Letters to the Editor

The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Evaluation of Family Care

To the Editor:

Dr. Stamps proposes a Family Utilization Index as a tool for evaluating the provision of family oriented health care in a family practice (*Toward the evaluation of family practice: Development of a family utilization index. J Fam Pract 7:767, 1978*). I question the validity of testing the Index on a population of patients that is predominantly composed of lower class urban blacks. A recent anthropological study indicates that black families undergo profound structural and functional changes as a means of adapting to and coping with exigencies of poverty.[1] A major component of the adaptation entails a diffusion of responsibility and tasks among an extensive kinship network with a concomitant reduction in the importance and efficacy of the nuclear family. The various categories listed in Table 1 of the article that contribute to the second component of the Index seem to be strongly oriented toward a model of a nuclear family composed of parents and children. How appropriate is such a conceptual model for the assessment of family units characterized by a high incidence of female heads and extensive kinship systems? Dr. Stamps does not address the crucial question of what constitutes a family among this population. If, in this study, the family is synonymous with the household then the Index contains no provision for the health seeking behavior of grandparents, aunts, uncles, cousins, and other potential household members.

Dr. Stamps reports the results of two cross-sectional studies of users of a family practice unit which are separated by a five-year interval. Comparison of the Family Utilization Indices computed for the two distinct samples suggests that the utilization behavior of families in the second sample is more concordant with the principles of family practice than that of the first sample. Dr. Stamps correctly points out that no antecedent-consequent association can be inferred from these findings since this was not a cohort study. However, this qualification is somewhat obscured by the statement in another part of the article that the study was "in-

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tended to identify whether patients were utilizing a family practice in a manner consistent with the theoretical framework noted by the model and then to note changes over time as the patients were exposed to the model.'' This statement implies a longitudinal design which, in fact, does not exist in this study. I disagree with the author's conclusion that differences in the demographic profiles of the two samples could not account for differences in the observed family utilization of health care services. As noted by the author, the 1975 sample contains a significantly higher proportion of families headed by a single adult female. The corollary to this is that the 1975 sample contained fewer families with both male and female heads. There is considerable evidence that adult males (particularly blacks) have lower rates of medical care utilization than adult females and children: thus the decreased number of adult males in the families sampled in 1975 has direct implications for the patterns of family utilization reflected by the Index. A family composed of both female and male heads and children in which the female head and all the children had been to the clinic would qualify for Category G and be assigned a weight of 60 percent. Deletion of the male head from the family with the same pattern of utilization by other family members would transfer the family to Category B with a weight of 100 percent. The demographic differences between the two samples as noted by the author indicate that a significant number of male heads were lost from family units during the five-year period. In summary, given the known utilization behavior of adult males as compared to females and children, the selective loss of adult males from the families would, in and of itself, result in higher family utilization indices.

The apparent differences in the utilization of family practice services between the two samples may also be explained by variables completely independent of the family practice clinic itself. For example, changes in the availability of alternative sources of health care could account for differences in patterns of utilization. According to the article there was no change in the proportion of users who reported concurrent utilization of other health care resources. However, in 1970 a primary care physician was the most common alternative source of health care, while in 1975 an immunization clinic was the most common alternative resource. Does this change reflect a decrease in the availability of other primary care physicians in the area? A reduction in financial barriers to health services could also account for the change in utilization behavior between the two samples. Did a higher proportion of the 1975 families have Medicaid as compared to the 1970 families?

This study raises some interesting research issues: however, the major question of whether or not contact with a family practice over a period of time occasions changes in patient attitudes and behavior in the direction of the conceptual framework of family medicine remains to be answered. In addition, as an instrument of evaluation, the Family Utilization Index remains to be tested on a population of families that is structurally concord-

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ant with the nuclear family model presumed by the Index.

Robert L. Blake, Jr, MD
Assistant Professor
Department of Family and Community Medicine
University of Missouri-Columbia
Columbia

Reference

1. Stack CB: All Our Kin: Strategies for Survival in a Black Community. New York, Harper and Row, 1974

The preceding letter was forwarded to Dr. Stamps who responds as follows:

Dr. Blake raises several interesting issues in his letter in response to my article on developing evaluation strategies for family practice (*Stamps PL: Toward the evaluation of family practice: Development of a family utilization index. J Fam Pract 7:767, 1978*). His major argument concerns the relevance of the proposed Family Utilization Index to a non-nuclear family structure. Table 1 and the discussion of the four components of the Index (pp 769-770) were intended to demonstrate that every effort was made to determine the composition and relevance of the extended family of every respondent. Perhaps it is the use of the term "head of household" that is inappropriate, as this usually connotates a father or a mother. Indeed, as discussed within the description of the first component, a great deal of time and effort was spent determining the relevant denominator. This denominator, of course, is the extended family. "Head of household" is intended to refer to whatever responsible adult lives in the household, regardless of identity, sex, or kinship. Category K (Table 1), which may contribute to a misunderstanding of terminology, was meant to imply those visits for only obstetrical reasons. The term "mother" is probably too narrow for this usage.

The arguments relevant to the impact of the change in marital status on the utilization patterns are well taken. Those persons who were left as single member households were excluded precisely to prevent this type of bias. It may be that those female-headed households may have been unfairly placed into category B (100 percent weighting) rather than into category G (60 percent weighting). This may be magnified by the relatively low utilization patterns of males, as noted by Dr. Blake. However, it is also true that there were more total visits to the clinic due to an overall increase in the number of family members per family unit using the clinic.

