

■ Plenary Session

The Challenge of Change in the Family and Family Medicine

Janet Christie-Seely, M.D. CFCP

University of Ottawa

The challenge of change is our bread and butter. Helping the patient see meaning in their predicament or a message for improving their lifestyle in their symptomatology adds meaning to the practice of medicine. The meaning of illness to a patient—the belief that it is a punishment for past guilts, the die cast by unpredictable fate, an unfair occurrence in a mechanical universe, or an opportunity to learn in the planetary schoolhouse, may make a difference to the experience of illness as well as to its outcome. The skilled clinician, without imposing his/her beliefs and values, can help lead the patient to a positive approach and to see crisis as opportunity.

By examining the broad international and national process of change, we can come to a greater understanding about the healthy individual patient. The concept of the planet as schoolhouse for nations as well as individuals helps in coping with the disasters we see and hear of daily. Look at the news through a new lens: “Who is learning what from this event?” and with what you see you will stop about being pessimistic about news events. Our own ability to change affects our attitudes. Some years ago Marilyn Ferguson (1), commenting on the title wave of change towards a new age, noted that people who had made their own dramatic changes in their own lives were the ones able to believe in change and to lead others toward

new visions.

In Canada there is a saying that a Chinese curse goes “may you live in interesting times”. That we live in a time of accelerating changes may be a curse or it may be a blessing! The Chinese symbol for crisis is, I believe, “dangerous opportunity” which suggests interesting times can be an opportunity. Our job is to minimize the dangerousness and help people cope. Virginia Satir (2), with whom I trained, often said, “the problem is not the problem, it’s the coping”. She also normalized chaos as part of the process of change. When a “foreign element” or change agent impacts on us, we move from the old status quo, which was comfortable because it was familiar, but often painful and dysfunctional, through chaos to new behaviours which have to be practiced and integrated, to reach a new status quo. The new status quo is much more appropriate to the circumstances and more functional. However as time goes by, this too will become of the old status quo and require change.

I am going to examine the old world status quo in regards to both family structure and the old status quo of medicine and family medicine. Hierarchy was a key characteristic. This implies that in any relationship one member is up and the other down (doctor-patient, father-son, mother-in-law-daughter-in-law, teacher-student, husband-wife,

etc.). In the hierarchy the value of an individual is to find by their role or status. People tend to be seen as either good or bad, right or wrong, a black and white world with a few shades of grey. Change tends to be avoided. If you are at the top, you want to stay there; if you are at the bottom, you are at least comfortable and know your place. As one man put it you have to know who is the king and who is the serf (servant) in each relationship and you're OK so as long as you know). His wife's face fell and she explained "I don't want to be the king or the serf in any relationship" -- the female world tends to be less hierarchical, at least in North America. Besides, most of us find change a challenge and uncomfortable, and we tend to move back to the old status quo as soon as we encounter the chaos. In order to move through chaos to new behaviours, which need to be, practiced and integrated, we need support--the support of a family physician, of a spouse or supportive colleagues, or family. Then we gradually find ourselves in a new status quo that suits everyone better.

The Old Status Quo

The old status quo of the family was a stable if often unhappy marriage with the wife subservient and children possessions who should be "seen but not heard". The emphasis was on duty, respect, loyalty and obedience, on discipline and self-denial. Relationships tended to be controlled by fear, power and authority. In Asian families the older generation were in charge and the family household often consisted of several generations and several families under rigid rules.

The old status quo for the physician was the "priestly model" or the "M.D.ity Syndrome" where the physician thought he was God and the patient did too! The health care system was and still is to a large extent extremely hierarchical. In many

countries family medicine is at the bottom of the hierarchy! Again the emphasis is on duty and dedication with workaholism and perfectionism the penalty for high prestige and authority and a marked power differential between physician and patient. Physicians were poor communicators--why should they learn communication when patients simply had to do as they were told and should not understand the disease that was beyond their ability to grasp. Patients were discouraged from asking questions and physicians frequently used jargon, which would create remarkable confusion if the patient did not understand what he was being told (e.g. a patient told he had Addison's disease, who happened to have secretary by the name of Miss Addison!).

