

# Physician Ineffectiveness Due to Family-of-Origin Issues

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*Physician family-of-origin issues can lead to loss of neutrality in the therapeutic encounter, causing fusion with the patients' problem-maintaining system and resulting in failure to achieve therapeutic goals. Bowen's family-of-origin theory, along with three physician case examples, are presented and discussed. Training implications for residency programs are discussed as well.*

Neutrality is the therapeutic stance of choice not only in family therapy but in family medicine as well (13). Neutrality allows the facts of the patient's condition and system to be accurately determined, encourages the easy negotiation of therapeutic goals and plans with the patient, and, probably most importantly, allows for the changing of tactics if feedback suggests that the current plan will not achieve the desired results. In short, neutrality encourages the free flow of the clinical management process as described by Taylor, Gordon, and Ashworth (16).

Unfortunately, there are many threats to neutrality. One threat, and the subject of this paper, is the physician's own family-of-origin experience. Bowen was the first to describe how this past experience can lead to loss of objectivity in the therapeutic relationship (3, 4). His work has subsequently been expanded upon by others (10, 17), but his theory still predominates in the family-of-origin field. Bowen's theory states that a person's ability to maintain his objectivity, and thus his ability to act consistently with the therapeutic goals in any given emotionally charged, provider-patient relationship, is dependent on how well he or she was able to differentiate, or become a "self," in his or her family of origin. The more differentiated the therapist is, the less he or she "fuses" with or becomes a part of the patient's system. As the patient's system, especially his or her family, is often

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maintaining the illness-related behavior in some way, such fusion by the physician can often lead to ineffectiveness and a failure to accomplish therapeutic goals. The physician, in essence, becomes a part of the patient's system, which maintains, rather than heals, the patient's illness.

Previous published examples of how the practitioner's family-of-origin experience can lead to therapeutic ineffectiveness have described the authors' own experiences (5, 7, 12). This article will expand upon those individual examples by looking at a series of physician cases and by examining in some depth exactly what family-of-origin factors led to therapeutic ineffectiveness.

## METHODS

In an effort to understand how family-of-origin issues might encourage fusion and therapeutic ineffectiveness, five primary-care physicians (three males, two females) practicing in the Seattle area were selected as subjects for this investigation. Four family physicians and one primary-care internist were interviewed. Participating physicians were not selected at random but for ease of access.

A structured interview was conducted with each physician. During this interview, the physicians were asked to remember and describe in detail three cases in which they had felt ineffective as a clinician. Open-ended questions were asked during this portion of the interview (2). Physicians were asked to describe the characteristics of the therapeutic relationship as well as the medical details. The physicians' feelings toward the patients and the other people involved in the cases were elicited, as well as the specific issues that the physicians felt were important to each case. Issues that seemed to lead to physicians' ineffectiveness were carefully explored using the physicians' affect as a guide.

After describing their cases, physicians were then asked to describe their family of origin. Open-ended questions and construction of a genogram were used during this portion of the interview (2, 11). Physicians were encouraged to describe characteristics of the relationships in his or her own family of origin. Family-of-origin issues and rules of interaction were elicited by asking physicians for examples or stories that typified their family-of-origin experience.

Characteristics of the relationships that were elicited in both the case and family-of-origin discussions included: specific conflicts that developed, whether alliances or triangles were present, whether disengagement or enmeshment occurred, and what communication patterns (complementary or symmetric) were in evidence. Definitions of these terms are presented in Table 1.

At the conclusion of the interview, the author compared the two situations to see if any similarities existed between the dynamics and issues of the physicians' cases and the dynamics and issues in his or her own family of origin.

TABLE 1  
Definitions of Measured Variables

Variable	Definition
Conflict	Emotional disagreement between members of the same system.
Triangle	Triadic interaction pattern often characterized by an alliance between two members of a system against a third.
Disengagement	Quality of a family system in which members are emotionally distant.
Enmeshment	Quality of a family system in which members are overly close emotionally.
Complementary	Communication pattern in dyadic relationships in which differences between participants are maximized. For example, when one partner is overly assertive and the other is overly submissive.
Symmetric	Communication pattern in dyadic relationships in which differences between participants are minimized. For example, communication among friends of the same peer group is often symmetric.
Rules/issues	Interaction patterns or behavioral laws that stabilize the family system, often manifestations of the ways families avoid open, active conflict.

