Letters to the Editor

Concepts of Family Practice

To the Editor:

Some ten years ago, I wrote a paper which I titled "Some New Basic Concepts for the Family Physician."[1] In this, I tried to express three concepts which I had developed over years of practice and which I found helpful in defining my role and responsibilities as a family physician.

The first concept was that of the "Triple Diagnosis" or "Diagnosis on Three Levels." I suggested that the physician is usually faced with several concurrent potential diagnoses (currently we would call these "problems") with each patient who comes to him. These include an individual personality evaluation which is unique to the patient, one or more chronic or recurring illnesses (which increase with age), and some acute symptom which brings the patient in at that particular time. It seemed to me quite important for the family physician to look for and deal with each of these problems at the same time as a part of comprehensive and satisfactory care of the patient.

My second basic concept was labeled the "Continuously Tentative and Evolving Diagnosis." I felt that every patient and his medical problems change with the passage of time, so the physician's evaluation and management should also change. This concept stimulated me to continually review and refine the impressions I had about my patients, and prevented me from falling into the trap of explaining new symptoms as part of pre-existing problems. It also meant I did not have to make an immediate "final diagnosis," but could take several visits to develop a complete evaluation and understanding of a patient.

The third concept developed from a gradual realization that physicians rarely cure either patients or problems. Much of the recovery process is really within the patient, and chronic illnesses are never cured. It seemed more realistic to think of the physician as a restorer of the "Equilibrium of the Patient's Health." A patient comes to the physician when something happens to prevent satisfactory functioning in his life situation. I suspect the objective is to get help in returning to his usual state of economic and social function, rather than to receive a magical "cure." The role of the physician is to evaluate the factors which have disturbed this equilibrium in life and to give advice and treatment to modify those factors. The physician's satisfaction is in helping to re-establish this equilibrium.

Shortly after my article was published, in some personal correspondence with Dr. Kerr White, he suggested a similar multilevel diagnosis and added a fourth level of "socio-economic diagnosis" as essential to the comprehensive evaluation and treatment of every family.

Over the years, I have continually tested these concepts in my medical practice and found them helpful and satisfactory. It has been of interest to me to periodically come across other expressions of similar concepts which have convinced me that my own ideas were not as unique as I had initially thought. At a recent conference on the "Academic Mission of Family Medicine," held at the Fogarty International Center, Dr. Scott Swisher of Michigan State College of Human Medicine presented a paper in which he stated, "Illness is infrequently encountered as a single diagnosis. Multiple disorders of several systems are common, particularly in an aging population." In a recent paper, Dr. John Burnum stated, "More often than diagnosis and dismissal, treatment consists of the readjustment of an equilibrium between the patient, his illness, his world, and the physician."[2]

The knowledge that other physicians work with concepts similar to

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my own is both humbling and reassuring. I am looking forward to future personal acquaintance with and sharing of ideas and experience with these particular individuals, and with others who have developed similar ideas independently.

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1. Burdette JA: Some new basic concepts for the family physician. Journal of the Tennessee Academy of General Practice, 1965, pp 21-24
2. Burnum JF: Primary care within the academic tradition. JAMA 233:974-975, 1975

Treatment of Peptic Ulcer

To the Editor:

"Self-Assessment in Family Practice" (*J Fam Pract 2:391-392, 1975*) discusses the diagnosis and treatment of peptic ulcer. I am in total agreement with the diagnostic steps. I cannot say the same for the therapeutic measures.

Having treated peptic ulcer patients for 30 years before retiring from private practice, I do know something about this disorder. Further, having taught medical students from 1952 to 1974 in one way or another, I have had to keep my knowledge contemporary. This article defies the current reference texts.

Anticholinergics *are* indicated in the treatment of peptic ulcer. This is not only my firm conviction but witness: *Textbook of Medicine,*[1] *Current Therapy,*[2] and *The Merck Manual.*[3]

Restricted diet *is* important, contrary to your "authority." No conscientious physician would permit an ulcer patient to drink booze, eat Mexican food, or munch raw carrots. Again, see the current reference texts.

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1. Beeson PB, McDermott W (eds): Textbook of Medicine, ed 14. Philadelphia, WB Saunders, 1975
2. Conn HF (ed): Current Therapy. Philadelphia, WB Saunders, 1975
3. The Merck Manual of Diagnosis and Therapy, ed 12. Rahway, New Jersey, Merck, 1972

Management of Enuresis

To the Editor:

In your recent article on enuresis, (*Bindelglas PM: The enuretic child. J Fam Pract 2:375-380, 1975*), the most useful treatment was left out. Dr. Franz Bauman, a pediatrician in San Francisco, has devised and used a method in treating enuresis which has worked in my practice very satisfactorily. The treatment comes out of Dr. Bauman's training in medical hypnosis, but would possibly fall into the category of behavior modification, or, very simply, teaching a child to wake up. The treatment program is in two simple steps as follows:

1. At bedtime, when the child is particularly suggestive, the mother or father suggests to the child "you can get up and walk to the bathroom if necessary."
2. After he is asleep, practice waking the child and having him walk to the bathroom, preferably without touching him. Be sure that he wakes up completely. Repeat the above suggestion as the child goes back to sleep.

I found in my practice that the most common thing in a child who is two to ten years old with enuresis is that the child just won't wake up. In having the child and parent check back in two or three weeks and following up, the parent is encouraged that this is the basic problem, that the child does not wake up, and to continue. I very rarely had to give any medical treatment in addition to the above. I have had one child who has had to use the alarm system because the habit pattern was not changed enough with the suggestion treatment above.

I object very strongly to the idea of giving medications unless this is really indicated, not only to children but to adults as well. The treatment of enuresis I think in the long run will be like the treatment of obesity. It is going to be up to the patient to develop different ways and better ways of handling the problem.

I would appreciate experiences from other family practitioners with regard to this problem, and challenge any of them that want a very simple method that has worked in my practice to try and evaluate the above.

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