Class 8

Psychosocial Aspects of Pediatrics: Middle-Level Theory Building

Braulio Montalvo, M.A., Edward L. Schor, M.D., and Margaret Moore, M.S.W.

It is inviting to apply existing systems theory to explain the professional behavior of primary-care physicians in the psychosocial aspects of their work. This seems premature. The psychosocial skills employed by primary-care physicians still require primary description. Before systems theories are summoned or developed to explain how those skills are displayed in transactions between the family, child, and doctor, more observation seems necessary. This paper contributes to the process of theory building by describing a number of rather complex transactions in a pediatric setting: the doctor's work in securing data and offering directives to the correct sectors of the family; the managing of issues of shared caretaking in the single-parent family; the expanding use of professional authority into the adolescent's caretaking domain; the unearthing of psychosocial roots in long-standing symptoms; the relating to overall circumstances as child abuse is presented; the grasping of the many layers involved in the compounded problem; and the generating of supportive ways of giving bad news and managing their effects. These observed behaviors are a few of the many common psychosocial transactions that need description and understanding prior to enunciation of theory.

INCORPORATING PSYCHOSOCIAL ASPECTS INTO PRACTICE

Despite the development of theories of human behavior and social interaction, concern with psychosocial aspects of pediatrics continues primarily to focus on specific interpersonal skills—skills concerned with interviewing,

Braulio Montalvo, M.A., is Consultant in Family Assessment, Department of Pediatrics; Edward L. Schor, M.D., is Chief of the Division of General Pediatrics; Margaret Moore, M.S.W., is Coordinator of Interpersonal Skills Training, Department of Pediatrics at the University of New Mexico.

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gathering basic information, introducing pointed questions, and clear and reassuring methods of patient communication while compiling information to determine an accurate diagnosis and enhance patient compliance. The avoidance of the application of theory at this juncture is appropriate. Yet, other skills, such as understanding when and how an illness occurs in a family's development, and sensing the effects of family and organization on the course of an illness, define broader psychosocial domains that are usually ignored in formal pediatric training, and beg the development of some more comprehensive concepts.

These uncharted domains require the art of engaging and maintaining the motivation of patients and those who surround them, and the skill to know through whom to usher the prescriptive remediation or corrective information and, sometimes, the bad news. Elusive psychosocial issues are involved in assessing the hierarchical problems in a family, who is in charge of whom, and in deciding whether to address that hierarchy directly or indirectly during patient care. They are also central to those interactions that expand the doctor's concept of the patient and that teach the physician to stretch his/her authority beyond the usual jurisdiction.

These psychosocial areas unfold as the doctor searches for knowledge of the living context of people who surround the patient and the effect they may have on his or her recovery. They are displayed through his/her concern with the timing of certain communications, which are intended to modify the actions of the surrounding participants on the health of the patient. Mastery of psychosocial aspects in pediatrics is built on sensitivity to the overall situation and to the way family members and others interact with the patient, particularly around decisions that enhance or impair the patient's self-management and self-care.

The following seven vignettes are presented to demonstrate and contribute to the gestation of theory building in psychosocial pediatrics. They represent an exploration designed to clarify what is required of pediatricians in this area. The vignettes were selected because of a fundamental observation: Pediatricians tend to assemble interpersonal systems out of whatever components are available to them in a given psychosocial context. In practice, doctors display flexible relationships to the variety of people and systems they encounter as they engage in diverse clinical tasks. The cybernetic schemes that stand for "theory" far outdistance developments in primary description and replicable therapeutics. Thus, though there is a need to formulate theory that can both explain and guide the primary-care practitioner's behavior in the psychosocial domain, we endorse a "back-to-basics" approach with a return to an appreciation of simple observations of doctors at work. Only then can accurate and useful theory evolve.

The clinical work of the pediatrician offers a starting point for building general systems theories to explain interactions with patients and their contexts. Among the rich and generally uncharted psychosocial domains in which the pediatrician operates, this paper explores the professional concern

with 1) securing data and offering prescriptive information in the right sectors of a system, 2) managing special issues of shared caretaking in the single-parent family, 3) expanding pediatric authority's jurisdiction into the adolescent's domain, 4) unraveling the symptom with long-standing psychosocial roots, 5) attending to the overall circumstances as child abuse is addressed, 6) developing alertness to the many layers of the compounded problem, and 7) discerning appropriate and supportive ways of introducing bad news and managing its consequences.