## RESULTS

In the interest of brevity only three particularly illuminating physician-case examples will be presented. In these descriptions, the identities of the physicians concerned are altered by the use of pseudonyms and by the modification of certain insignificant details, such as geography. The family of origin of each of the three physicians will be described first, followed by the description of the case in which he or she felt particularly frustrated and ineffective. An analysis of the case to detect similarities in dynamics and issues between the frustrating case and the physician's family of origin will follow. Table 2 presents a summary of all the results and shows that issues and rules that led to ineffectiveness in the cases were very similar to the issues and rules in the physician's family of origin.

### *Physician 1*

George is a 30-year-old physician. He spent his childhood in a small New England community. Both parents grew up in a small rural community and knew each other throughout their school years. Their relationship became closer after World War II, which interrupted his father's college experience, and eventually led to marriage. George says that both parents describe their courtship in joking, romantic terms; found the separation caused by World

TABLE 2  
Summary of Results

Physician	Family-of-Origin Issues/Rules	Case Issues/Rules That Led To Therapeutic Ineffectiveness
George	Father—symmetric Mother and brother—conflicted, complimentary Sacrifice competence Keep secrets	Symmetric relationship with men Complementary relationship with women Sacrifice competence Avoid discussing sensitive issues
Nancy	Father—distant Mother—enmeshed, symmetric Parental child	Distant relationship with men Alliance with women Overly responsible with children in patient's family
Paul	Father—distant Mother—enmeshed, symmetric Rational and passive Mildly parental and protective	Distant relationship with men Passive, rational stance with patients Overly responsible and protective
Sarah	Father—close, symmetric Mother and sisters—conflicted, complimentary Competence Passive	Conflicted or distant relationship with women Friends with men Passive
Gary	Father—distant Grandmother and mother—close, complementary Perfection Secrets	Overly close relationship with women Distant relationship with men Fulfilled expectations of what female patients desire

War II difficult but bearable; and had no difficulties worth mentioning after the war. When George's father returned after the war, he took over the family business. A few years later George's sister, Sue, was born, then George, and finally George's brother, Bob.

George described his mother as energetic, talented, artistic, creative, and industrious. His father is a competent, good man who George described as more rational than his mother. He stated that on the surface, their relationship is a good one, yet there is a "hidden" relationship characterized by mother's animosity toward George's father, which resulted in a lot of "sniping." During the interview, George became very angry as he described this sniping or "putting down" of his father. He related one story of his parents' high-school years in which his father, who was second chair in the cornet section of his high-school band, intentionally dropped down to fifth chair in the cornet section to be closer to his mother, who was first chair in the adjacent violin section. George felt angry at his mother for making his father appear more incompetent than he really was.

family projects together. George felt comfortable with his mother, but then stated angrily that he could never talk with his mother about his life. In college, George was carrying on a long-distance relationship with a woman at an Ivy League college a few hundred miles away. He wanted to talk to his mother about the difficulty he was having in maintaining this long-distance relationship. He stated that his mother wouldn't listen to him and just ended the conversation by saying, "Your father and I did it. Why can't you?" Interestingly, George did not defend himself against this maternal charge of incompetence.

