reframe the parents' behaviors as both complementary (4) and useful in the care of their daughter. He also suggested that they solve these medical decision-making issues with more mutual participation. Finally, we explored various intervention possibilities to provide the Johnsons with alternative behaviors regarding medical decision-making for Rebecca.

However, it soon became clear that both Mr. and Mrs. Johnson were quite attached to perpetuating their conflict surrounding Rebecca's doctor visits, and they were unwilling to allow it to be resolved easily. In fact, their "problem" was a "solution" that allowed the family to remain in balance, however painfully. For example, Dr. Smith suggested that certain medically appropriate criteria could be developed (e.g., fever, diarrhea, etc.) that would indicate a visit to the doctor was necessary for Rebecca. Mrs. Johnson vehemently opposed this idea, stating that each illness episode was unique and too idiosyncratic to be governed by a fixed set of rules. Similarly, both parents felt it would be impractical to allow Mr. Johnson primary decision-making authority in instances of Rebecca's illness, because his work called for him to be away from home for extended periods of time. The couple doubted that dialogue between them could achieve anything except prolonged bickering.

At the close of the interview, each parent admitted that the other indeed was a responsible parent, capable of effectively managing the health care of their child, who would do nothing knowingly to harm her. Despite the lack of a clear course of action for handling future situations, Dr. Smith was hopeful that we had "cleared the air," and that the parents would henceforth work together more effectively to attend to Rebecca's illnesses. I wondered whether Dr. Smith had considered disclosing to Mrs. Johnson some of his own frustration regarding the way she tended to draw him into Rebecca's health-care problems. Dr. Smith admitted he did not feel comfortable enough with the Johnsons to share these feelings. He stated that he "pitied" Mrs. Johnson because of her daughter's condition, and he felt she had enough to deal with without being rejected by him. Thus, Dr. Smith's "pity" had now become an integral part of the system's homeostasis.

Over the next month, Mrs. Johnson scheduled two appointments for minor complaints, which, as Dr. Smith expressed it, "were nothing more than excuses to ask me questions about her daughter." Dr. Smith's pity for

Mrs. Johnson quickly turned to irritation and annoyance, and he began to dread seeing her name on his appointment schedule.

Soon afterward, Dr. Smith and I spent about half an hour discussing his shifting feelings toward Mrs. Johnson and her family. He realized he had been angry at her for a long time for dragging him into these incidents with Rebecca; he was also angry at himself for not putting a stop to it earlier. He acknowledged that at times, when Rebecca came to the clinic with her mother, a transitory but intense wave of horror would sweep over him. Dr. Smith's wife was at that time expecting their second child. While Dr. Smith denied anything beyond the "usual" worries related to congenital anomalies, it is easy to postulate that Rebecca represented, at one level, the worst possible outcome of a pregnancy. It is likely, therefore, that at times Dr. Smith saw himself not only in a consultant/physician role vis-à-vis Rebecca, but also in a personal, parental role. He would then feel so guilty for this involuntary and, as he viewed it, unprofessional reaction that he would try to "make it up" to Mrs. Johnson by listening to her talk about Rebecca's latest illness and encouraging her to solicit his advice. As Dr. Smith stated at one point, "You know, I've never really seen Rebecca as a little girl. I've always seen her as a tragedy." This strong choice of words might also suggest that Dr. Smith viewed Rebecca as a tragedy he feared might await him and his wife as well. Finally, Dr. Smith also felt guilty that as a member of the medical profession, he could not offer Mrs. Johnson a cure for Rebecca and that by continuing to interact with Mrs. Johnson about her daughter's medical condition, he was attempting to repudiate Mr. Johnson's conviction that doctors "are only good for signing the death certificate."

We spent the remainder of this time exploring the role Dr. Smith would like to take vis-à-vis his primary patient, Mrs. Johnson. He decided that he did not object to providing a second opinion on occasion, but he was uncomfortable with the subterfuges in which Mrs. Johnson engaged and with the feeling that she often had discussions with him that might be more appropriately held with her daughter's pediatrician or her husband. He also began to see that if he had failed his patient in any way, it was not because he could not miraculously cure her handicapped daughter, but because he had allowed his feelings about Rebecca's handicap in effect to handicap his relationship with his patient.

