FAMILY NURSING

THEORY AND ASSESSMENT

MARILYN M. FRIEDMAN

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Preface

Within the last ten to fifteen years there have been numerous texts and articles written for nurses and other health professionals about family health care. In reviewing these writings one can readily see that there is no consensus of what family health care, family nursing, family-centered nursing, or family-centered community nursing mean or involve.*

Since my initiation into community health nursing and later into teaching, I have been struck by the contrast between what has been promulgated in nursing literature (in particular community health nursing) and by the American Nurses Association (ANA) and National League for Nursing (NLN), and what actually exists in practice. The family-centered approach is a stated ideal rather than prevailing practice—not only in the primary care settings, but also in the community health settings, where for years community health nurses have been proselytizing the concept that the "family is the patient and focus of our services."

To discharge a stroke patient with thorough instructions on how to transfer from wheelchair to toilet, and then find that the wheelchair does not fit through the small doorway at home is an illustration of the common problems we run into when family and home are not considered. Furthermore, the return into the family network of a family member who has been removed due to illness changes the person's participation in the family and frequently requires serious professional help. Mauksch states:

> It does not matter whether those issues ought to be the concern of the physician, the nurse, the social worker, or any other member in the galaxy of health functionaries. What does matter is that the family as a target of health care and as a conceptual autonomous unit requires professional perspectives which go far beyond the commonly observed approaches to problems and complaints.[1]

Unfortunately, our practice and specialty areas in community health nursing health care delivery patterns belie this approach. Maternal-child health, occupational health, school health, and geriatrics all show the emphasis to be on the individual rather than the family unit. Our health care delivery patterns, particularly the convenient working hours, also make it impossible to provide services to families. As early as 1955 Johnson and Hardin showed that patients, not families, were the primary targets of a community health nurse's service.[2]

My ardent belief is that health professionals who work with families, regardless of the setting, for the purpose of providing effective service must broaden

* These terms seem to be used interchangeably in nursing and health literature, with one possible exception—family health care is seen in some texts as a broader term denoting care delivered by more than one health profession.

their commitment so that they serve families as units, as well as individual family members. One of the primary obstacles to providing family health care is a lack of substantive knowledge. Vast amounts of literature are available on the family—in the fields of sociology (family sociology), social psychology, anthropology (cross-cultural family studies), psychiatry, social work, and nursing. But how much and what really do we teach in nursing that actually enables a nurse to work with families, such as knowledge and skill in taking family health assessments, making family diagnoses, and planning and implementing family care plans? I would suggest that very few nursing schools include adequate family theory to provide the necessary foundation for family-centered practice in their curriculum. In all the health professions, such as nursing, medicine, and social work, there is an enormous concentration of curricular focus on the individual client or patient, with little focus on the family system. No one would negate the importance of studying the client comprehensively, but because the family is greater and different from the sum of its parts, both the familial and individual level of assessment and intervention must be the focus when working with families. Sweeney expresses a similar conviction:

> The difference between philosophy and practice in public health nursing will be reconciled only when the public health nurse internalizes family concepts in relation to the needs of individuals and the needs of the family as a whole.[3]

Not only is there a paucity of knowledge provided in nursing and other health curricula, but in nursing literature there also is a serious lack of systematic, comprehensive family assessment tools. Several community health texts have included a family data collection instrument as part of their book (notably Tinkham and Voorhies, Freeman, and Leahy et al.[4–6]) but there have been little related theory or in-depth descriptions of the family structural and functional dimensions.

A comprehensive family assessment tool, based upon a structural-functional theoretical framework, is presented in Part II, which elaborates upon each facet of the tool from both a theoretical and applied perspective. Although several chapters are devoted to other major theoretical frameworks used for family analysis, the structural-functional approach has been selected because of my belief that this approach provides an umbrella framework, sufficient to cover the many relevant concepts and areas needed for assessment. The family assessment tool becomes the basis for the selection of family content and the organizing framework for the book. The family assessment process and much of the family theory presented in this textbook represent the product of my teaching in community health nursing for 13 years. I started with a very rudimentary tool. Gradually, as the result of insights gained from usage and student and faculty feedback, the family health assessment tool grew into a series of self-learning modules incorporating much of the content within this book. The learning objectives and study questions have been retained from these original modules to assist students with their learning. The study questions (evaluation) at the end of the chapter test the objectives, and upon successful completion of the study questions (all correct) the learner will have mastered the chapter objectives.