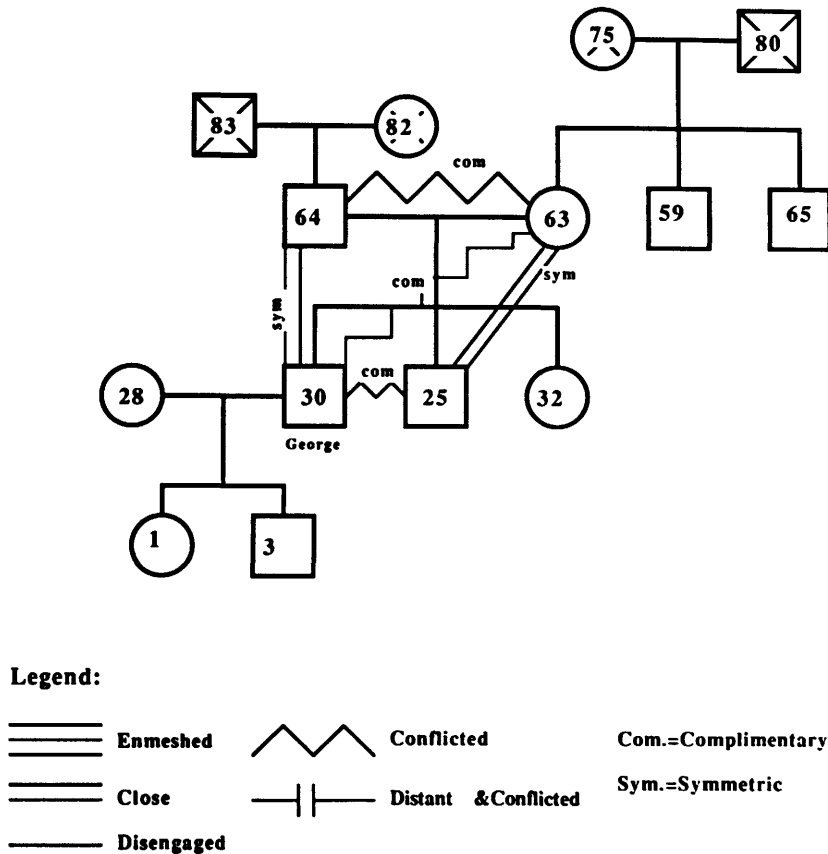
George had a good relationship with his older sister, describing it as "close, we could talk." George's older sister was often in charge of baby-sitting him. He was, however, in constant conflict with his younger brother, who had congenital clubbed feet. He described a situation in which he was very angry with his brother, Bob, because Bob was "in command" of a whole box of chewing gum at two years of age. Because of this and other favors Bob enjoyed from his parents, particularly George's mother, George used to hit Bob in the hall whenever they passed one another. George says Bob was greatly relieved when he left home.

At the conclusion of my interview with George, he stated, "It would probably be better if you approached people you didn't know, as it's more likely that you would get more information out of them." I asked why and George stated, "People, you know, might keep secrets."

As shown in Figure 1, George enjoyed a close symmetrical relationship with his father. He was in a conflicted complementary relationship with his mother. Conflict also occurred in his relationship with his brother and in his father's relationship with his mother. Mother and Bob were close.

In his family of origin, George learned that men should be passive, rational, and "one down" to women, who are overtly critical of a man's competence, in order to maintain relationship harmony. Women should be active, energetic, creative, and idealized. Women, however, should never be criticized or confronted about their own incompetence. Furthermore, George learned to keep secrets about issues that might result in conflict, particularly female incompetence.

*Case.* George's first case involved a 62-year-old white female with obesity and insulin-dependent diabetes mellitus. At their first meeting, George noted an elevated blood sugar and inquired about the patient's management of her diabetes. George learned that the patient didn't know much about diabetes, and that the husband gave the patient her insulin shots. In fact, the husband often arbitrarily decreased his wife's insulin dose, as he was worried that she was getting too much and might have a "reaction." George didn't like the husband, describing him as a "nerd" and an "Archie Bunker type." George noted that the husband had a paternal, distant relationship with his wife, even though the above evidence suggests enmeshment. George con-



fronted the husband on his "competence" in taking care of his wife's insulin dosage. He also frequently talked with the wife about her own incompetence and lack of participation in her own care. No changes occurred, however, and George began to feel more and more responsible for the patient's health care. Other problems that George noted but did not attend to included: 1) a schizophrenic son who lived in an upstairs room and never came out, whom George never asked to see; 2) maternal concern over husband-daughter incest, which was never confronted by George; and 3) subsequent development of loose associations and decreased short-term memory in the wife, which George did not work up but attributed to their "weird" family.