Dr. Smith finally agreed that he needed to confront his patient directly about these feelings. During this session, at which Dr. Smith, Mrs. Johnson, and I were present, Dr. Smith was able to express his feelings that he had become an unwitting pawn in a power struggle between Mrs. Johnson and her husband (16). He shared that he felt frustrated during visits with Mrs. Johnson in which she appeared to want to mobilize his support of her behavior against her husband. He went on to say that this was not a good situation for Rebecca, for Mrs. Johnson, or for himself. Dr. Smith suggested that Mrs. Johnson and her husband meet with Rebecca's pediatrician directly to discuss their daughter's care. Mrs. Johnson acknowledged that she often

sought out Dr. Smith's advice, but she said this was because, "The pediatrician doesn't understand me. He thinks I worry too much. He takes my husband's side." Clearly Mrs. Johnson had been turning to Dr. Smith to balance out the equation. Mrs. Johnson also revealed that not only did she regularly call Dr. Smith about Rebecca's complaints, but she also solicited advice and support from her mother and her sister.

At this point, Dr. Smith told Mrs. Johnson that he cared a great deal about her welfare and Rebecca's welfare as well. He reassured her he had no intention of abandoning her, but he felt that she and her husband, as well as he, were stuck repeating unproductive patterns (9). He volunteered to help the Johnsons seek out a new solution to the problem of taking Rebecca to the doctor. But first he needed to understand a bit better why the dysfunctional patterns kept recurring. He arranged to meet briefly with both parents the following week.

At this next session, Dr. Smith confessed he was puzzled by the chronicity and intensity of the parents' conflict over taking Rebecca to the doctor. He knew that they were concerned parents who had attended a parenting class to improve their relationship with their two children. He also knew that they were committed to their marriage, and that they had attended Marriage Encounter as a way of working on problems in their relationship. Therefore, it was difficult to understand how the conflict around Rebecca's visits to her physician had become so entrenched and had managed to endure unabated and unchallenged for the past five or six years. He needed their help in understanding how, although both parents could predict a certain cycle of events regarding Rebecca's symptoms of illness (Mrs. Johnson would become tense and nervous at the first sign of sickness; she would talk to Mr. Johnson, who would dismiss the whole situation as trivial; she would call her mother, her sister, and often Dr. Smith for advice; finally, she would go to the doctor, sometimes on an emergency basis; meanwhile, Mr. Johnson would be barely tolerant of his wife's "emotionality," and while not overtly forbidding her behavior, would indirectly communicate his contempt of her indulgence and silliness), neither was willing to alter this cycle.

At this point, I suggested that it might be helpful if we explored the family-of-origin attitude for both Mr. and Mrs. Johnson toward health and illness (10). This comment immediately evoked smiles from both Johnsons. They behaved as though we had stumbled on something of a family secret. Mrs. Johnson revealed that her family, and her mother in particular, tended to be very concerned about health issues. Her mother's philosophy, as she phrased it, was "better safe than sorry." Her mother acted as an advisor on matters regarding both grandchildren's health and had been a particular source of support and guidance concerning Rebecca. It further emerged that Mrs. Johnson's mother had lost a son when he was small, and she had considerable guilt as to whether she had pursued medical care for this child with sufficient diligence. Mrs. Johnson noted with some surprise, "You

know, I never made this connection before, but whenever I take Rebecca to the doctor, it's like I'm saving my brother's life."

Mr. Johnson, by contrast, came from a family that prided itself on its healthy living habits, its longevity, its self-reliance, and its avoidance of physicians. The family as a whole scorned medical treatment except in life-or-death emergencies. In discussing his family of origin, Mr. Johnson realized that although he stated his family had accepted Rebecca "beautifully," he continued to feel ashamed and inadequate that coming from a family of superb physical specimens, he had produced a "defective" child. He went on to say that every time Rebecca became ill and went to the doctor, it was a reminder to him, and to his family, that she was not a normal little girl. The longer he could stave off that fateful visit to the physician, the longer he could claim that "nothing was wrong," the longer he could preserve the fantasy that his daughter was normal and, even more importantly, that *he* was normal.

