Toward Clarification of Objectives for Family Practice and Family Medicine

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This paper analyzes the social boundaries derived from an adequate definition of family practice and family medicine and explores the social dynamics between them and other social institutions and disciplines. More precise objectives for family practice and family medicine are delineated using a model which specifies social targets, methods, and purposes of intervention. Implications for further research in family medicine are discussed as well as their future effect on family practice.

The term "family practice" is understood to define particular methods of health care intervention. The term "family medicine" is understood to define a growing body of theoretical knowledge: (a) underlying family practice, (b) structuring undergraduate and graduate curricula, and (c) providing a source of hypotheses for further research. This paper will explore the social boundaries of family practice and family medicine. Against this background, a model for intervention will be proposed consistent with the comprehensive responsibilities of this developing specialty.

The Social Boundaries of Family Practice and Family Medicine

Figure 1 illustrates the integrating function of family medicine and family practice in coordinating the knowledge of modern science and technology in delivering health care to persons caught in the dynamic life styles of modern society, whether in a rural or urban setting. Family practice and family medicine mediate within the medical subculture between the sources of immediate care available from either an Emergency Room or a primary physician and the highly selective attention available through the specialist or subspecialist. The family physician provides continuity of care. He recognizes the formative nature of the past and anticipates the novelty of the future; he is not merely a triage officer presiding over the episodic management of transient problems. The institution of family practice plays more than a purely medical role. It also provides prospective and preventive support to the family and community through consultation and referral to institutions of inspiration and growth, as well as institutions of rehabilitation and correction.

Beyond the traditional medical concern for general pathology and its implications for treating the individual, family medicine must consider epidemiology and its implications for the care of families in the context of the community – neighborhood, suburb, county, or state. Family medicine and family practice must also become competent in gleaning from anthropology the implications for health and disease intrinsic to the system of ideas, expressive symbols and value orientations of a culture and its subcultures. In turn, they must be able to draw from both anthropology and the sciences of sociology and psychology if they intend to intervene therapeutically in the role interaction of family members while continuing to respect each individual's unique needs.

Family medicine owes its genesis more to a humanistic and professional response of physicians to the societal dis-ease in the twentieth century than to the growth of medical technology and professional role proliferation within the medical subculture. Certainly other factors have also substantially contributed to the rise of family practice and family medicine: (a) the isolation of medical education in mainly teriary care centers, (b) inequitable demographic distribution of doctors, (c) unfavorable specialist-generalist ratios (four to one in the United States), (d) lower indices of health with higher doctor-population ratios than in other countries, and (e) economic factors (in 1972 the average American family of four spent $1,600 on medical care).[1] Family medicine and family practice are caught between the explosion of knowledge in the larger scientific community and the accelerating mobility of individuals and families within an increasingly diverse, atomistic culture.[2,3] Family medicine is seeking humane treatment protocols for the physical as well as the emotional consequences of humanity's attempt to cope with situations as diverse as "future shock" among the affluent or simple survival in a culture of poverty. How, then, are family medicine and family practice to intervene in the process of twentieth century civilizations?