The assessment process presented in the following chapters has proved to be a valuable teaching-learning tool in the several schools that use it. One obvious limitation to its usage in its pure form is that it is quite detailed and elaborate, precluding use in every day practice. I believe, however, that a detailed approach is initially necessary to learn family nursing meaningfully. Once the content and skills are grasped, a more practical, attenuated assessment process may be initiated.

I have heard students say that all this information about families is just common sense. It is true that studying the family in one's own society is different from studying many other subjects like mathematics, science, or history due to our personal familiarity with families. This familiarity and expertise in family relations can be both a help and a hindrance: a help because we have some understanding of what goes on in families, how important they are, and some reference from which to tie theory; a hindrance because our own experiences with family life are constricted and biased. Our very familiarity may stand in our way of attempting to step back and assess families objectively and from a broader perspective.

Another observation I have made is that most of us have the natural tendency to assume that the way one's own family does things is, if not the only way, certainly the best way (a brand of ethnocentrism). This, of course, constricts and biases our observations and assessments.

Reiss believes that the study of family theory and research should help students increase their understanding of human interaction since "the reality of human social interaction is a complex phenomenon, and simple truisms and common sense will not be sufficient to understand it."[7] Robischon and Smith[8] strongly emphasize the need for nurses to become skilled in family assessment as a requisite for family nursing. With the increasing emphasis in nursing on the nursing process and with assessment being the foundation for practice, I believe that

family health assessment will grow in importance as has the recent interest in nursing assessment of individuals. This is not to suggest that assessment alone provides sufficient knowledge and skill for family health care. Education in family nursing must include discussion of and practice in the other components of the nursing process—diagnosis, planning, intervention, and evaluation.

This book is subdivided into three broad areas. Part I includes four introductory chapters that discuss the family's importance and family definitions; family nursing goals and roles; nursing process; and the basic approaches used in family analysis. The chapter on family-centered roles covers the new thrust of health care—health promotion, wellness training, and prevention of illness and dysfunction. As I am sure most of you are aware, this positive approach to health care is not new. Community health and nursing have been advocating its primacy for a number of years. But because of the present recognition that life style and the environment are the major determinants of disease and illness, and because of the rising costs of crisis-oriented medical care, health promotion and preventive modalities are receiving renewed enthusiasm from both health providers and consumers (albeit limited primarily to the middle and upper classes).

Part II introduces the reader to the actual family assessment model (tool), which forms the core of this text. A modified structural-functional approach has been used as the tool's guiding theoretical framework. I have integrated pertinent theory and content within each of the assessment chapters. The four large areas of assessment are: identifying data, environmental data, family structure, and family functions. Family structural dimensions are crucial to family assessment since they cover family dynamics consisting of power structure, role structure, communication patterns, and value system. The affective function, socialization function, health care function, and family coping function are four essential family functions discussed under family functions. Chapter 17 explains cultural differences and contains family descriptions of the two largest ethnic groups in the United States, the black and Chicano cultures.

The appendixes contain the complete family assessment tool, a family case, and an analysis of the family to give students an opportunity to retest themselves on all the significant areas of family assessment by applying their knowledge to a hypothetical family situation.

Throughout the book I have used the word client rather than patient because of its broader meaning and applicability. Client covers all recipients of our services—individuals, family groups, and even communities, regardless of the recipient's health status.

I wish to extend my thanks to Chris Barnett and Krista Barrett, who diligently typed the manuscript, my family, who encouraged this endeavor and tolerated all the inconveniences associated with having a partially absent mother, and Leslie Boyer, Nursing Editor at Appleton-Century-Crofts who provided not only support but also superb guidance and direction throughout the book's writing.

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I

INTRODUCTORY CONCEPTS AND APPROACHES

1

Introduction to the Family

LEARNING OBJECTIVES

1. Describe the basic purposes the family serves for society, the individual family member, and the health care provider.
2. Define:
   - **a.** family
   - **b.** nuclear (conjugal) family
   - **c.** extended family
   - **d.** family of orientation or origin
3. Describe how family and society mutually affect each other.
4. Give examples of how the family influences the health status of its members and how the family is influenced by illness or injury of one or more of its members.
5. Define variant family forms and give examples of several types of traditional and nontraditional (experimental) family forms.
6. Identify several stressors commonly found in single-parent families.