Involving the Right People

Consider how a doctor juggles the coexisting demands of interviewing and educating. This requires obtaining the basic information she/he needs to make a diagnosis, while also providing well-timed feedback that encourages the patient to assume as much responsibility as possible for the self-management of his disease or condition.

We observed a doctor meet such a challenge in the case of a 16-year-old boy who had been seen the week before by another physician for a suspected hepatic infection. The boy's mother brings him to see the doctor. The doctor soon excuses the mother and continues with the young man alone, in his effort to get as much information as possible about the patient's contact with the saliva, semen, or blood of others. During this routine interview, the questions are quite educational, yet they allow the young man to deny, if he needs to deny, where he got the "problem." The questions are cueing the patient as to what to avoid in the future, what to watch out for, and provide preventive information while attempting to gather "the facts." The young man looks very shy and says "no" to the question of "Did you have sex?" He also says "no" to the question, "Did you come into contact with anybody who seemed to be sick?" Soon after, the doctor offers a brief, exonerating explanation: "Well, the way one catches it makes no difference in the way in which it is treated." He gives the youngster a set of preventive measures to use around the suspected disease. He also provides a guilt-exonerating, nonjudgmental attitude. He clearly prepares this teenager to know what to avoid in future encounters with the suspected disease without making him feel unduly guilty or defensive. The precautions that he must take—washing his hands, not using utensils of other people, and so forth—are provided in a most natural way that almost belies anticipatory guidance.

Next comes the need to relax the patient in order to check on the possibility of an enlarged liver and shoulder-related pain. The doctor gently asks him to take off his shirt and lie down in order to examine his shoulder and belly. While the young man is lying down and the palpation begins, the doctor shifts to deliberately chosen, casual topics: "Have you ever been on TV?" (there's a camera in the room), "Are you playing ball in school?", "Are you very active?", and so forth. Throughout the examination, the simple, casual

questions continue, thus lightening the atmosphere and distracting the young man, which relaxes him. This happens during the time when the patient might be most afraid of being hurt or exposed.

Next the doctor works on "the scaffolding" of the session. The doctor explains to the young man what he must do to recover from this illness. He must reduce physical activity; he must understand that this is not like a regular virus or cold that goes away in a certain number of days. This will take longer—the young man cannot go to physical education, play baseball, etc. The doctor treats this young man as if he is totally self-sufficient and completely in charge of his own body.

Right after the physical, the mother steps into the room, and a different picture is presented. The doctor begins anew with the mother, as if he had not provided corrective information to the young man at all. The wise pediatrician secures information through both the youngster and the parent, which ensures that his input is likely to be followed. After all, compliance in adolescent medicine hinges on at least two participants, not just one, and particularly not the less mature of the two. Securing vital information in both generations of the family by enlisting the parent's cooperation as much as that of the youngster seems to be a basic skill characterizing effective pediatric contact.

Special Problems of Single-Parent Families

Another set of skills in the handling of elusive psychosocial aspects of pediatric interviews is observed in a physician's work with the single-parent family. The husband is in jail, and the young mother had returned to her own mother for help in the handling of her two young daughters. The presenting problem is discomfort on the part of a little girl, some kind of pain in the vaginal area. Grandma brings the two children; mother is expected later if she can leave her work in time. It is evident that the doctor treats the grandmother as if she is fully in charge, as if she knows the children. Indeed, the grandmother has a nice manner with the children. She helps them take off their clothing and facilitates the physical examination of the children without rushing or scolding them. This behavior is modeled by the physician. Because the doctor is calm and firm with the grandmother, she in turn becomes calmer and firmer with the children. The doctor, through his attitude and his pacing, facilitates the caretaker's feeling of calm and control in this situation.

The doctor correctly guesses that the girl was probably irritating herself in the vaginal area because her nails were too long. Carefully and soberly he conveys this information to the grandmother, while at the same time telling the grandmother that he wants to do some other tests in case of infection or other findings.