A Method of Intervention

Figure 1 illustrates the social terri-

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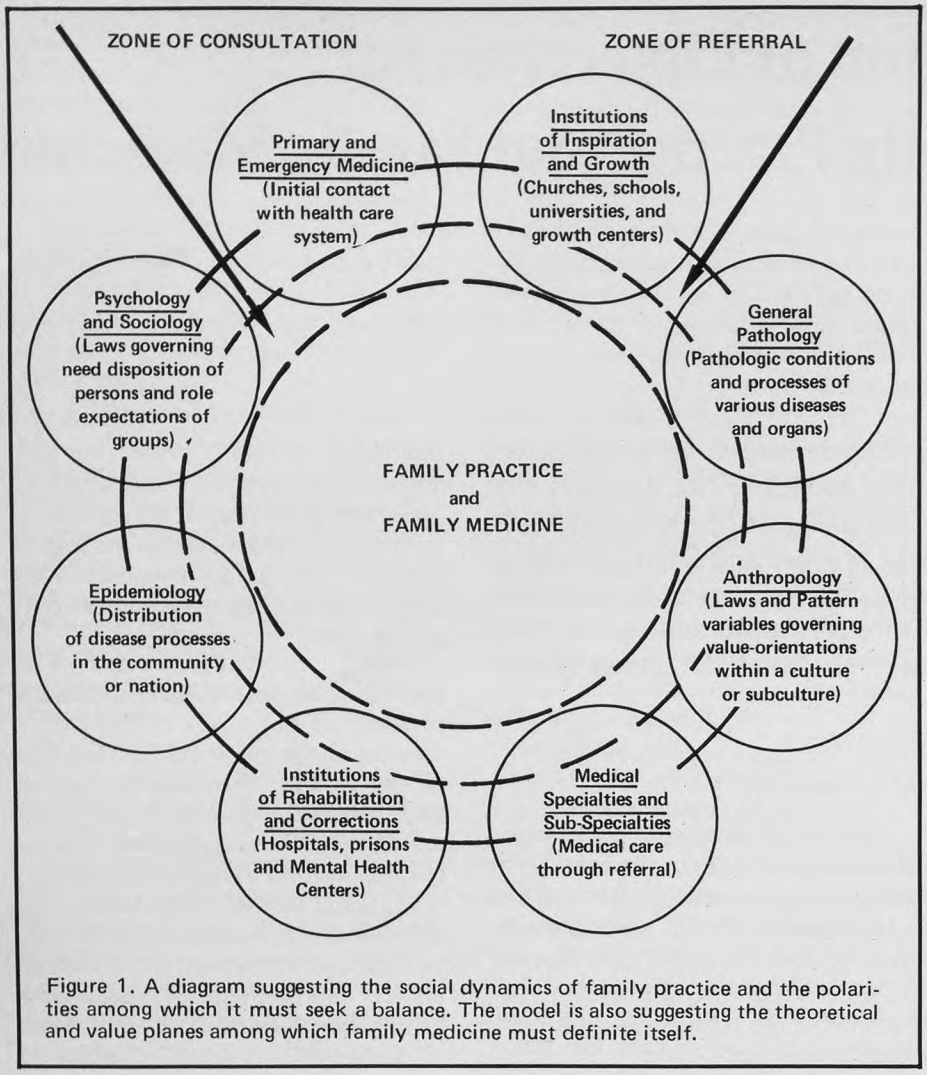

Figure 1. A diagram suggesting the social dynamics of family practice and the polarities among which it must seek a balance. The model is also suggesting the theoretical and value planes among which family medicine must definite itself.

tory surrounding the institution of family practice and the discipline of family medicine; however, it does not detail the center. The target of family practice and family medicine remains an open space more limited by its interfaces with other institutions and disciplines than by the realization of clearly defined objectives for practice and research. Figure 2 details the *targets, methods,* and *purposes* of family practice and family medicine.[4]

This model of intervention, composed of 36 individual cells, is first to be understood in the light of specifying precisely for either family physician or family medicine researcher the objective he or she is pursuing in service or in research. For example, *direct service* provided to the *primary group* for *remediation* would not initially be evaluated for its effectiveness in promoting *development.* However, interaction factors should not be excluded in conceptualizing this model. For example, what change in *direct service* provided to *individuals* for *remediation* is noted as a result of providing *consultation* and training to *secondary groups* for the purpose of facilitating healthy growth and *development*? Likewise, it should be noted that *targets, methods,* or *purposes* of intervention are not necessarily mutually exclusive. For example, a *media* intervention of audio cassettes on noncoital methods for pursuing sexual *development,* directed to a *primary group* may at the same time alleviate *individual* requests for *direct service* in treating occasional sexual dysfunction, ie *remediation.*

The model in Figure 2 implies that the *individual* can no longer be seen as the only significant object of attention for the family physician or the health care team. Equally deserving of attention are the *primary groups,* particularly the family. However, roommates, close friends, or intimate associates are also included. The *primary group* is an intimate, continuing, personal association on a face-to-face basis determined by degree of intimacy rather than proximity or complementary role status.[4,5] Intervention at this level, or at other levels, may include any number of physical, psychological, social, or cultural factors involving disease and health; they cannot be elaborated in this article.

The *secondary group* consists of relationships of choice or chance including classes, clubs, professional groups, collectives, or the health care team itself. Such a group may share similar needs, interests, objectives, or values. Secondary groups, like primary groups, involve face-to-face interactions, while *institutions* or *communities* do not necessarily involve any such interaction. A school, university, hospital, religious denomination, union, corporation, and the state or federal government are all examples of institutions. One can readily imagine the significance to health, disease, and growth resulting from behavioral patterns imposed by these and other institutions. It is the purpose of family medicine, partially in conjunction with family practice, to move beyond imagination through research; however, it is not bound in its research goals by the limits of family practice *per se.* Family medicine must verify precisely the consequences for disease, health, and growth embodied in the institutional behavioral patterns (values) affecting particular groups.

Remediation is usually necessary in the case of pain or failure, when a significant discrepancy has developed between the "organism" and its environment. "Organism" may be understood here as the biological, biochemical, or psychological system of the individual, or the sociological, sociocultural system of the primary group, the secondary group, or the institution. Remediation, in its most general sense, may call for medication, hospitalization, learning, training, or political reform. At all four target levels, values and priorities may have to shift, roles alter, and personal identities change. To bring about such changes, a variety of talents and personnel may be required; their coordinated efforts at every level are necessary.