The Negative/"Dark Side" of Hierarchy

The dark side of the old status quo in families was the poor, often indirect and dictatorial communication patterns which evoked fear and anger in those who were subservient (wife and children) and isolation work stress and loneliness in the men, as well as guilt when they abused their power. Feelings were not expressed, with the exception of anger, which was expressed by the man. Children were often triangulated (caught between the parents) or scape-goated and could not wait to grow up and leave, when they often reproduced the same pattern of abusive parenting. Family secrets were frequent: alcoholism and violence, sexual abuse, and physical and verbal abuse were often almost the norm. The negative/"dark side" for physicians was that doctors lectured and advised, but had poor listening skills and often totally ignored feelings. In the medical world, which has been likened to an abusive family system (3) with extreme hierarchy, family secrets such as physician impairment and alcoholism, and the sexual abuse of patients, which became an enormous scandal in

Canada 10 years ago, and other forms of abuse of power over patients. There was a conspiracy of silence over this just as there was in families about sexual abuse and violence. Physicians would protect one another in the old rigid code of ethics. (Now a physician who fails to report another physician known to have sexually abused a patient can be fined \$25,000.00). However the emotional and physical cost for physicians was high as well (4). We have had extraordinarily high stress, have high expectations of ourselves and others, poor self care, and are often cut off from our feelings and from our families. There is a high morbidity and mortality rate among physicians, as well as a high suicide rate, a high rate of addictions to drugs and/or alcohol, high suicide rates in our spouses, and high divorce rates. There is a high psychiatric morbidity in physicians' children.

Training is brutal. Pre-medical students have often led narrow lives as they focus on grades and getting into medicine. Then they are subjected to brutally long hours, exhausting competition and demoralizing treatment from their seniors. The abuse in medical school and residency years is considered normal and necessary. It has been said, "the only way we tolerate the inhuman treatment of patients is because we have tolerated inhuman treatment of ourselves". "Twenty-four hour shifts in emergency are insane" and also "normal"...and this is all under the intense pressure that you never make a single mistake. Even more is the pressure to look like you could never make a mistake." A study in Montreal found that medical students, in comparison to engineering or biochemistry students, learned through the four years of medical school to discount their mistakes. However, under this rationalization is a deep feeling of fraud or shame. In a recent teaching session with residents, all but one put up their hand when asked if they felt like a fraud, as if someone was going to find them out soon!

The Foreign Element or Change Agent

A foreign element is a change agent or event that triggers the need for change. It may be an illness or a powerful life event such as falling in love or a death or birth of a baby, or simply a chance statement by a friend or a program on television that somehow has sufficient impact that change of scene is necessary.

The foreign elements for the world have been dramatic and painful. In the family, the emancipation of women has been a result of two World Wars, the birth control pill, the Women Rights Movement and the increased divorced rate. I gather that in Korea the divorce rate is now 30%, not as bad as the 50% in Canada, but it is increasing. I have also seen the role of women as still belonging to the old hierarchical world, but it is also changing here. The planet has become a global village as a result of media coverage of all corners of the planet and of the mass movements of people through immigration, wars and tourism, and the influence of returning peacekeepers. Media coverage can be a mixed blessing, either increasing empathy and understanding, or increasing cynicism and dulling the response to terror and inhumanity. However, I was struck after September 11th, 2001 by both the worldwide empathic response and the positives that came out of that event at all levels. The planet is a schoolhouse full of learning events for countries as well as individuals. The US has learned a great deal from the event-hopefully.

The nuclear threat and world hunger and poverty and the environmental crisis have created a perceived need for collaboration for the first time. Minority rights, the rights of the elderly and the rights of children, the publication of the hidden sexual abuse by the church in Christian countries, and ending the conspiracy of silence over the sexual abuse and violence and alcoholism in families, has prompted enormous change in a very positive direction.

ction, at least in North America. Sexual exploitation and the disempowerment and degradation of women in other countries is only just now beginning to change, but will change at a more rapid rate as the media and influence of other countries escalates.

The horrors hidden in the old family and the horrors of the last century—the Holocaust, Mylai massacre, Bosnia, Rwanda, and September 11th, to name only a few, have been and can be enormous foreign elements to trigger change for humanity.

What About Medicine?

Change in the medical hierarchy is being forced by the increasing costs of care and decreasing budgets, with consumerism increasing the demand in an increasingly egalitarian community which asks for accountability, communication and collaboration. A \$2 million study in Ontario called “EFPO”, which stands for Educating Future Physicians of Ontario, (5) interviewed a very broad range of consumer groups. There was a consensus among this large section of the Canadian public that physicians should not only be medical experts, but should be effective gatekeepers/resource managers (i.e. help regulate the rate of consultation, surgery and medical interventions in a just way) good communicators/educators/humanists/healers, and good collaborators (i.e. have an egalitarian relationship with the patient as well as with other health care providers). They should also be lifetime learners, scientist/scholars further advancing medical knowledge; they should be health advocates and as people, they should be human. The public has very high expectations of physicians! This study has been a major foreign element in Canadian medical education with all Ontario universities now teaching about these eight roles in medical school.

