The family physician has the opportunity to aid families in attaining maximal health for their children. The developmental dynamics of children allows the physician to utilize his full armamentarium in providing prevention, acute and chronic illness care, as well as the social and behavioral needs of the child and family. Health practices developed by young families have the potential to be carried through generations. In addition the commitment to their children’s health is frequently an avenue to improve the health of parents and even the extended family.

That family influences both the health and illness of children is an accepted fact. From genetics to the exposure to passive smoking to the negative influences of the disrupted families, physicians must take into consideration the family’s role in the development of health and illness, their ability to promote wellness or deal with the effects of acute or chronic disease. Children who are taught the sick role not only develop poor self image but not infrequently lose significant time from normal activities. Illness may delay their social, emotional, and educational development. Use of a genogram or another recording method which includes generational problems, data on medical and psychosocial risk factors, is an important aid to providing child health care. The opportunity for longitudinal impact as a family physician is no greater than involving the care of infants and children.

Core Problems and Issues

Longitudinal Child Health Care

Premarital exam

In the idealized family practice the expectations of a couple regarding child-bearing and rearing should be discussed. The concepts can be dealt with either at a premarital exam or at the time of future preventive health visits. Areas of congruence and noncongruence are identified and used as building blocks for the relationship and the decisions to begin the next stage in the family cycle. Religion, family of origin practices, attitudes, projected family size, time of parenting, genetic factors, environmental stresses, fears and so forth are best understood and managed prior the decision to rear children. With many couples delaying child-bearing until their late twenties, and early thirties, there is an assumption that they have communicated concerning these issues and that congruence has occurred. Indeed the change in lifestyle created by marriage and children may provide more stress and concerns than occurs with younger couples.

The influence on the fetus of occupational exposures, tobacco, alcohol, drugs, and various diseases such as gonorrhea, herpes simplex II, cytomegalovirus and chlamydia should be known to prospective parents. Contraceptive advice and assurance of protection against rubella are other issues that should be considered.

Prenatal Pediatric Visit

Preventive care of the developing fetus as well as preparation of the family for inclusion of a new member is carried out either along with the obstetrical care or as a separate visit or visits. It is important that attention to these needs not be masked by the bodily changes occurring to the mother.

The first trimester of pregnancy is a tenuous time for the fetus. A time when spontaneous abortion may occur. Organogenesis may be affected by exposures to substances such as...
drugs, radiation, and alcohol prior to the time that a woman is aware that she is pregnant. Attention to environmental and lifestyle exposures is important. Live virus vaccines are potentially hazardous to the fetus and since maternal antibodies are protective to infants during the first 4 months of life, it is important that women have current immunizations prior to becoming pregnant.³

Readings for parents, and birthing and childcare classes are available in most communities. Family physicians often participate in these classes and can therefore assure themselves of the quality of these offerings. The following list contains the issues that ideally should be discussed with both parents prior to delivery:

1. Lifestyle changes
2. Feeding (breast, bottle, introduction of solids, obesity)
3. Crying, sleeping, elimination, activity
4. Dress, home environment (temperature, crib or substitute, sleeping arrangements)
5. Stresses (job, extended family, other children)

Many of these issues can be reinforced following birth but parents are less likely to remember facts with the excitement of their new child. Since hospital stays have become significantly shorter, the prenatal period is the best time to provide this education.

With the development of more and more prenatal diagnostic techniques, the family physician may at times be called upon to assist families with accepting a child with abnormalities prior to the child's birth. Community resources when available can be of major assistance and each practitioner should be aware of local and statewide programs.

**Birth**

The family physician can facilitate the birthing process for the whole family. Occasionally he is called upon to resuscitate a compromised newborn. Recognition of high risk situations, an organized delivery room with familiar equipment, and defined procedures that can be frequently reviewed will promote improved outcomes. The attainment of an airway and pulmonary ventilation followed by adequate circulation are the immediate goals. Once these are established, detailed evaluation, treatment and transfer if needed can be considered. The family physician should be fully familiar with resuscitation procedures and maintain his skills either through continued use for review and practice if the clinical situation is infrequently encountered.⁴

Maternal and if possible paternal attachment should be fostered in the delivery or birthing room. Rooming in with visitation of family members aids in the transition to accept an addition to the family. The practice of allowing young children to be present at the birthing which became somewhat popular in the last decade has been criticized by those who have studied the effects on the viewing children. Careful evaluation of each individual case is needed before this practice is supported.

During hospitalization, which ranges from 6 to 72 hours for an uncomplicated delivery, attention should be paid to reinforcing the issues covered in the prenatal care. Parents should be aware that the range of normal crying is 60 to 360 minutes a day and that at least one-third of the crying has no discernible etiology. Sleep is also quite variable and encompasses the extremes of 10 short hours to 20 hours as a maximum. A child who cries 300 minutes a day and sleeps 10 hours is very different to care for than a child who sleeps 20 hours and cries only 60 minutes.

Parents should know that infants have periodic breathing and when listening to them in a quiet room, one hears fast rapid breaths followed by silent periods. This normal pattern can be quite disconcerting to the new parents the first night at home. Elimination is also a point of worry and the range of 4–6 stools daily to one stool every 3 days may be normal providing the stools are soft and the infant is receiving adequate nourishment.

Time spent providing this information is helpful in allaying parental anxiety and helping the early parent–child relationships. It also aids the family physician by reducing unneeded telephone calls and office visits.

**Discharge Examination**

The discharge examination should be carried out with both parents present. All aspects of the infant, skin, bodily features, activity and so forth should be pointed out to the parents. Fears based upon experience, fantasy, or stories told by friends and relatives should be uncovered. Observed parental attitudes toward the infant and each other often provides useful information for the future. Parents should be encouraged to write down questions, everything from visitors, to temperature of the house, to sibling reactions may be of concern. It is useful, when siblings are at home, that the father carry in the new baby and the mother who has been absent be able to attend to the older child or children.

Automobile safety is a must with most states requiring car seats for infants. Finally a discussion of possible illness symptoms in the first few weeks of life should take place. Care must be taken to impart the knowledge to enable parents to act in a timely fashion without raising undue fear. Many parents are unaware of the seriousness of illness in the first few weeks of life and may delay seeking medical attention.

In order that the physician be able to support early discharge from the hospital, parents should understand that the infant must reach thermal homeostasis and have a successful feeding. A schedule for follow up care in 24 to 72 hours either at home or in the office should be agreed upon and the cord blood should have been sampled for hypothyroid and phenylketonuria screening.⁵

**Well-Baby Examination**

An examination schedule that includes three to six examinations in the first year of life has been shown to be adequate depending upon the infant's wellness and parental needs. The minimum required is that needed for carrying out the initial immunization schedule but most child care physicians schedule 4 to 5 visits during the first 12 months.

The first office visit can be at 4 to 6 weeks although many physicians and parents find that a 2-week check to assess growth and answer parental questions is cost-efficient. This visit carried out in the home provides additional information. Many family physicians train the nurse to carry out this visit or may combine with the visiting nurses in their area. At the