One year after meeting the patient, George conducted a chart review and noted that a complete physical exam had never been done. He resolved to raise this issue at the patient's next visit. When George raised the issue, the patient asked if a complete exam included a pelvic exam. When George said yes, the patient asked if he was married and George sensed "sexual over-

tones.” Because of these overtones, George did not pursue scheduling the patient for a complete physical and did not confront the patient with his discomfort about those overtones.

Six months later, the patient was admitted with chest pain. In the course of that hospitalization, the patient developed deep venous thrombosis and pulmonary embolus. She was placed on anticoagulants. One week after discharge, the patient developed profuse vaginal bleeding. George did a pelvic exam at that time and noted an obvious fungating mass that turned out to be a cervical carcinoma. The patient was readmitted for radiation therapy. In the hospital, the patient’s diabetes came under better control as the carcinoma was treated. During the hospitalization, George met the patient’s daughters, two “absolutely gorgeous” businesswomen, who were very concerned about their mother. The daughters asked, “How was this carcinoma missed during the previous hospitalization for chest pain?” George did not defend himself.

George said his therapeutic ineffectiveness in this case was not doing a pelvic exam earlier, in the hope of detecting the carcinoma sooner.

*Analysis of case.* An analysis of this case reveals that the overriding issue is George’s competence as a physician. In this case, George, as his father had taught him, sacrificed his competence by not performing a pelvic exam, rather than confronting the patient on an issue (sexual overtones) that might have resulted in a conflict. George was more comfortable in keeping those sensitive issues secret, as was done in his own family, rather than risking an argument and possibly ending the relationship.

Other parallels exist. Rather than work with the patient’s husband, who inadequately managed the patient’s diabetes, he chose to get into a conflict with the husband as he didn’t fit George’s idealized notion of what a man should be—passive and competent like George’s father.

Ironically, this maneuver also compromised George’s competence as it resulted in his never being able to get his patient’s diabetes under control, since the patient’s diabetes was controlled by her husband. Also, rather than defend himself to the two “gorgeous” sisters, who, like his mother, appeared competent and action-oriented, and who George idealized, he chose to remain complementary (one down in this case) and accept this mistake as his responsibility alone, even though the patient never requested or scheduled a complete exam.

## *Physician 2*

Nancy is a 28-year-old physician. She grew up in a small rural community in northern Utah, and is the oldest of four girls. Nancy’s parents were married after a short courtship. Unfortunately, their relationship quickly deteriorated after their marriage. Fundamental religion, Nancy’s father’s

alcoholism and his womanizing were all sore spots in her parents' relationship. Because of these difficulties, the parents separated when Nancy was three and saw each other only on weekends. This arrangement continued until Nancy was 14, when the parents finally divorced. After the divorce, Nancy's mother moved the family to a conservative religious community.

Nancy stated that early on she became a "parental" child. Mom worked nights, so Nancy put her sisters to bed on time and got them ready for school in the morning. She helped them with their homework. She set up the rules for the younger sisters to follow and she enforced those rules.

Nancy stated that her mother was her best friend. She felt very sorry that her mother had to work long hours to support the family. Nancy did everything she possibly could to help her mother, including buying her clothes, loaning her money, and organizing the household.

Nancy described herself as being closest to her mother and next closest to her youngest sister, who Nancy described as the "baby." This sister had a very close relationship to her mother, with whom she slept until she was 13. This was a problem for Nancy. Nancy tried to intercede in this overly close maternal-daughter relationship by encouraging the mother to allow the daughter to sleep alone but "got nowhere."

Nancy was not close at all to the next youngest sister, who often "acted out sexually" and who has had three abortions. She also was not close to the next oldest sister, whom she described as bright and talented. Nancy resented this sister's unwillingness to perform household tasks and take responsibility for her other sisters, as Nancy did.

Nancy was very distant from her father, having little contact with him after the divorce.

As shown on her genogram (Figure 2), Nancy enjoyed an enmeshed symmetrical relationship with her mother, a distant conflicted relationship with her father, and a close relationship with her youngest sister. Nancy's relationships with her other two sisters were complementary and conflicted.