Prevention may be little more than extrapolation from the data gathered

in remediation, while *development* implies the "farther reaches of human nature." Prevention as a purpose for intervention may follow a stress or life events model used to anticipate potential problems when certain limits are exceeded.[6] Also, an awareness of normal growth and development patterns in persons, groups, and cultures could alert the health care team to problems requiring support and suggest areas of further research for family medicine. *Development* relies on the sensitivity, imagination, and humanistic concern of individuals and various professional agencies in responding to the needs of individuals and groups. Hopefully, as in the case of the Medical Care Research Unit at Harvard, 1964, which evaluated the impact of the Family Health Care Program of Harvard Medical School, family medicine will be responsive in its study of the innovations made in the area of family practice.

The *direct service* of the family physician has been improved by his further training in behavioral sciences and work with allied health personnel in the residency program. Time spent in *consultation and training* improves service to the public and coordinates more effectively the health care team in the management of any single problem. As family practice and family medicine move into the *media* through television and radio, the possibility increases that every target level will be positively affected. Significant research (seven million dollars) and consultation with over 300 professionals went into a new television series on health. The series, which began last October, ran for 11 one-hour weekly presentations on 250 stations of the Public Broadcasting Service. This was the first television series to employ an independent agency to assess the changes in health care practice during and following the presentation of the series.* It is essential that family practice and family medicine move to use the media responsibly in providing health care and uncovering the consequences of such intervention. Such public activity is much more than a positive political gesture; it has become an ethically responsible, professional deed that has measurable consequences on the health of individuals, families, and communities.

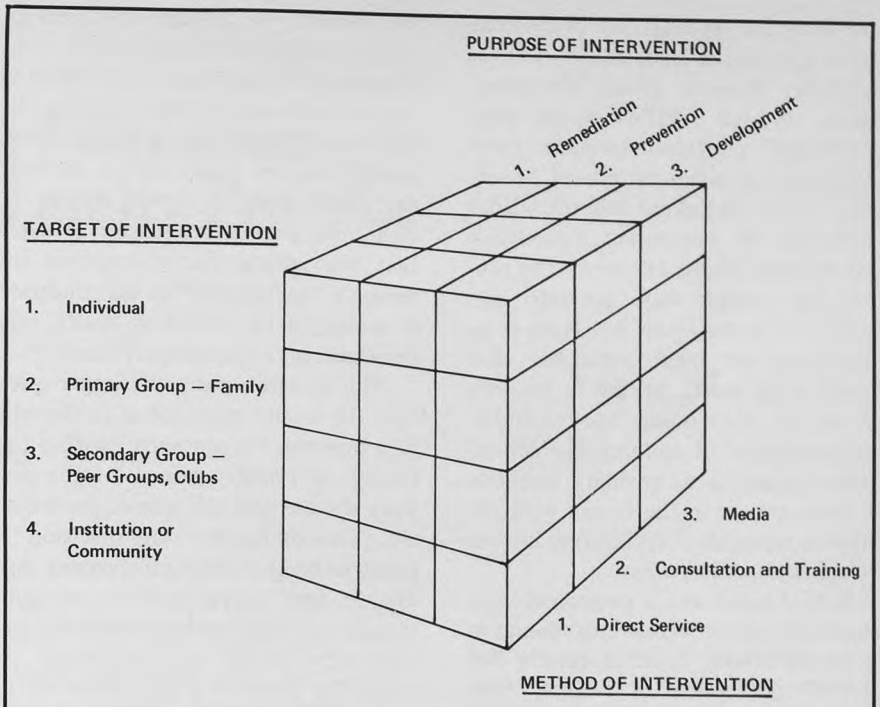

Figure 2. A model directing family practice in specifying targets, purposes, and methods of intervention, and directing family medicine in areas of research. Revised from figure by Morrill, Oetting, and Hurst. Copyright © 1972.