INTRODUCTION

One of the most important aspects of pediatric, maternity, community health, and mental health nursing is the emphasis placed on the family unit. Empirically we realize that the quality of family life is closely related to the health of family members. Nevertheless, remarkably little attention has been paid to the family as an object of systematic study in nursing curricula. Apart from simple evaluative labeling of families with terms such as "good," "problem," "multiproblem," or "disorganized," nurses are generally unable to describe objectively the families they see. Furthermore, too little research has been devoted to examining the relationships between the family—its structure and functions—and the health and development of its individual members.

This chapter will attempt to set the stage for a systematic study of the family by describing basic purposes of the family, basic family definitions, how the society and family mutually influence each other, and, most importantly, the salient interrelationship between the health status of family and the health status of its individual members.

Because the family forms the basic unit of our society, it is the social institution which has the most marked effect on its members. This basic unit so strongly influences the development of an individual that it may determine the success or failure of that person's life.

The family serves as the critical intervening variable (or as some authors term it, "buffer" or "bargaining agent") between society and the individual. In other words, the basic purpose of the family is *mediation*—taking the basic societal expectations and obligations and molding and modifying them to some extent to fit the needs and interests of its individual family members. At the same time the family provides new "recruits" and prepares them for assuming roles in society.[1]

Each family member has basic physical, personal, and social needs. The family must serve to mediate the demands and wishes of all the individuals within the unit. A family is expected to be concerned with the needs and demands of parent(s) as well as children, making it a difficult task to assign priorities to diverse individual needs at any particular time. On the other hand, society expects each member to fulfill certain obligations and demands. The family has to mediate the needs and demands of the family member with those of society.

A number of groups have a mediating function, but the family is important in that it is *the* primary group for the individual. Each family member belongs to a number of groups, but usually only the family is concerned with the total individual and all facets of his or her life. The highest priority of the family is usually the welfare of its family members. Other groups such

as co-workers, church, school, and friends do not have this concern for the complete individual, but usually limit themselves to one facet of the individual's life; for example, cooperation and friendliness at work, sincerity and involvement in church affairs, or productivity and achievement in school. This is not to say that other groups cannot serve as, or even replace, the family. In communes, monasteries, custodial hospitals, kibbutzim, or various rooming situations, nonfamily primary groups may provide the critical mediating function. The main difference between these primary groups and the family is that the family still retains the replacement or reproduction responsibility. The other primary groups do not generate new members in order to guarantee the survival of the group.

To restate the family's role, the family unit occupies a position between the individual and society, and its functions are twofold: (1) to meet the needs of the individuals in it and (2) to meet the needs of the society of which it is a part. These functions, which are fundamental to human adaptation, cannot be fulfilled separately. They must be joined in the family.

For society, the family functions to fill a vital need through its procreation and socialization of new members. It forms a grouping of individuals that society treats as an entity; it creates a network of kinship systems that help stabilize a society, even in its industrialized state; and it provides status, incentives, and roles for its members within the larger social system.[2]

As mentioned above, the family also functions to meet the needs of its members. For the spouse or adult members it serves to stabilize their lives—meeting their affectional, socioeconomic, and sexual needs. For the children, the family provides physical and emotional needs care, and concomitantly directs their personality development. The family system is the main learning context for an individual's behavior, thoughts, and feelings. The family's mediating function also protects individuals from direct contact with society.

Parents are the primary "teachers," since parents interpret the world and society to children.* The environment—outside forces—is important mainly as it affects parents, since the parents are the ones who are translating to the children the major meanings these outside forces will have on the family.

The family has a crucial influence on the formation of an individual's identity and feelings of self-esteem. An individual is the repository of group (especially primary group or family) experience. His or her identity is both individual (intrapersonal experiences) and social (interpersonal experiences). A person's intrapsychic experiences are largely developed from his or her interpersonal experiences, e.g., as through the parent–child relationship. It has been repeatedly found that a meaningful conception of an individual's mental health status can be achieved only as we relate the functioning of the individual to the human relation patterns of that person's primary group or family.