In her family of origin, Nancy learned that men are distant, unruly, and uncaring. From her mother she learned that she should never be "dependent" on a man, as her mother often felt trapped in her relationship with Nancy's father. She also learned that it is important to take responsibility in situations in which no one else does, even though one doesn't have the parental authority to exert such responsibility. Nancy was willing to confront her parents on emotionally charged issues, such as her father's alcoholism or her mother's desire to sleep with her youngest daughter, but these confrontations were not successful and only served to distance Nancy from her mother and father.

*Case.* Nancy's frustrating case was a 45-year-old, mentally retarded woman with multiple medical and psychiatric problems who was admitted to the hospital with bilateral leg paralysis. Despite the fact that another physician was on duty for the practice, Nancy took care of the woman



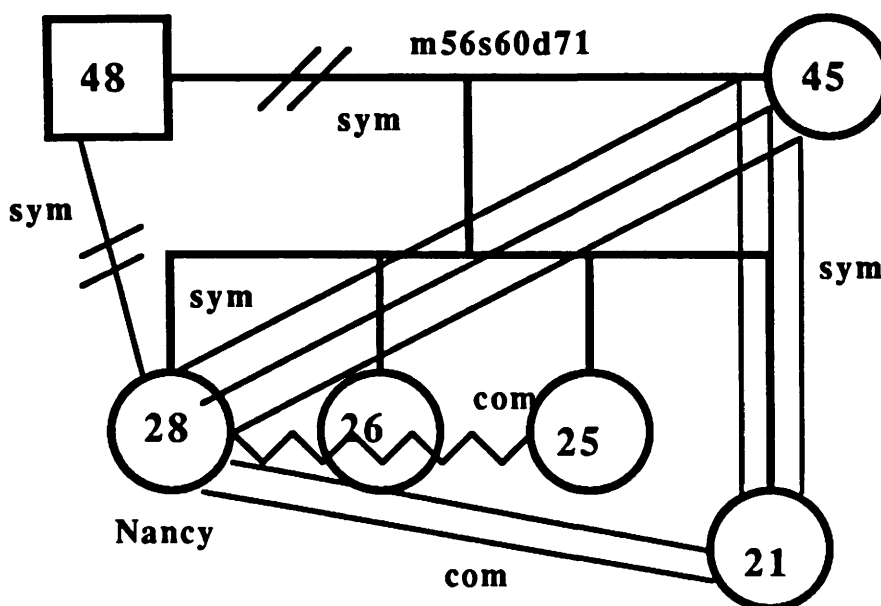


Figure 2. Nancy's Genogram

because "no one would do it right." Nancy added this patient to an already full caseload. Nancy described the patient as sweet, simple, and childlike. The patient lived with her parents. The father was an alcoholic who had sexually and physically abused the patient. During this admission, the patient's father had been drinking very heavily and the mother was quite distraught. Nancy thought that the paralysis was psychogenic and due to a family crisis. After a negative medical evaluation, the paralysis cleared, so Nancy decided to have a family conference. Her goal was to reduce family stress and foster her patient's independence by trying to admit the patient into a halfway house. Even though Nancy invited all members of the family, only the mother appeared and she came one hour late. The mother denied the stress of the family situation and denied that the patient's father might be making sexual advances again. Nancy described the mother as not wanting to divorce the father because of the money she received from his railroad job and wanting to keep the patient at home because she received social-security money for her. Nancy was very frustrated with the mother and felt that she had to "protect the patient because she was like a little child." After the conference, Nancy felt defeated and so discharged the patient to her current situation, adding that "nothing changed" by the time that she left her residency.

Nancy felt ineffective in this case because of her inability to move the patient away from the family and into a halfway house.

*Analysis of case.* The similarities between this case and Nancy's own family of origin are striking. They include an alcoholic father, ineffectual mother, and a patient who resembled her baby sister. In this case, Nancy

took over the role of being a “parental” doctor, just as she had done in her own family of origin. Unfortunately, Nancy did not have the parental authority to exercise such responsibility. Thus, her goals were thwarted by the person who did possess that authority, the patient’s mother.