Meanwhile, the mother has arrived about two-thirds through the interview and an opportunity to observe another important piece of psychosocial

information occurs. Is grandmother able to make space for her daughter to act as a mother? Mother moves in without problem, and has some questions for the grandmother as to what has been happening. Grandmother relinquishes caretaking responsibility to her daughter and relays the basic information she has just obtained. She smoothly gives up the children to the mother. The doctor watches all these proceedings with peripheral vision for whatever it may tell him about safety cracks in this family.

Despite the fact that he has been through an extensive presentation of feedback to the grandmother, the doctor now turns to the young mother and again, as in our previous case, explains completely what needs to be done. Of particular interest from the standpoint of pediatric skill is the doctor's action at this point. The doctor takes the hand of the little girl and carefully shows the mother the length of the little girl's fingernails and explains to her that they have to be cut in a particular way to prevent the child from scratching or lacerating herself.

The participation of the young mother is not taken for granted. The doctor does not assume that because he told the grandmother he does not need to tell the mother. The doctor does not expect the grandmother to relay information for him. Instead, the doctor directly centralizes the young mother. He respects her position as the real mother of the children and shows it by the way he handles her when she arrives at the interview. The psychosocial sensitivity of the physician is focused on issues other than securing information. Here, the physician clearly gives priority and ascendance to the young mother. This compensates for losses in the mother's position by her having to go to work and no longer having a husband available. While attempting to provide for her children, she has diminished her role of authority, sharing caretaking with her own mother. Considering this context, it is important that the doctor allow her to compensate for this, to participate actively. Here, the pediatrician understands the significance of the interpersonal process of taking turns, or changing of the guards, in the care of the children. Observation of collaboration during that process reveals to him how the child's health is maintained.

Expanding the Pediatrician's Role

Neglected psychosocial aspects of pediatric practice also surface when pediatric authority and jurisdiction expand because of effective consultation. Consider a situation in which a pediatric resident reacts to the psychosocial pressures impinging on a traumatized adolescent, a 12-year-old girl who, upon examination, is found to be pregnant. The girl panics in front of the resident, expressing the extreme difficulty of her situation. She faces being evicted from her home, a group home for adolescents. She is so emotional and so truly frightened about being kicked out that the resident is shaken. Having faced a series of abandonments early in her life, the girl has just begun to feel that she has a spot in the world to call home. Now, no one

will support her. She is about to be kicked out, and this is all going to happen precisely when she most needs to feel sheltered and secure. The resident seeks immediate consultation.

During the on-the-spot consultation, several interesting developments occur. With guidance from her supervisor, the resident reconsiders the situation and realizes that she could redefine the extent of her jurisdiction and involve herself with the girl's psychosocial context without the need to refer. The resident has already established continuity by giving the girl a new appointment, by insisting that the girl call her, by making herself very available. But beyond these common ways of establishing continuity, the resident now also feels that she can and should call the people at the girl's present residence. She plans to use her authority to obtain assurances that her patient will not be left immediately without a home. Plunging into the living circle of the patient, she exercises her power to the benefit of the young patient. The resident learns that the task of a pediatrician does not end with diagnosis and feedback. Rather, it extends to the application of professional influence on the social context of the young patient's life, thus preserving both her emotional and physical welfare. The resident learns the lesson well because the supervisory feedback occurs precisely when she is most in need of advice. In this circumstance, the supervisor suggested an idea and learning occurred for the resident because the timing of the suggestion was appropriate. The idea to extend the context and jurisdiction of the physician's role happens to be one much needed but not prevalent in today's health-care delivery services.

During this exercise, the resident learns that there is *no* substitute for the authority of the doctor in these matters and that her own strength and position can be used to change the level of pressure upon the adolescent. More important, she learns that a doctor's jurisdiction can expand to include psychosocial consequences of the pregnancy "news," preventing fragmentation of care.