*The interpretation parents give of the world and society is naturally based on their experiences and their "reality." If they have been discriminated against or lived in a crime-ridden community, they may see the world as being "dangerous," "hostile," a place to avoid, and thereby impart these perceptions to their children. If, on the other hand, the world has provided stability and security for them, this perspective will be transmitted to their children.

Why Work with the Family?

In the preface it was noted that family-centered practice has been promulgated by community health nursing for quite some time. Why has there been the emphasis on working with families? The family provides the critical resource for delivering efficacious health services to people. Tinkham and Voorhies refer to the family as being the community health nurse's "patient," with the major focus being family health needs and their resolution.[3]

The following are the most cogent reasons why the family unit needs to be focused on:

1. There is the belief that in a family unit, any dysfunction (illness, injury, separation) which affects one or more family members may, and frequently will, in some way affect other members and the unity as a whole. The family is a closely knit, interdependent network where the problems of an individual "seep in" and affect the other family members and the whole system. If a nurse assesses only the individual and not the family, she or he may be missing the gestalt needed to gain a holistic assessment. One of the important tenets of family therapy is that the symptoms of the identified patient (the family member with the overt behavioral problems or psychosomatic illness) are indices of family pathology.
2. There is such a strong interrelationship between family and the health status of its members that the role of the family is crucial during every facet of health care, from preventive strategies through the rehabilitative phase; thus assessing and rendering family health care is critical for assisting each family member to achieve an optimum level of wellness.
3. Through family health care that focuses on health promotion, "self-care," health education, and family counseling, significant inroads can be made to curtail risks which life style and environmental indiscretions create. The goal is to raise the level of wellness of the whole family,

which should then significantly raise the wellness level of each of its members.

4. Case finding is another good reason for providing family health care. Disease in one member may lead to discovery of disease or risk factors in others, as is common with many of the communicable and chronic diseases. The family-centered nurse works through the family to reach individuals.
5. One can achieve a clear perspective of the individual and his or her functioning only when the person's family is also assessed. This enables the nurse to view the individual in his or her primary social context.

THE FAMILY-SOCIETY INTERFACE

As the basic unit in society, the family shapes and is shaped by the external forces (community, large social systems) surrounding it. Most sociologists would agree that the influence of society on the family is greater than that of the family on society, although the family exerts an effect on the society also. In spite of the greater impact society exerts on the family, the family should not be considered a passive, reactionary agent in the process of social change. Through history the family has demonstrated its tremendous resiliency and adaptiveness, just as political, educational, and other societal institutions have shown their ability to change as need dictates. Moreover, the forces operating in society and in the family are continually intervening, interacting, and changing.

Tinkham and Voorhies point out that tacit sanction by society of the communal form of group living, for instance, has modified socialization patterns of the family. The adulation of youth by society has completely altered the function of the family relative to its role in assisting parents and grandparents.[4] Society, with its beliefs, values, and customs pervades every facet of family life such as the age at which children may go to work and the age at which they are legally given adult status. Society also sanctions illness definitions, sick role behaviors, and the appropriateness of treatments.

On the other hand, the family influences society, which in turn may alter societal norms. Tinkham and Voorhies again cite a case in point by explaining that when families socialize their children to settle disputes and conflicts by nonviolent means, the use of war as a means for handling disputes becomes a less acceptable strategy. Also the egalitarian roles which women have assumed in family life have made drastic changes in the way society now views women and their roles and capacities.[5]

The controversies over family planning services and, later, abortion laws exemplify the way in which the family exerts pressure on society to change. In order for parents to be liberated and maintain an acceptable living standard, families are urging society to make birth control services accessible.

The great forces of a modern industrial nation, with its emphasis on individual achievement and autonomy, have been effective in shaping family patterns in such a way that the atomistic nuclear family has emerged. Its organization is geared to the needs of a complex, urban, industrialized society. In contrast, the organization of the extended family consisting of parents, grandparents, children, aunts, uncles, and cousins is more tailored to a rural, agricultural society, which is rapidly disappearing in the United States. Goode summarizes this process in the following statement:

> Because of its emphasis on performance, such a system (industrialization) requires that a person be permitted to rise or fall, and to move about wherever the job market is best. A lesser emphasis on land ownership also increases the ease of mobility. The conjugal family is neo-local (each couple sets up its own household), and its kinship network is not strong, thus putting fewer barriers than other family systems in the way of class or geographic mobility. In these ways the conjugal family system "fits" the needs of industrialization.[6]

Without the extended family's great involvement, nuclear family relationships become more intensified and continuous. There is little cushioning of the negative impact which some family members have on others and few relatives available to participate in child rearing, i.e., babysitting or giving counsel and support to parents.