### *Physician 3*

Paul is a 28-year-old physician in private practice in the Seattle area. Paul began his description of his family by stating that he was much closer to his mother than his father. His father “wasn’t in the family at all.” This lack of paternal involvement often upset the mother, who Paul felt was “left raising us.” Paul resented the father for not being a part of things and related a story in which his personal physician asked his father to teach Paul the “facts of life” when he was an adolescent. The father never did, and the task was completed by his mother. The only function that Paul remembers his father fulfilling was one of discipline, when father reinforced mother’s directives. Even though the mother initially supported the father in discipline efforts, after the children were punished Paul’s mother would often go into their rooms to help them “understand” their punishment.

Even though Paul was closer to his mother, he often viewed his mother’s actions as irrational and inconsistent. Paul described one incident in which he was forced to take his younger sister, Julie, outside into the neighborhood wearing a sign that stated “I am a liar.” Evidently, Paul’s mother had caught Julie lying and gave Paul the responsibility of walking Julie around the neighborhood. After the public humiliation was over, Paul retreated into his room. Retreating into his room and being an “undemanding, passive, perfect child” were the ways Paul avoided conflict in his family.

Of the children in his family, Paul was closest to his youngest sister, Susan, whom he described as the “baby” of the family. Susan was always very personable and outgoing. Paul often gave his mother advice on what to do when Susan was experiencing difficulty. Paul described the worst relationship in the family as that between his parents and Julie. Paul described Julie as a radical who was irresponsible and did “crazy things” as a child. Paul was not close to Julie because Julie and Paul often competed in school. Paul often won these competitions. Paul stated that even though he disliked Julie, he often played the role of a mediator in the fights between Julie and their parents.

Paul’s genogram is diagramed in Figure 3. Paul was in an enmeshed, symmetrical relationship with his mother. The parents were engaged in a complementary, conflicted relationship, with Paul in a very distant complementary relationship with his father. In his family, Paul learned that men should be distant and rational, as his father was and as he himself behaved to avoid conflict. Furthermore, Paul learned that it was permissible for women to express their emotions, even to an irrational extent, as long as they served as caretakers of the family. Paul learned to be a peacemaker in

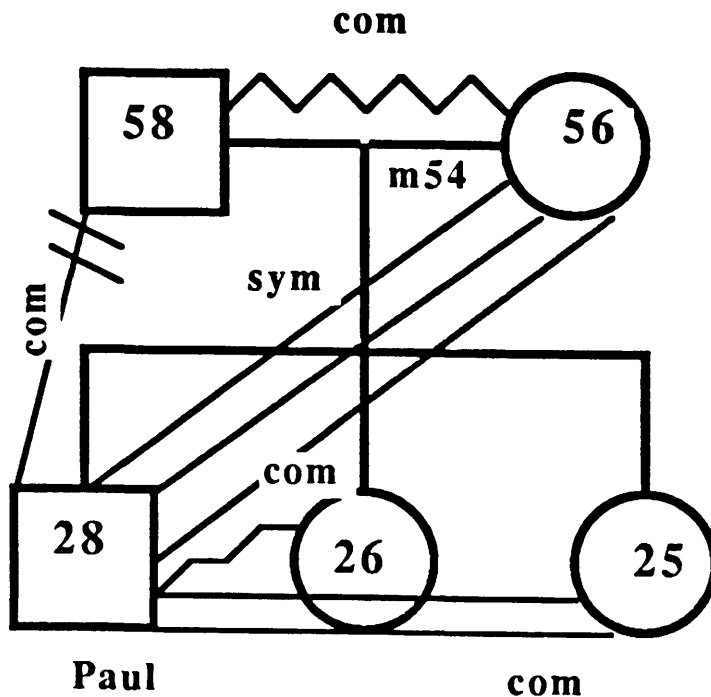


Figure 3. Paul's Genogram

conflicts that did not directly involve him and to exercise responsibility over people, such as in his role as a parental child with Susan.