Complex Roles for Complex Problems

Neglected psychosocial aspects of pediatric training are also revealed in the following situation. A young patient comes to the clinic one night claiming that she has some problems with her skin and that she is losing her hair. An alert doctor realizes that something else is probably at work. The patient looks emaciated. The doctor suspects anorexia and confronts her with his suspicions. The girl's potassium level appears to be dangerously low, and the actual risk of an electrolyte imbalance leading to cardiac arrest is quite real. The doctor recommends admission, but the patient is unwilling. He then insists that she come back the next day. Of course, the next day the girl does not show at all. The problem becomes what kind of persuasive skills, what kinds of convincing must doctors learn to do to encourage the girl to come in immediately. The only available means of prevention at this

point is the phone. The doctor on duty that morning steps in and talks to this girl about the laboratory results. The doctor explains in a clear, nonsense way that it is crucial that she come in immediately. From the girl's voice and hesitant manner, the doctor begins to sense that she is meeting the typical evasiveness and duplicitousness of the anorectic patient. The girl is lying. The girl begins to put off coming in, demonstrating a pattern similar to that of the evening before. She says she will come in Friday, about three or four days later. Over the phone, the doctor has to quickly reemphasize in an unequivocal, authoritative manner the severe danger in the situation. The doctor's skill here lies in forthright use of language. She expresses, "You have to come, or otherwise this will kill you." One of the physicians supporting the intervening doctor suggests that if the girl does not show up by 2:00, someone from the staff must go and get her.

This kind of responsive care, which matches the true urgency of the situation, characterizes the institutional concern required in dealing with psychosocial aspects of the adolescent in crisis. This suggestion comes from the experience of working with children where a parental mantle of vigilance is very uncertain and where one cannot be sure that anyone is really in charge. Obviously, effective pediatric adolescent medicine has to be forceful in ways which address these issues. The anorectic girl in this vignette was shuttling between the houses of her mother and her grandparents. Later, we found that she was in charge of them, instead of them being in charge of her. She was cooking for them and telling them what to do. The mother had a history of feeble responses toward this girl whom she considered to be too independent and too strong for her. The mother had watched this young woman lose 30 pounds, but still had not called the doctor. Fortunately, the pediatric intervention is persuasive, effective, and carries a strong sense of urgency with the suggestion of the threat of death. The young lady shows up, is hospitalized, and after a week has gained enough weight to earn her release. Of course, the larger problem remains. The pediatrician has identified a psychosocial context that remains incapable of supporting the maintenance of the girl's gains.

The anorectic young woman's family dynamics offer other lessons that pertain to neglected psychosocial aspects of pediatrics. One lesson involves the handling of assaults on the doctor's authority. In this situation, the patient has attacked the doctor's credibility and qualifications. The doctor confronts her with the fact that she had not been totally candid with him during the first interview. While she claimed that she had a problem with her hair, she knew full well that she had an anorectic history. At this point, the young lady jumps on him, questions his qualifications and tries to render his authority invalid. "What kind of doctor are you? You're not a specialist on the mind, so I'm not going to cooperate." The doctor, unrattled, then defines his jurisdiction as that of the health of the body, emphasizing his concern with the physiology of the problem, the potassium level, which obligates him to intervene. The effect of this calm, redefining response is

that he recovers authority and competence and manages to continue the interview in an effective manner. By this we mean that the patient collaborated, allowing the doctor to enter her turf.

The larger familial context that engenders and maintains the anorexia in this young woman was more fully addressed at a later time. The patient, after having gained weight begins to relapse, drops weight, and the physician in charge engages the cooperation of the social worker. The social worker, in consultation with an attending physician, discovers that this family operates without any sense of rituals around eating. The girl cooks in one house one day, and the next day cooks in the other. The family never meets as a total family at a predictable time for meal consumption. Though this kind of arrangement would not necessarily prove dangerous with other adolescents, in this situation it becomes lethal. The social worker, the doctor in charge, and the consulting physician convey to the family that they want them to choose a particular time for eating together. This mealtime is going to be strictly enforced. The medical staff will be checking on it. The mother reacts cooperatively to this suggestion and relinquishes enough of her previous style to begin to cook for this girl. The desired situation develops in which the girl is surrounded and supported by significant others in the simple activity of eating. With this accomplishment, the deteriorating process of the patient's continued weight loss is arrested. The girl stays within a certain zone of weight gain that permits her to continue to work and prevents further hospitalization.