HEALTH STATUS OF FAMILY AND FAMILY MEMBERS

Health and illness behavior are learned, and the family is the primary source for health education. In one way or another, the family tends to be involved in the decision making and therapeutic process at every stage of a family member's health and illness, from the state of being well (when promotion of health and preventive strategies are taught) to diagnosis, treatment, and recuperation. The process of becoming a "patient" and receiving health services encompasses a series of decisions and events involving the interaction of a number of persons, including family, friends, and professional providers of care. Generally speaking, the role the family plays in the process varies over time depending on an individual's health, the type of health problem, i.e., whether it is acute, chronic, severe, etc., and the degree of familial concern and involvement. Six stages

of health/illness* will be presented to further illustrate the family's major involvement.

Prevention of Illness and Promotion of Health

The family can play a vital role in all forms of health promotion and prevention. Modern medical science has produced vaccines and suggested preventive behavioral measures such that many forms of illness can be avoided. Vaccines for poliomyelitis, measles, mumps, smallpox, and diphtheria are among the more common vaccines available to the public for preventive purposes. Smoking, lack of exercise, poor diet, high blood pressure, prolonged stress, and obesity have been well documented as factors influencing the occurrence of coronary heart disease and other major diseases, and preventive behaviors have been recommended to reduce their deleterious effects. Many other examples of recommended preventive practices could be cited, but these few suffice to make the point that many forms of health promotion and prevention exist. Whether a child gets a particular vaccine, whether a father is encouraged to get more exercise and eat less, or whether a mother receives proper prenatal care, all involve family decisions and participation to a great degree. *Public health begins in the family.* Wellness strategies usually require improvements in the life style of an entire family, and varying degrees of conflict may ensue because of the wider impact on the family. Moreover, an individual's body image and self-view—as either healthy and active or sickly and frail—are learned largely within the family context.

Symptom Experience Stage

The symptom experience stage begins when symptoms are (1) recognized, (2) interpreted as to their seriousness, possible cause, and importance or meaning, and (3) related to with varying degrees of concern.

The family serves as the basic point of reference for assessing health behavior and provides basic definitions of health and illness, thus influencing the individual's perceptions. In the American family, the mother is frequently the major determiner of the health behavior in the family. Litman reported in family studies he conducted that the mother acted as health decision maker 67.7 percent of the time, while the father acted in this capacity only 15.7 percent.[8]

Disease and socioeconomic status are interrelated. In general, there exists an inverse relationship between prevalence rates and socioeconomic status, resulting from the greater susceptibility of lower income groups to disease. This inverse relationship also reflects the fact that members of lower income groups are slower to respond to initial symptoms or may not recognize symptoms as signs of disease or as needing medical attention.[9] The family exposes its members to health hazards to a varying degree and provides the basic interpretations of symptoms.

Families not only influence recognition and interpretation of symptoms of illness, but they may be the *genesis* of illness among family members. Family social disorganization often has negative health consequences for family members. A variety of specific health problems have been found more frequently in "socially disorganized families," among them tuberculosis,[10] arthritis,[11] mental disorders,[12] hypertension,[13] coronary heart disease,[14] and stroke fatalities.[15] The classic Newcastle-upon-Tyne studies[16] showed the pervasive influence of family on health. When deprivation, deficiency of care, and dependence on community were all present within a family, there was a higher incidence of infections, enuresis, short stature of children at age three, convulsions, and strabismus. This study also showed a higher incidence of streptococcal infections and childhood accidents following an acute family crisis.