Litigation has been a force for good as well as

prompting negative, defensive medicine, particularly in the US. No matter how one feels about lawyers, it is no longer possible to get away with carelessness and a cavalier attitude towards patients, and it is well known that the patients who sue have had a doctor with whom they do not get along. Good communication skills are the biggest protection. Competition from nurse practitioners, midwives, chiropractors and alternative medicine is now enormous, and often these people have a much better bedside manner than physicians who now have to improve or suffer financially.

The number of women in medicine is increasing. When I graduated there were only 10 women to a 100 men; now 50% of the graduating class is female. The female culture trains communication from early childhood so that women culturally and perhaps hormonally are more interested in people and in relationships and communication. This has had a major impact on medicine in North America.

The migration of people has meant enormous cultural diversity in North America, with 50% of Toronto’s population speaking a language other than English. Physicians have therefore been forced to understand and appreciate other cultures, particularly where it impacts on health. Cultural ideas about illness, about physician behaviour, about effective therapy have a great impact on patient behaviour. Cultural sophistication is perhaps the most important educational challenge facing us now.

Current Medical Challenges

Medical challenges include the increasing numbers of elderly. The over 65 year olds occupy half of all acute care beds and most of the chronic care beds. The population over 80 years in North America will double in the next 20 years and triple in the next 40 years. In North America the elderly have been increasingly cared for by people other than their families, unlike your country, so that

hospitalization rates are enormous and health care underfunded. This is slowly being examined and in some places reversed, but governments are slow to act.

Obesity

Last year the Institute of Medicine, National Academy of Sciences in the US reported on: health and behaviour (6), the interplay of biological, behavioural and societal influences. This was a major report of a distinguished interdisciplinary group of 14 experts with some dramatic data. However, it was unfortunately overshadowed by another report on the number of deaths resulting from medical mistakes in the US with even more dramatic data. This report will also be presumably a foreign element triggering change in the medical system that is not always as careful as it should be about iatrogenesis. We need mechanisms to prevent errors in the thousands of medications we now use, often with insufficient evidence of efficacy; drug companies and physicians can sometimes be cavalier about serious side effects. The public is rightfully nervous about the use of medication and medical interventions, but it in turn needs to learn the incredible complexity of medicine and the humanity of physicians who probably make more mistakes when made extremely anxious and defensive in what they do. The public has a short memory and forgets how many diseases were fatal or incapacitating before the advent of drugs. These are learning events for everyone. The Institute report focused particularly on obesity and diabetes, showing a truly dramatic increase between 1990 and 2000 from all states in the USA having more than 20% obesity in 1990 to over half the country having over 30% of the population obese by the year 2000. The rate of diabetes was similarly exponential.

The findings of the report were: 1) that health

and disease are determined by dynamic interactions among biological, psychological, behavioural and social factors. These interactions occur over time and throughout development. Cooperation and interaction of multiple disciplines are necessary for understanding and influencing health and behaviour. 2) The social and psychological factors include socio-economic status, social inequalities, social networks and support, work conditions, depression, anger, and hostility. 3) There is evidence that behaviour can be changed and interventions can successfully teach new behaviours and attenuate risky behaviours, but improved health outcomes often require prolonged intervention and lengthy follow-up protocols. 4) The old adage "an ounce of prevention is worth a pound of cure" is valid in the context of behaviour and health as well. Improving access to healthy foods or safe places to exercise at the community level is important as well as individual behavioural change. Change in cigarette taxes and public advertising has major effects on smoking. Increasing opportunities to exercise during the school day or improving walking on bicycle paths can prevent obesity.

Positive health includes a healthy body, high quality personal relationships, a sense of purpose in life, self regarded mastery of lifestyles and resilience to stress, trauma and change. Societal efforts of prevention will be enormously more effective than attempting to medicate the problem when it has already occurred. Medications have complications and if not used appropriately can lead to weight gain rather than weight loss. They generally only achieve a five percent weight reduction in addition to the five percent reduction from behavioural/dietary control.