Clearly, the management of this case shows that from the expansion of the pediatrician's concern into the larger context of family patterns, it is possible to enhance the possibility that hospital gains will carry over into life away from the hospital, bringing about a more normal life pattern. However, new issues often emerge that pertain to the original psychosocial situation. As the social worker and the doctors continue to probe the surface of the case, they come upon additional data that reveal this anorexia has been of a long-standing quality because of concealed psychosocial arrangements in the family. They discover that as the girl gains weight, she becomes pretty. When she becomes attractive, she engages the interest of an uncle who lives across the street and who has made incestuous approaches to this girl in the past. By becoming thin and skeletonlike she can ward him off and avoid his advances. The family's involvement as an accomplice in the development and maintenance of the anorexia becomes clear with the discovery that this uncle, the mother's brother, helps his sister pay the rent. Throughout the years, this woman has been indebted to this man, and she lives in a twilight zone where she pretends she does not know the price she pays for being dependent on her brother. The girl's anorexia protects her mother, particularly her mother's tie to her brother.

This finding discloses how pediatric concern with the psychosocial roots of the symptoms in the patient can reveal long-standing phenomena. These phenomena must be managed if any effective resolution for the patient and

the family is to be obtained. The staff concerned with this case now searches for a way of asserting their authority in such a way that the mother realizes how extremely important it is that she present a boundary, a barrier, to the advances of her brother. The girl must understand that within her family there is a possibility of receiving protection, rather than being the one who offers the protection. If protection is uncertain, some avenue must be organized for her to escape with the sanction and approval of the outside authorities, the pediatrician, and his assisting staff. Ahead lie the tasks of helping the mother cope with the financial and other demands for which she is now indebted to her brother. Counseling or social-service intervention must assist her in finding ways of supporting her family other than having to use her daughter in this destructive arrangement.

The pediatrician must not only refer and collaborate, but also stay in the case, using his authority in such a way that the mother understands the message that the outside world requires her to protect her daughter. This case takes pediatric jurisdiction far beyond the usual areas of concern. But it is clear that this jurisdiction is well within the domain of the pediatrician's justified concern for his patient in the establishment of a maintained recovery of normal weight.

Before being viewed in its psychosocial context, this case hovered around a family-medicine clinic for years. As the young girl moves into late adolescence and young adulthood, the chronic status of the case is readily apparent. In the past, no one has been able to fully tackle the reality of incest underlying this particular anorexia.

Behavior Defined by Context

Another area that illustrates neglected psychosocial aspects of pediatrics pertains to how the doctor handles the overall situation when presented with a child who has been sexually abused. The effective physician develops some immediate method of assessment as to whether he is the second, third, or fourth person to question, pump, or unwittingly harass a youngster overstressed by the nature of the adult intervention process. The effective pediatrician asks some preliminary questions of the people who bring the child to quickly establish the extent to which the youngster has been squeezed for information. If the adult interventions seem to be in close sequence, this should influence the way in which the examination is conducted. Some doctors convey to the parents that in the first interview, the purpose is to establish trust and that they will delve into the case more thoroughly at a later time. At this point, the doctor makes an appointment for the next session. In this format, the attempt is to make the experience small, manageable, and child-centered, so as to help the youngster discover that the doctor is a helpful and benevolent person. This approach is particularly important in handling the child who has been abused by adults—adults who trespass, move in without consent, or exploit. The pacing and control of

how much interviewing or examining is done in any session is related to the doctor's attention to the length of time and number of people who have been converging on this child.

Additional extraordinary considerations reveal whether the doctor has a good command of the psychosocial issues involved in sexual abuse. Abuse that occurred nine months before may have been discovered the night before by the parents. For the parents, this is an urgent situation. For the doctor, however, who looks in the waiting room, there are people with more acute and difficult problems that require immediate attention. There is a temptation to handle this problem through the development of a screening procedure employed by nonphysician staff members that will quickly determine whether the youngster's abuse occurred fairly recently or a long time ago. However, it is dangerous to assume that parents who recently discovered abuse that occurred a long time ago can be sent home or asked to wait. This assumption creates an offended set of parents and adds stress to an already stressful situation. The sensitive pediatrician recognizes and responds to the family's sense of urgency.

An effective protocol used by our staff is to have the doctor, through discussion with a significant adult, quickly determine a complete abuse history and assess the emotional tone and tense atmospherics that now prevail in the family. The doctor offers his help and his expertise in such a way that the family feels his support. He is not rushing to dismiss them because other problems are declared priorities.