Discussion

The social institutions and disciplines among which family practice and family medicine must develop have been reviewed. A method of analyzing the social process of medical interventions has been suggested. The impetus for such research in family medicine lies in the fact that no other institution is so directly involved in observing and recording through time the consequences to medical and mental health resulting from its own intervention and the press of society at large. The *individual* (patient) is no longer to be viewed exclusively as an isolated biological entity whose physiological pathology must be arrested. Rather, as Schwab, McGinnis, and Warheit have suggested, a more extensive definition of "impairment" is necessary.[7]

In fact, the global rating for social psychiatric impairment encompasses four dimensions: 1) symptomatology; 2) capacity to function, that is, the ability to carry out the expected social roles and performance consistent with one's age and sex; 3) the quality of interpersonal relationships; and 4) an aspiration-satisfaction index.[8]

In its most simple form the medical-social psychiatric impairment factors, "problems," can be studied profitably with reference to the independent variables: sex, socioeconomic status (particularly family income), migration patterns, marital status, age, race, etc.[9] Thus, family medicine through research must begin to account for the medical-social psychiatric impairment of the *individual* as well as noting identifiable patterns of symptoms or disease within the family.[10] The family physician may note some of these same "problems" in the *individual's* POMR. For example, an office audit, facilitated with a computer terminal, may reveal larger amounts of stress symptomatology or higher demands for service, ie, calls and visits, among families with particular *secondary group* and *institutional* affiliations. Consequently, in the future, the method of intervention may be augmented by *consultation and training* with the new purpose of *prevention* as opposed to *remediation.*[11]

Another example of a potentially meaningful research project with direct implications for practice would re-

*For more information on this "Sesame Street for Adults" write: Eliot Tozer, Assistant Project Director, Public Affairs, Health Series (Box A) Childrens' Television Workshop, Lincoln Plaza, New York, NY 10023.

sult from the investigation of medical-social psychiatric impairment vis a vis particular *primary group* structures. Again, through a POMR audit, what "problems" are found to occur more frequently or what pattern of "problems" occurs in patient subpopulations identified by one-parent households and children under 18 years? The professional reader may generate any number of hypotheses, involving combinations of these variables, that would seem worth testing in his own setting. He is encouraged to remember the possibility of *training and consultation* or *media* as ancillary methods of intervention in the future with the purpose in mind of facilitating human growth and *development*.

Several years ago, a surgeon specializing in detached retina repair found in reviewing several hundred cases a 400 percent difference in healing time from the most to least rapid recovery. The normal range of variance in similar biological processes is 18 to 20 percent. Together with other health care personnel, 116 cases were analyzed for physiological factors that might correlate with the speed of healing: age, sex, severity of damage, type and extent of surgery, type and degree of anesthesia, body chemistry, and the presence or absence of other diseases. No significant physiological factors were found. Further study which involved over 500 cases reviewed during an eight-year period eventually revealed that the critical factor involved the person's "acceptance" of his condition as measured by attending health care personnel on a ten-category scale.[12]

This research poses the larger question for family medicine as to the relation between "acceptance" within the family, or *primary group*, of the person's disease and the rate of his recovery. Concomitantly, the question is raised as to the effect on recovery rate due to the "acceptance" or recognition of the diagnosed condition by the *secondary group* or *community* of which the person is a part. What methods of intervention are most effective in modifying the person's, family's, or community's acceptance of a morbid condition? These and a host of related questions await the discipline of family medicine, and challenge the practicing physician.

References

1. Janeway CA: Family medicine – fad or for real? N Engl J Med 291:337-343, 1974

2. Bonfenbrenner U: The origins of alienation. Sci Am 231(2):53-61, 1974

3. Ryder NB: The family in developed countries. Sci Am 231(3):123-132, 1974

4. Morrill WH, Oetting ER, Hurst JC: Dimensions of counselor functioning. The Personnel and Guidance Journal 52:354-359, 1974

5. Cooley CH: Social Organization. Glencoe, Illinois, The Free Press, 1956, pp 22-31

6. Schuman SH, et al: Time-flow analysis, life events, and computer-based records at MUSC, Charleston, SC. Paper presented at the Sixth World Conference on General Practice-Family Medicine, Mexico City, November 6, 1974

7. Schwab JJ, McGinnis NH, Warheit GJ: Toward a social psychiatric definition of impairment. Br J Soc Psychiatr Community Health 4:51-60, 1970

8. Schwab JJ, Warheit GJ: Evaluating southern mental health needs and services, a preliminary report. J Florida Med Assoc 59(1):17-20, 1972

9. McGinnis NH, Schwab JJ, Warheit GJ: Prediction of social psychiatric impairment in a community sample by sociodemographic characteristics. Proceedings, 80th Annual Convention, American Psychological Association, 1972, pp 353-354

10. Cobb S, et al: The intrafamilial transmission of rheumatoid arthritis: An unusual study. J Chron Dis 22:193-296, 1969

11. Kasl SV, Gore S, Cobb S: The experience of losing a job: Reported changes in health, symptoms, and, illness behavior. Psychosom Med 37, in press, 1975

12. Reeves RB: Healing and salvation: Some research and its implications. Union Seminary Quarterly Review 24:187-197, 1969