AIDS and Uganda

The world provides endless natural experiments to demonstrate the change process. The impact of

AIDS in Uganda is one example. Uganda was a highly hierarchical patriarchal system which encouraged polygamy so that women were at risk for AIDS and if infected were forced into prostitution, increasing its spread. The old status quo included a high incidence of family violence and hard labour largely done by women as was childcare. However, men owned the property and inheritance rights. Women had no time for self care, no power over their own sexuality, nor the ability to challenge men's behaviour. The reverence and fear of elders resulted in low communication of the diagnosis of HIV, low use of condoms, and the avoidance of peer counselling groups that were set up. In the old status quo "churches continue to campaign against condom use and soldiers rape with impunity. Without a revision of the some aspects of existing health, political and social institutions and a total change individual's world views, the fight against AIDS will be futile" (Kabahendra-Nyaabwa-"Uganda and the Challenge of AIDS", presented at 16th Canadian Association of African Studies, Toronto, Canada, November 13-15, 1992). Then AIDS hit a population of just under 17 million with 1,700,000 cases in 1992 of whom 85% were between 15 and 40 years, many educated professionals. This left almost 1 million orphaned children in a country where adoption is stigmatized. The result was a dysfunctional government (already in chaos because of a mad leader) and companies and a drop in coffee production, which is 90% of the country's GMP. All of this was a massive foreign element for change. The good news is that the women of the country organized among themselves to produce rapid social change and a turnaround in productivity. A recent book corroborates this. In "Women in Politics in Uganda" (7), Aili Mari Trip analysed the changes that produced a significant economic recovery after the catastrophic decline.

Chaos

Chaos is an inevitable part of change. Note that the new chaos theory says that the "edge of chaos" is the most productive place to be (8). Someone commented that "Family Medicine is always on the edge of chaos"!

The feelings that have been aroused during the chaos of discovery of the horrors of this past Century include fear (of annihilation-wars and crime), shame (of humanity's atrocities such as the Holocaust and other mass murders, cults like Waco and Aum Shinri Kyo, and of sexual abuse which occurs in one in every 4 to 10 females and one in every 9 to 20 males) guilt (of the perpetrators, of collusion and the conspiracy of silence, of one's own impulses).

There has been a huge paradigm shift (9) in the middle of this chaos. Antonovsky, an Israeli researcher coined the term a "Sense of Coherence" defined as "the world is ordered as it should be and I have a place in it" and found this variable had the highest correlation with both mental and physical health (8). The world's sense of coherence has been turned upside down. The old world order has disintegrated, leaving many groups reactionary and defiant and trying desperately to return to the old status quo (for example, the fundamentalist Muslims who want to step back several centuries with the men having total control of women as chattels). However the signs of change are everywhere, with businesses moving to an egalitarian creative structure and countries embracing democracy which is "a poor form of government but the best yet invented". Against a backdrop of denial of the need for change, of blame and revenge, and despair, inertia and cynicism are many signs of a positive move towards enlightenment for humanity. Several leading thinkers (2,11,12,13) have described the paradigm shift from a fear-based hierarchical model that was necessary for our survival in the

past, but is now threatening our destruction, to a growth or love-based model that is becoming our new status quo. A win-lose defensive approach based on the belief that the world is dangerous and basically bad is giving way to a win-win response to life as challenging where the glass is half full, not half empty, and humans seen as basically good. Relationships in the survival model are hierarchical, competitive and judgmental with "I-it" attitude between self and other. In the growth model relationships are egalitarian, collaborative and nonjudgmental, and based on an "I-thou" response to the other (11).

In the survival mode of living or worldview, 1) energy is directed as being right, looking good (in a judgmental world) and being in control (dominating or avoiding being dominated). In the growth model energy is freed up for creativity, contribution, caring and sharing of ideas and feelings (which need not be guarded in a world where people's intentions are good). 2. Responsibility in the survival mode tends to be avoided for fear of one's own or other's judgement. Blame (projection), denial, or self-blame (experienced as victimhood of others, of events, or of one's own personality) are the common stances. With the growth worldview, self-esteem is enhanced by taking responsibility for one's self and others and for the outcome. 3. Choice is experienced at least of one's response, if not of the context and events. One is "response-ive" and "response-ible" rather than defensive and avoidant. 4. The payoff of the old status quo in the survival mode is that it is comfortable and safe because familiar. Being right props up self-esteem which suffers from isolation from others and lack of congruent (the ability to be the same on the inside as on the outside). There is a sense of independence despite the aloneness. On the other hand the survival mode pays off in creativity and fun and high self-esteem and in the sense of interdependence. There is usually

much more feeling of being alive. Clearly these are extremes and there are positives to be said for hierarchy in times of extreme stress or war. However, even military hierarchy disappears in the trenches. Some of the old virtues are valuable: loyalty, duty and obedience to old important values -when not excessive so that they stamp out creativity and freedom and high self-esteem.