*Case.* Paul's first case involved a 20-year-old female who was first seen by a medical student. Joyce was six weeks pregnant and came in for abortion counseling. She had given up her first child for adoption. She was involved with a fisherman who was in town one day a week. She didn't know how he felt about the baby. She had a history of abusing alcohol, heroin, and cocaine. Joyce came from a large family, the father being "totally out of the picture," with Joyce still living with her mother. At the first visit, the medical student discovered that Joyce wanted to be in a detox program so she could withdraw from her alcohol, heroin, and cocaine use. She did not want any part of Alcoholics Anonymous meetings or outpatient therapies, as these programs had failed in the past.

In presenting the case to Paul, the medical student was very angry with Joyce, feeling that she would be a poor mother. The medical student felt that an abortion was the preferred option, particularly given the potential drug effects on the fetus. Paul tried to defuse the student's anger by rationally pointing out that the choice was Joyce's. Paul then went to talk with Joyce about the moral implications of her decision. Paul learned that Joyce wanted the baby, was morally against abortion but realized the effects the drugs

might have on the fetus. She said that she would talk to her boyfriend and requested that Paul look for an in-patient program to treat her addictions. Paul agreed to this and suggested that Joyce come back in one week. At the conclusion of the interview, the medical student wondered why Paul wasn't angry at Joyce and marveled that he was so able to separate his emotions from his intellect.

Joyce returned in one week, having been unable to get in touch with her boyfriend but having decided that she would not obtain an abortion. As the patient had little money, Paul could not find an in-patient drug-treatment program that would accept her. Paul suggested that she sign up for public assistance as a way to gain enough financial resources to be admitted to a program. After that interview, the medical student stated that she was still angry at Joyce for keeping the baby. Paul was not angry and felt close to Joyce because she had such a hard decision to make.

Joyce came in for a prenatal visit one week later. She arrived in a very inebriated state. Paul confronted her with this fact and she admitted it. Rather than chastising her for coming in drunk, Paul asked her questions about how she felt about being drunk again and what she was going to do about it. Paul took this low-key approach because he did not want to embarrass her or make her feel that she could not see Paul if she was drunk. They arranged to have one more meeting after which Paul felt it would be necessary to transfer Joyce to a physician who took obstetrical patients.

At the last meeting, Joyce arrived with a girlfriend. Her mother arrived separately during Joyce's visit and wanted to see Paul alone. Paul learned that the mother was a recovering alcoholic who "behaved poorly" during their meeting and was still drinking heavily. The mother had just asked Joyce to leave her house. Joyce was now living with her girlfriend. Paul stated that he had hoped to use the mother as an ally in his struggle to get Joyce into treatment, but thought instead that the mother would not be a good ally because of her own problems, so he "got rid of her." During that meeting he transferred Joyce's care to another physician. One week later Joyce had a miscarriage. Joyce never returned for treatment of her multiple drug addictions.

Paul felt he was ineffective because he did not meet his goals of getting Joyce into a program that would treat her drug addictions.

*Analysis of Case.* Striking parallels exist in this case between Joyce in her system and Paul in his family of origin. In this case Joyce occupied the same role as Susan did in Paul's family—as someone to be cared for and nourished. Paul entered into a very complementary relationship with Joyce just as he had with Susan, being very responsible and parental. Also complementary to Paul's very rational behavior in this situation was the medical student's anger, which very closely resembled his own mother's emotional behavior. Similar to Paul's family of origin, there was a father who was distant and unavailable. Paul's reaction to Joyce's mother is interesting and may rep-

resent the fact that Joyce's mother did not fulfill Paul's template of what an ideal mother should be: emotional and ineffective. Rather than coming to Paul for guidance in this case, the mother simply took action and ejected Joyce from the home. Seeing this difference, Paul, rather than working with the mother as an ally in an attempt to get Joyce into a treatment program, simply rejected her. We see that Paul's passive rationality and failure to recognize and deal openly with the emotional components of this situation resulted in what for him was a poor outcome.

## DISCUSSION

When Albert Einstein was attempting to explain his theory of relativity to a group of reporters in the 1930s, he stated that if matter did not exist, there would be no time or space (6). Matter, just by the nature of its existence, causes time and space to exist. Likewise, each person, just by the nature of his or her own existence, carries with him or her a context or system. In this article, we have seen how the clinician's system can have an impact on his or her effectiveness as a health-care provider.