Paradoxically, although one might think the information elicited in this session would polarize the parents event further, in fact it resulted in a diminution of the tension between them. Each parent now recognized that the attitude of the other was not only personal, but also a reflection of a long-established family tradition and history. Before Rebecca's birth, they remembered, they had laughed about the opposite extremes of their families in matters relating to health. Now they laughed together again, and in the process, they were able to laugh a bit at themselves.

After Dr. Smith and I finished with the Johnsons, we spent a little extra time discussing his reactions. He mentioned that during the session he had noticed some similarities between Mrs. Johnson's and his own family of origin. His family had also lost a younger child (to leukemia) when Dr. Smith was a boy, one of the factors that impelled him toward a career in medicine. He felt he understood very well the fear and anxiety around health-related issues that existed in Mrs. Johnson's family. Simultaneously, however, he realized that just as he had often played the rescuer in his own family of origin, this was the role he unconsciously had adopted vis-à-vis the Johnson family.

A final session was scheduled as a home visit at which both Dr. Smith and I were present. We initiated this meeting by asking the Johnsons to tell us something about their own relationship. What emerged was a portrait of Janice Johnson as an extremely dependent, frequently depressed wife, with poor self-esteem, who was cared for and protected by her husband. Tim, on the other hand, was the "up" one of the couple, optimistic, competent, confident, a believer in "positive thinking." Mrs. Johnson described her husband as Mr. Perfect. Although Mrs. Johnson felt ambivalent about her dependent, helpless role in the family, neither she nor her husband had seriously questioned this foundation of their relationship until Rebecca's birth.

Like many expectant mothers, Mrs. Johnson had been convinced during

her pregnancy that something was terribly wrong with her baby. In the absence of any confirmatory medical evidence, Mr. Johnson had ridiculed this fear and reassured her that everything was going to be fine. But unlike past experiences in the marriage, where the prevailing family myth allowed Mr. Johnson's actions and decisions to be viewed as omnipotent and omniscient, in this case Mrs. Johnson's fears were justified. Her perfect husband had guaranteed her a perfect baby, but instead she delivered Rebecca. Mrs. Johnson's enormous rage at Rebecca's disabilities had never really found an outlet in the face of Mr. Johnson's optimistic platitudes and determination to cope successfully with this "input." However, as she disclosed in our conversation, Mrs. Johnson felt that her husband had deceived her, had failed her. Although she continued to acknowledge him as the competent leader in the family, fundamentally she no longer trusted him. She was not going to give him a chance to fail her again. Each time Rebecca became ill, it was as if Mrs. Johnson relived her own prenatal fears and, as it turned out, her husband's false assurances. Taking Rebecca to the doctor, on the slightest pretext, was an indirect way of telling her husband how angry she was that he had, in her eyes, betrayed her trust.

This revelation was a moving experience both for the parents and for us. Mrs. Johnson became aware that she had given Mr. Johnson much more power than he could really exercise in their situation. Mr. Johnson began to see that he had not given either himself or his wife permission to mourn for the loss of their anticipated perfect child (2). They both had achieved greater insight into the ways in which intergenerational and marital issues had conspired to charge a simple behavior—a visit to the doctor—with enormous negative affect.

At the close of this session, Dr. Smith and I made several suggestions to the family regarding changes they might make in terms of managing Rebecca's health-related problems. Mr. and Mrs. Johnson agreed that for the time, Rebecca's medical difficulties would be dealt with primarily within the nuclear family. This meant no more advisory calls from grandma, no more guilty reporting to his parents on Rebecca's medical status by Mr. Johnson. Second, within medical guidelines that would safeguard Rebecca's health, Mr. and Mrs. Johnson agreed to switch roles the next time a medical decision-making situation involving Rebecca should develop, i.e., Mr. Johnson would take the initiative in seeking immediate health care for his daughter, and Mrs. Johnson would counsel and practice restraint. The purpose of this exercise was to give each parent the opportunity to experience the other's point of view and a joint problem-solving task. When the two had mutually agreed upon a course of action, each would compliment the other on the concern shown for Rebecca's welfare. A meeting between the Johnsons, Dr. Smith, and the pediatrician was also arranged to develop better communication between the Johnsons and their daughter's primary physician. This further helped clarify Dr. Smith's role in relation to Rebecca's care.