In short, though the contact may be brief, it is important that these cases are seen by the physician, not just by support staff, and that the physician directly addresses the concerned adults who bring the child. A fairly brief contact with the child is all that is necessary in this meeting. At the next appointment, a more thorough physical examination of the child can be undertaken to look for evidence of sexual abuse. Sensitive physicians also relate to attitudes or nuances that reveal whether the family can tolerate a male physician examining the child. One female pediatric resident feels that on many occasions, the parents are not even consulted as to the gender of the physician who is going to examine the child. Later, iatrogenically induced explosions from family members eliminate any chance of rapport. At worst, the family feels it has been raped again by the male physician's examination of the child.

A necessary addition to the list of neglected psychosocial dimensions in the pediatric curriculum is to teach the doctor to be concerned with the general circumstances in which he is asked to check for sexual abuse and try to lessen the possibility of prolonged emotional strain for both the child and the adults involved.

Children as Barometers of Families

Another area worth mining for hidden psychosocial lessons is the compounded problem. For instance, a girl in diabetic crisis shows up for the

physician to handle. Later, we find that this is compounded with suicidal ideation and deeper biosocial problems. The girl is hospitalized and treated as a diabetic until she regains control with insulin. When the doctor is ready to send her home, the young teen refuses and claims she is ill-equipped. Later, we find that the girl's reluctance to go home is related to her mother's struggle with the appearance of cancer. In terms of anticipatory sensitivity to psychosocial dimensions, the lesson here is always to treat symptoms in the child as if they could be precursors or concomitants of a larger stressful situation at work in the family.

In the particular case mentioned, the surfacing of the mother's cancer was not fully explicit. Yet the mother must have been changing her behavior toward the teenager in such a way that the teenager felt that proper care for her special needs was not available within the family. Possibly the sick mother was hostile, self-absorbed, or depressed. It was under these conditions that the teenager tried to kill herself. Since at the moment of diabetic crisis, no one could establish what was happening with the mother, the home-based, interpersonal sources of stress contributing to the girl's condition were underestimated. The lesson for the pediatrician seems to be that the presentation of pediatric symptoms may not speak only of past or current tensions at home, but also of tensions that are currently brewing, mounting, and developing and will peak later in more specific syndromes and problems among other family members.

Bearing Bad Tidings in Healthy Ways

Let's end with the situation in which a physician presents to the parents the diagnosis of inevitable chronicity or death for a child. For physicians, this is a predictable psychosocial dilemma that requires a set of orienting principles as to: 1) how to estimate the possible consequences of the news, 2) how to make sure that the parents have a support system, 3) how to ascertain the surrounding context and its capacity to support the caretakers and the patient, and 4) how to determine whether a period of preparation should occur before attempting to present the bad news in a straightforward manner.

The training need is to explicitly teach physicians the art of breaking bad news, an aspect of the psychosocial curriculum that is usually incidentalized. To meet that need, we can learn from a prototypical situation in which a doctor has to tell a mother than her young second child, a child of three, is displaying symptoms of chronic and potentially lethal disease. This is a condition that took her first child, and it is the doctor's job to convey that this child, too, may have the dread disease. When we look at the pediatric contact, it is immediately evident that the doctor takes full advantage of the presenting complaint. The mother comes to deal with the ostensible complaint that the little boy has a cold. First, the doctor works through the

conspicuous, ostensible complaint. He examines the child fully around that presenting complaint, though he knows that more is going on.

The doctor uses his ability to re-create experiences that may prepare the mother: "You probably know more about this situation than anyone since you had your first child." The doctor, in a very polite way, sporadically reminds the mother of her experience with the first child who died. In this way, he is equipping her to deal with the reality of the second child. After completing the physical examination, the doctor acts a bit dismayed, possibly discouraged. This is not so much to depress the mother as to emphasize that the situation is a reality about which there is little humans can do. He reemphasizes the professional impotence, not only of himself, but of other experts as well. He talks to her about "Dr. so and so," a renowned expert who thinks similarly. Throughout, he sprinkles the conversation with comments that reveal that he has called on other, more experienced colleagues who helped in shaping his opinion. The message that he had to go for further consultation, as well as the tone in which he communicates this information to the mother, conveys the need for her to prepare herself for bad news.