The Care-Seeking Stage

The care-seeking stage begins when the family decides that the ailing member is really sick and needs help. The ill person and family start to seek alleviation, information, advice, and professional validation from extended family, friends, neighbors, and other nonprofessionals (the lay referral structure). The decision as to whether a member's illness should be treated at home or medical clinic or hospital tends to be negotiated within the family. For example, Richardson, in a study of low-income, urban households, found that about one-half of those with illnesses reported consulting another family member concerning what they should do about the situation.[17] Knapp also found that the family was the most frequently mentioned source of information concerning home remedies and self-medication.[18]

Not only does the family provide the basic definitions of health, but family members may press the individual into this stage if they believe he is failing to react favorably. This process is extremely difficult for the family, particularly when a psychiatric disorder is the major problem, because it may mean that the family must label the person as mentally ill and isolate him and/or acknowledge their own feelings of guilt and shame. The problem is compounded when the affected person denies the disorder or blames the family.[19]

*The following six stages represent an adaptation of Suchman's five stages of illness and medical care.[7]

The Medical Contact Stage

This stage commences when contact is made with the health services. Studies have clearly shown that the family is again instrumental during this stage. The family (usually the mother-wife) will refer a family member to whatever type of service is felt appropriate. The family, serving in this capacity, is referred to as "the primary health referral agent."[20]

In the 1950s Koos noted that while families may consult a different physician in special circumstances, the family doctor remains the one to whom they turn for all the family's ordinary medical needs.[21] This pattern probably still exists among many inner-city, poor families due to the lack of availability of specialists. Most health data, however, show that emergency rooms are fast becoming the poor family's most common resource for initial medical care. Among working and middle-class families, there has been a growth in the number of families making use of group practice arrangements and medical clinics.[22]

The type of health care sought varies tremendously. The folk practitioner, the unorthodox "healer," the holistic health practitioner (using sometimes esoteric modalities such as hair analysis and iridology), the superspecialist (such as a neurosurgeon), the independent nurse practitioner, and the primary care physician should all be considered as possible sources of health care (thus broadening antiquated definitions of medical care).

We know that families with higher income, families with children present in the home, and families who have resided in the community for some time usually have a regular physician or source of health care and that the reverse is often true—families not possessing one or more of the above characteristics do not routinely make use of the same care source.[23]

How do families decide what clinic or health provider to contact? While such variables as acceptability, appropriateness, perceived adequacy of service, and seriousness of condition are important, the proximity to a primary care facility seems to be a prime determinant of whom families contact. In other words, the closer the facility, the greater the usage factor.[24]

The Dependent-Patient Role Stage

As the patient accepts care of health practitioners, he or she surrenders certain prerogatives and decisions, and is expected to assume the patient role, characterized by a dependence on the health professional's advice, the willingness to comply with medical advice, and a striving to recover. How this role is further defined and enacted at home will be individually determined within each family. Some families exclude the sick member from all responsibilities and "serve and assist" to the fullest extent. Other families expect little change in the ill member's behavior, hoping that he or she can carry on as usual; this way of handling is seen frequently when it is the mother who is sick. Litman explains the difficulty mothers often have when sick:

> In view of both her rather pervasive and pivotal role as an agent of cure and care within the family setting, the mother may find it not only extremely difficult to fulfill her obligations to all the members of the household when one or more is ill, but she may experience considerable difficulty in maintaining her normal role and responsibility when she herself is the one who is ill.[25]

Hence, mothers generally have a great deal of reluctance in accepting a patient role.

Thus the family unit plays a pivotal role in determining the sick member's patient role behaviors. The family is also instrumental in deciding where the treatment should be given—hospital, home, clinic, etc. Efforts to treat illness and promote good health may often conflict with family values and attitudinal patterns, making medical compliance problematic.

The Rehabilitation Stage

The presence of a serious, chronic illness in one family member usually has a profound impact on the family system, especially to its role structure and to the carrying out of family functions. The disruptive effect may, in turn, negatively affect the outcome of rehabilitation efforts. Can the patient reassume his or her prior (preillness) role responsibilities or is he or she able to establish a new, "workable" role in the family? The way in which this question is solved usually has to do with two factors: (1) the seriousness of the disability and (2) the "centrality" of the patient within the family unit.[26] When either the nature of the person's condition is serious (greatly disabling or progressively deteriorating) or the family member is a pivotal, crucial person to the family's functioning, the impact on family is much more pronounced.

Families play an important supportive role during the course of a client's convalescence or rehabilitation, and, in the absence of this support, the success of convalescence/rehabilitation decreases significantly.

In summarizing the six stages, Haggerty highlighted the ways in which families influence the health of their members as being (1) a cause or the source of illness, (2) a factor affecting the outcome of illness once present, (3) a locus for spread of illness from one family member to another, and (4) a determinant of who is brought to the doctor and when.[27]