Follow-up with the Johnsons and Dr. Smith indicated several improve-

ments in the situation. Dr. Smith reported a decrease in phone calls from Mrs. Johnson regarding her daughter. He also noted that Mrs. Johnson was less likely to seek informal medical advice about her daughter during her own scheduled appointments. Further, the number of Mrs. Johnson's visits to Dr. Smith decreased noticeably, from 12 in the six-month period preceding intervention to only two in the following six months. Mrs. Johnson stated that her trust in Dr. Smith continued, and she felt he was sincerely concerned about her problems. Mr. and Mrs. Johnson both reported a general reduction in tension in their relationship. Although they had reverted to their traditional decision-making roles after the role-reversal experiment, they both felt that medical decision-making regarding their daughter was handled in a more mutual and supportive fashion. They both stated that having better understood some of the issues informing their earlier behavior, they had an improved ability to focus on their daughter's needs in these situations, in contrast to using Rebecca's medical condition as a way of informing their own emotional needs, which were operating at an implicit, preconscious level.

Mrs. Johnson also reported that she felt better able to approach her pediatrician with questions and concerns regarding Rebecca's symptoms. The Johnsons subsequently reported that they had returned to marital counseling to further address issues of control and dependency in their relationship, and they were participating in a grief workshop through their church to help them come to terms with their daughter's handicaps.

Dr. Smith reported a change in his own feelings toward the Johnsons. He stated that he felt more in control of the relationship with Mrs. Johnson, and he was pleased it had been able to survive his confrontation with her. He felt that the quality of their interactions had improved and that they were more open, more authentic, and more personal. He also noticed he was more genuinely interested in the family, and he no longer pitied them. He made a point to ask Mrs. Johnson about Rebecca at times other than medical crises, and he became involved with her progress and development. He was especially pleased that he had been able to persuade Mr. Johnson to come in for an annual physical, something Mr. Johnson had not had since he was a child.

DISCUSSION

This case, which involved three 20- to 30-minute sessions with one or both parents, a home visit, and a follow-up report from the mother, illustrates certain art-of-medicine issues for physician, parents, and patient. Dr. Smith had identified a situation that was resulting in irregular, crisis-oriented, over- or underutilized health care for the child patient; marital conflict between the parents of the child; and tension in his relationship with his own patient, the child's mother. Dr. Smith had to attend to the art-of-medicine issues on all these levels. The level with which he had most difficulty

dealing was his own feelings for the Johnson family. It was easier for him to define the problem as existing entirely within the boundaries of the Johnson family. However, the boundaries of this problem (20) encompassed not only the Johnsons' nuclear family, but also Dr. Smith, the pediatrician, the grandparental generation, and almost certainly other connections and extensions that we did not have time to investigate.

What were some of the art-of-medicine issues involved in this case? Initially, Dr. Smith ventured into the arena of "art" when he identified chronic marital tension between his patient and her husband. His "artful" effort at intervention focused primarily on patient education, which, of all the "arts," falls most comfortably into the medical purvue. What he learned during this session was that the art of medicine may require the physician to probe deeper, go beyond patient education, in the face of the patient's secondary gain from the symptom of conflict.

Dr. Smith discovered that his own feelings of pity for and fear of Rebecca made it difficult for him to relate to the family in an open, honest, and direct manner. He had colluded with Mrs. Johnson's help-seeking behaviors because he "felt sorry" for her. He also had engaged in avoidance strategies with Mrs. Johnson. Ultimately, the more difficult he found it to control her behavior toward him, the angrier he became. Although Dr. Smith professed "pity" for the Johnsons' situation, in reality his feelings were more complex (21). They included anger at Mrs. Johnson, fear and revulsion toward disability, guilt at his "unprofessionalism," helplessness at the limitations of the medical profession, and even the survivor guilt and self-pity often associated with siblings of pediatric cancer patients. It became clear that Dr. Smith's behavior with the Johnson family was strongly impelled by personal issues with his own family of origin (5), particularly his need to be a rescuer in the face of a childhood tragedy. Thus, Dr. Smith became aware that in desiring to "solve" his patient's problem, he had to start not with the patient, but with himself and his own family of origin in relation to the presenting problem. In this case, attending to the physician's feelings, in combination with the family distress, resulted in the most productive interactions.