In the cases described, certain facets of the physician's own family of origin, that context which the physician carries with him or her to all patient-care situations, led to therapeutic ineffectiveness. This ineffectiveness usually resulted from the physician fusing with the patient's system because of certain characteristics that resembled the physician's own family-of-origin system. For example, a common pattern in many of these cases was a developing alliance with the patient or with a part of the patient's system that closely resembled an alliance in the physician's own family of origin. Likewise, conflicts developed between the physician and the patient or the patient's system in areas that were similar to conflicts in the physician's own family of origin. Other characteristics of the relationship, such as the complementarity of the relationship, and certain family-of-origin issues such as keeping secrets, avoiding conflicts, or assuming parental responsibilities, also had implications for physician ineffectiveness.

The psychological process through which this phenomenon occurred has been well described in the countertransference literature (15). Evidently each of us, because of past family-of-origin relationships and experiences, carries within us a template or system map upon which we try to fit new experiences. This system map is so profoundly embedded in our internal psyches that we are compelled to try to fit situations we encounter into it, even when they are not a close fit. The power of this tendency can be explained by object-relations theory (14). Briefly, this theory states that we become very comfortable with our own system and try to replicate it in our dealings with the outside world. Our own system is comfortable to us because it was the system that gave us nurturance, support, and maternal love as a child. This tendency to replicate our own system in the world around us, or in the physician's case in his or her therapeutic relationships with patients, can be

seen as one reason why fusion occurred and ineffectiveness resulted in the cases described.

Because these system similarities encourage the physician to fuse rather than view the patient's situation neutrally, we can speculate that if the patient's situation or system had been very different from the physician's, another outcome might have resulted. For example, if Nancy, who was more comfortable in alliances with men, had encountered George's first case, in which the patient's husband was managing her diabetes, the outcome might have been very different, since Nancy might have been more willing to work with the patient's husband.

This phenomenon may be the origin of the widely held belief among health-care professionals that they are more effective with certain cases than others. Perhaps those cases that trigger our own family-of-origin experiences and lead to rapid fusion result in such conflict or passivity and, thus, ineffectiveness, that those patients end up quickly going elsewhere for their care. Patients with systems that don't trigger such rapid fusion, probably because they are dissimilar from the physician's own family of origin, stay with the physician as he or she is able to deal effectively with them.

These findings have training implications. Balint was the first to examine difficult physician cases within a group setting with the goal of improving the doctor-patient relationship (1). Such "Balint" groups are now a common feature of many family-practice residencies. It would be easy to incorporate family-of-origin teaching in the discussions of such groups and should prove immensely beneficial for the doctor-patient relationship of residents, given the results of this study. In addition, individual family-of-origin therapy has been advocated as a way therapists can achieve more differentiation in their therapeutic settings (9, 10, 18, 19, 20). Such therapy should also help physicians who note problems in dealing with "difficult" patients.

Just as in nuclear physics, when either the mass or the momentum of a particle but not both can be measured accurately in a specific system, so in this study either the specific systemic relationships or therapeutic ineffectiveness could be measured by one observer, but not both. In this study, specific systemic relationships were chosen as the variables to measure, leaving the judgment of therapeutic ineffectiveness to each physician. In fact, many clinicians reading this report might take issue with whether the physicians were truly ineffective. Thus, because no objective measure of therapeutic ineffectiveness is included in each case, the true link between family-of-origin issues and therapeutic ineffectiveness awaits further studies that can objectively measure ineffectiveness. The effort in this study was to concentrate on systemic variables and to postulate such a link in the hope of encouraging future research.

In closing, this article attempted to describe how physicians' family-of-origin experiences can be a threat to the neutrality of their doctor-patient relationships. Such a threat exists because physicians, out of their own family-of-origin experiences, can fuse with the patient's system rather than act

as agents of change. This fusion results in therapeutic ineffectiveness because interactions take place that are not designed to be therapeutic but that result in the maintenance of the patient's family system. Such unconscious interactions should be amenable to change through use of the "Balint" group or specific family-of-origin therapy, with resultant improvement in the physician's neutrality and level of effectiveness.

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