Perhaps the extremes of parenting illustrate this best. The old status quo of rigid and excessive rules, as described by Barbara Colorado's "brick wall" parents (14), produce children who are stifled, timid, and fearful or rebellious and who hate their parents. On the other hand, some modern parents have mistakenly moved to the opposite, equally unhealthy, extreme; they become "jellyfish" parents and chaos reigns in their households with inconsistent or absent rules. In these families the parents end up hating the kids. (It is of interest that families with overly rigid rules and families with chaotic or absent rules both have a higher incidence of physical illness as well as mental illness, just as do families with overly close intrusive, enmeshed ties and families who are disengaged and disconnected from one another (15). It is optimum to be a backbone parent who provides firm but flexible rules with age appropriate autonomy (and close but not intrusive or controlling relationships).

Chaos and the Family Physician

As we are bombarded with the need for change and take on more and more roles likely like those as listed by EFPO (5) and deal with increasing members of patients who are increasingly sophisticated about their disease and demanding of optimum care, we move into chaos. When a patient produces literature on their illness from the Internet that is beyond our knowledge, we may want to fall back to the old autocratic model. We fear litigation, fear for our image with patients and

colleagues, and fear for financial survival. Prevalent is the fraud syndrome ("somebody will find me out one of these days"). We may feel shame at our inadequacy and force us coming to temptations like trips supplied by drug companies. We feel guilt over mistakes and missed diagnoses, and above all having insufficient time with our patients and our families (16). The perennial pressure of journals reminds us that we are not sufficiently up-to-date. On top of all this someone says, "you need to be aware of the impact of the family on your patient and you should, by the way, be doing better at self care" and we may move into denial. "I'm fine, I don't need to change" or "it's the systems fault, patients are too demanding", "my wife does not understand" etc. Denial and blame or despair, inertia and cynicism we move back to the old status quo.

Like patients we need support to move to a new paradigm and a new way of practicing and particularly a new way of relating to ourselves, that this more appropriate for today and better for our health. Getting together with colleagues to talk about self care and difficult patients helps a great deal. Groups organized to improve the hospital system, work hours and vacation make you feel less alone. Change in the medical system and change in medical education are slowly working to improve practice for the benefit of both patient and physician.

New Behaviours

To stay with the chaos long enough, without moving back to the old status quo out of fear, requires support. The family physician is often in the position to support change, whether through normal stages of the life cycle such as the birth of a new baby, school entry, the empty nest or coping with death, or when illness moves an individual or family into chaos as in a new diagnosis of diabetes. We will then help them re-organize the kitchen

and family diet, teach about medication or insulin injections and help them manage an exercise program. We will help the whole family learn to live with diabetes in a healthy way.

Thus with families and the community, Family Medicine's patient education will include better means of communication and understanding of family dynamics, a win-win/no blame approach to family problems and illness. We will help publicize the facts of violence, guns, incest, addiction, and the impact of lifestyle on health. We will appropriately refer when needed and have a collaborative approach to patients, families and other health professionals. We will be good role models for teamwork and equality, and egalitarian communication between professionals. Family physicians will have group learning/discussion networks-between physicians as in Balint (doctor-patient relationship groups) and support self help groups for patients around illness or addictions (AA, ACOA, Al-Anon, Kidney Foundation, groups for diabetics, etc.). We will empower individuals and communities to change themselves! We will role model for other physicians broadening the medical model and decreasing the stigma of psychosocial issues.

Family Medicine has already taken the lead in Family Systems Medicine, created by a group of family physicians also trained as Family Therapists. They are teaching family physicians to see a patient as "a piece of a family", to metaphorically see the family sitting around the patient, even when there is only the one person in the office. Family stress is a major contributor to illness which is a result of varying doses of: external agents/organisms/stressors, genetic predisposition, psychoneuro-immunologic response, subconscious and conscious decisions, family expectations, themes, and self-fulfilling prophecies and repeat patterns, cultural meanings, traditions, expectations, and of the survival mode of living. One of the most potent triggers for illness and in fact death in the subseque-

nt year is the loss of a spouse. The mortality rate is higher with any disease examined in the widowed compared to married at the same age (17). The best predictor of angina in a prospective study of men in Israel was the question, "Do you think your wife loves you?" A negative response was a better protector than cigarette smoking and equal to cholesterol level (18).