Art-of-medicine issues also came into play in Dr. Smith's efforts to place the Johnson family in the context of their own families of origin. Perhaps one of the reasons why Dr. Smith's early efforts at intervention were unsuccessful was that he wished to act in an "artful" manner before he fully understood what informed the Johnsons' and his own behavior. The second session with the couple, which explored family-of-origin issues, reduced tension not only between the Johnsons, but also between the couple and Dr. Smith. Previously, Dr. Smith had labeled their behavior as irresponsible, irrational, crazy. In listening to their respective histories, he found commonalities with his own past and comprehensible themes that had their own intrinsic logic. He came to realize that Mr. and Mrs. Johnson were not simply being foolish or difficult, and they had compelling reasons, handed down from their own families, for behaving as they did. In effect, each was

behaving like a "good child," and each was being rewarded by the respective family of origin.

Problematic parent-professional interactions formed an important component of this case and illustrate how the art of medicine is involved on this level as well. On the one hand, Dr. Smith allowed himself to become the mother's ally in an ongoing battle with her husband (and less overtly, with her pediatrician). By attempting to support her unconditionally out of pity and his own sense of helplessness, he quickly became enmeshed in the family system (12). The pediatrician, by contrast, had apparently adopted a more disengaged posture toward the family, playing a remote, perhaps somewhat hostile role, which the husband found well-suited to his purpose (having as little to do with physicians as possible) but which the mother found alienating. Dialogue between parents and professionals in this case was essential to realigning and balancing the various roles, allowing Mrs. Johnson and Dr. Smith to become less involved with the situation, and moving the pediatrician and Mr. Johnson toward a position of greater involvement while retaining Mrs. Johnson's centrality as guardian of her daughter's health.

The art of medicine also was involved in identifying some of Mrs. Johnson's devastating anger toward her husband and Mr. Johnson's almost desperate efforts to keep his marital and family situation controlled, contained, and "perfect." Willingness to examine these themes required considerable courage and compassion on the part of Dr. Smith. It required, in the words of Napodano, that he "take on some of the concerns, some of the suffering of this patient" (12). That Dr. Smith was able, in some measure, to do this reflects on his own growth during this period of family counseling.

Finally, art-of-medicine issues were involved in helping both physician and parents deal with unresolved themes of loss. Incomplete processes of grief served to contaminate Dr. Smith and Janice and Tim Johnson's present interactions with and perceptions of Rebecca. Dr. Smith was still grieving for the loss of his younger sibling, as was Mrs. Johnson; Mr. Johnson still mourned the loss of his idealized perfect child. The unelucidated nature of these various griefs allowed all involved to make Rebecca the stage on which they attempted to act out their feelings. In this case, insight was helpful in pulling back both parents and physician from repetitive dysfunctional, patterns.

The starting point of this case history was Dr. Smith's professed desire to "help" the Johnsons resolve a source of longstanding conflict, namely, how to deal with their handicapped daughter's illness episodes. In the process, Dr. Smith learned several things: that preventive or corrective "education" alone, as was attempted in the initial session, will not always successfully change behavioral patterns that are deeply rooted in family and personal histories; that the "problem" as he perceived it extended beyond the marital couple to include families of origin, himself as the primary-care physician, and the family's pediatrician; and that in attempting to "help" a patient and her family, he first needed to deal with his own feelings about

disability, as well as his feelings about a patient whom he experienced as behaving in a dependent, manipulative fashion (3). While this incident seemed to be about how to deal with unresolved marital conflict in a patient's family, it was also about how to deal with problematic doctor-patient interactions and how to deal with oneself as a physician. Because of the number and richness of levels, the case provides an excellent illustration of an application of the art of medicine.

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