But that is only one level in this complex interaction. Also involved in here is how the doctor, while doing the physical, seems to enjoy this sick little boy. Through his attitude and conduct, he is attentive to the boy's curiosity. When the boy opens the drawers in the examining room, the doctor comments on how smart he is. Everything about the doctor seems to say, "*I can enjoy him now and you should too.*" That is, the doctor conveys a philosophy for the mother about "enjoying him now" through his positive behavior with the child. Later because of her own strong, independent coping skills, the mother dwells on how focused she is on enjoying him now. However, she adds, "We all live on borrowed time." With this statement, she demonstrates that she is also preparing for the worst.

To underscore his message, the doctor follows his previous statements with another set of more obvious interventions. This involves his use of larger classifications and categories in which he includes the patient. He offers the mother a telephone number and a brochure of a group that works with children with catastrophic illness. The preparation process is evident.

Beyond this process of equipping the mother to deal with the child's fate, the doctor extends himself and uses more subtle, time-tested notions of time distortion to rescue the mother's self. After the physical is completed, and he has conveyed to the mother the sense that there is little that can be done, he introduces questions like "How's your job?" and "What are you going about your school?" He is checking on the mother's career and initiating her future disengagement from the child. He centers his concern and his attention on her, which reaffirms her approaching independent existence. The doctor secures this communication by talking about his career and his own plans to leave soon. He actively relates her to the process of saying goodbyes by talking about what his own future will be. At this moment, he is meeting her as an equal. Professional distance disappears. They are both

simply people who will go ahead after their immediate task is completed. For the mother, the message seems obvious. As her immediate task of caring for this child is completed, she too must "pick up and carry on" with her life. This prepares her for what really will be happening as she loses that child. The doctor goes further. From a very humble position, he now questions the mother as to "How can you do it?" He admires her strength and elicits more of her philosophic outlook. She again tells him openly, "I'm going to enjoy him" and "You do the best you can and you move on." Without the mother realizing it, the doctor has reinforced her commitment to herself.

In summary, the useful ideas guiding the doctor's intervention include the following points: his attitude is humble; while he works through the ostensible problem, he addresses the more fundamental one; and he reminds and re-creates for the mother her previous loss of a child, particularly those experiences that could equip her to deal with the anticipated loss of her second child. The doctor does not hide his impotence and that of other medical experts. He informs the mother that the child's illness was too big for him, and he consulted with more expert people who also indicated there was nothing they could do. The doctor shifts gears and concentrates himself on the positive enjoyment of the child now, showing by his conduct what he believes the child deserves. The doctor moves further and begins to disconnect the mother from the child. Through the power of imagination, he transports her to the moment when she has no child and is engaged in her own development, her own career, her own personal goals. The doctor is open about admiring the strength of the mother, rewarding her coping efforts while she explicitly articulates her commitments.

SUMMARY

The central message to be garnered from the above is that practitioners should not lose the empirical base provided by their clinical experience. Theoreticians should temper their enthusiasm and restrain themselves from premature expostulation. As is the case in pediatrics, the different fields of medicine offer well-developed traditions from which individuals can and usually have developed principles of practice. The process of developing general concepts from specific experiences is integral to the development of clinical skills and provides an extraordinary array of therapeutic interventions. Too often teachers and researchers lose sight of the wealth of experience each trainee brings to patient encounters. The systematization of psychosocial aspects of pediatrics is in its infancy. Though many existing theories of human behavior, including family-systems theory, could be applied by pediatricians and other health-care providers to their work with children and families, such a leap would be premature. Given the paucity of existing organized observations of pediatric practice, the formulation of new theories is also difficult to justify. Systematic observation provides the

basis for assumptions about psychosocial aspects of pediatrics and must precede the enunciation of any theory. The discussion above represents only a few examples of the empirical base of pediatrics. Those concerned with the education of physicians and the process of doctor-patient interaction should consciously search for more.

Requests for reprints should be sent to Edward L. Schor, M.D., Department of Pediatrics, School of Medicine, University of New Mexico, Albuquerque, NM 87131.