Working with the family in primary care means "thinking systems". To understand the meaning of that, you will need to come to my workshop! It means at times facilitating family communication; anticipatory guidance before hospitalization or family change; family support and education; crisis intervention when needed and appropriate referral. It implies a nonjudgmental approach and focusing on health and strengths and not on "pathology" (the growth model). Working with the family in primary care (19) is not Family Therapy but is Knowing the Family (have met the family together at least once, e.g. on a housecall or in the hospital), understanding the illness in context and treating the illness in context when appropriate. This does not take more time unless production line medicine of 60 patients a day is the norm. There are many busy family physicians with a systemic approach.

The family physician of the future will be a leader in the medical community. He/she will be a leader in the new worldview with an ecological, nonjudgmental approach, believing in the positive potential of human nature and the value of diversity. Physicians have become increasingly community leaders, for example, their role in physicians for the Prevention of Nuclear War, now Physicians for Social Responsibility, which received the Nobel Peace Prize. Family physicians will be leaders in the medical system. There is increasingly happening now with innovative collaborative approaches to budget issues and planning, and leadership in curriculum change with increased communication skills training (e.g. in Ottawa from 4 sessions to 14 half

days in first year medicine). Family physicians (e.g. in Toronto) are emphasizing cultural competence and training in ghetto inner city areas where the language is rarely English and facilitating new attitudes to racial, gender and cultural differences. They are encouraging the creative rather than dehumanizing use of technology and encouraging evidence-based medicine that includes qualitative research. They tend to role model self care and a humane physician lifestyle in comparison often with their specialist colleagues. They tend to be more collaborative and destigmatize the psychological response to stress, encouraging communication of feelings so that a physical illness as a stress response is less likely. They are expanding the medical model and teaching systemic thinking as well as emphasizing compassion, empathy and a nonjudgmental approach to illness and patients.

The New Status Quo

In the West families are now moving to egalitarian democratic relationships with acceptance of many different forms of family structure. The stigma of divorce has decreased for the children, although embattled communication still tears children apart and continues the old world attitude of blame and revenge. There is increasing talk and encouragement of forgiveness, witness a recent book about both international and individual forgiveness as a resolution of world hatred at the micro and macro level (Henderson). Families and communities are much more growth-based than fear-based now with a win-win collaborative approach to conflict. Parents and teachers of the backbone variety are now more common than brick wall or jellyfish! There is of yet not much understanding of the family as a system but an increasing ecological approach in other areas is having an impact.

In the medical system, you see increasingly the

seven C's of Collaboration, Caring and Compassion, Cultural competence, Communication, Congruence (open, honest and respectful communication), and Change seen as positive, diversity as valuable. Crisis is seen as an opportunity as in the Chinese symbol for crisis as dangerous opportunity.

The cultural competence of the future implies:

1. The ability to respect and appreciate the values, beliefs and practices of others, and learn to perceive through other cultural lenses;
2. Knowledge of the specific values, beliefs and cultural practices of those in one's community;
3. Comfort with differences, avoidance of the trap of defensiveness/anxiety re one's own culture;
4. Ability to change false beliefs, assumptions, and strategies learned for dealing with others;
5. Ability to think and behave flexibly and recognize one's own way of thinking and behaving is not the only way.

Germain Greer commented that "The opposite of patriarchy is not matriarchy but fraternity, and I think it is women who are going to help break the spiral of power and find the trick of cooperation". There is still a long way to go but we are moving towards a world of egalitarian growth-or love-based values. We are on our way to a new status quo for all of us, when:

1. Humanity will be aware of its dark side without denying, blaming, condoning or despairing;
2. We will reach a mature state of responsibility for our actions, our health care system and our health, and the health of the planet on which that depends;
3. We will have the excitement of learning from other cultures and other medical traditions, and from medically or developmentally challenged people. We will join in our similarities and learn from our differences (Satir);

4. We will recognize there is no "they" versus "we"- "they is us". Connecting through our similarities on a shared planet "we are none of us home till we are all home".

Of greatest importance to the family physician is our ability to help the patient transform the crisis of illness into an opportunity. Carefully choosing our timing for such comments, helping the post myocardial infarction patient recognize the importance of his relationships with his estranged teenagers and wife compared to his work, or helping a newly diagnosed diabetic gain a sense of mastery and purpose as he learns more about the illness, and empowering the patient who comes in with Internet information that you, the physician, can learn from about the patient's illness. The suffering find some meaning in their suffering. This crisis as opportunity is the essence of family medicine.

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