It is true that there are several limitations to this study. One is certainly the overall inability to control important environmental and external factors, including Medicaid support. These limitations are due to the inability to conduct a prospective study. However, these limitations of methodology as well as the limitations of the Index itself, are clearly pointed out in several places in the article.

In summary, I do not believe that the conclusions of this study are overstated: at no time is a

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causal relationship implied, nor is the utilization of the Index in its present form suggested. Rather, it is the purpose of this article to suggest that we begin the long and tedious process toward developing adequate measurement instruments that can be utilized to evaluate the impact of the model of family practice.

Paula L. Stamps, PhD
Associate Professor
Health Services Administration
University of Massachusetts
Amherst

Follow-up Studies in Thyroiditis

To the Editor:

The Journal of Family Practice Grand Rounds discussion of thyroiditis, in December 1978 (*Wherry RA, Purdy DD, Eilers GA: Thyroiditis: A case presentation and discussion. J Fam Pract 7:1221, 1978),* suggests that the I^{131} uptake is the test by which to follow the course of thyroiditis. It suggests that treatment continue until the I^{131} uptake returns to normal. Given the increasing concern of the long-term effects of thyroid irradiation, a more appropriate test may be the I^{123} uptake since I^{123} follows the normal iodine metabolic pathway and offers less radiation exposure. Comparison of the estimated dose of irradiation to the adult thyroid for I^{123} scans versus I^{131} scans is 2.8 rads vs 100 to 200 rads, respectively.[1] The I^{131} radiation dose exceeds the I^{123} dose by 33 to 66 times. If the radiation exposure difference of uptakes is similar to that of scans, then the I^{123} uptake is the preferred test as it does less harm.[1]

Timothy G. Reekie, MD
The Family Practice Program of
Chestnut Hill Hospital
Philadelphia, Pennsylvania

Reference

1. Irradiation-Related Thyroid Cancer. In Division of Cancer Control and Rehabilitation, National Cancer Institute (Bethesda, Md): DHEW publication No. (NIH) 77-1120. Government Printing Office, 1977, p 20

The Family in Family Medicine

To the Editor:

In response to a recent Journal article by Authier and Land (*Family: The unique component of family medicine. J Fam Pract 7:1066, 1978*) criticizing the paucity of emphasis on the "family" in family practice residency training, we would like to make a few observations. Looking at the lack of appropriate family orientation by residency staff or the impracticality of a family therapist viewpoint is placing the blame one step beyond the real problem which is the definition of family medicine. Until we know what family medicine is, what it means to treat a family as well as an individual, neither physicians with episodic training backgrounds nor family therapists will be able to teach it.

Efforts to define family medicine to this point have mainly emphasized what family physicians already do.[1,2] (Certainly what is de-

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fined here is primary care, and not family medicine.) Theoretical definitions, such as the officially sanctioned AAFP definition, use vague, global terminology: "continuing, comprehensive. . .care."[3] Neither of these definitions confronts the basic dilemma as mentioned above. That is, family physicians treat individual patients and *not* the family. It is true that they keep family records and often think about the influence of the family (as well as school, work, etc) on the problem at hand. But while family therapists literally treat the entire family, family physicians have yet to find family diseases. This whole area of research has yet to be adequately explored.[4]

Thus, until research finds family pathology which requires family physicians' intervention, we will continue to treat individuals, albeit as "whole persons." And, of course, we will, therefore, not be able to teach residents anything but this "whole person" medicine.

David Swee, MD
Karen Swee, MEd
Department of Family Medicine
College of Medicine and Dentistry
of New Jersey-Rutgers
Medical School
Piscataway, New Jersey

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1. Marsland DW, Wood M, Mayo F: A data bank for patient care, curriculum, and research in family practice: 526, 196 patient problems. J Fam Pract 3:25, 1976

2. Anderson JE, Lees REM: Patient morbidity and some patterns of family practice in southeastern Ontario. Can Med Assoc J 113:123, 1975

3. The official AAFP definition of family practice, Family Physician. AAFP Reporter 2(6):10, 1975

4. Weakland JM: Family somatics: A neglected edge. Fam Process 16:263, 1977

The preceding letter was referred to Dr. Authier and Ms. Land who respond as follows:

With reference to our paper, "Family: The Unique Component of Family Medicine" (*Authier J, Land T: J Fam Pract 7:1066, 1978*), Swee and Swee contend that the real problem is "the definition (or lack thereof) of family medicine." It appears to us that searching for a definition of family medicine is analagous to asking Webster for a definition of the term dictionary. Family medicine has been defined since its inception. As Carmichael has stated: "There is no better retort to those who ask the question, 'What is family medicine?' than to respond, 'Read Medalie'."[1] We would also respond, read Geyman, Curry, Bauman and Grace, Carmichael, Stephens, Rakel, and Burket.

Granted, as Swee and Swee indicate, some previous efforts to define family medicine have entailed looking at what family physicians already do. However, the aforementioned authorities agree this is inappropriate since to date too few "ideal" family physicians exist. That is, currently, few practicing family physicians clinically apply the theoretical and philosophical definition of family medicine which makes them different from other medical specialists, most notably the general practitioner, as few have received training in those parameters. The specialty of family medicine is a relatively new academic discipline. As such, it is in the process of developing its own clinical model, which realistically cannot be drawn totally from existing models.

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It appears that Swee and Swee are suggesting training without objectives and goals. We submit that the current definition of family medicine (which incidentally is rather generally agreed upon by the authors cited above) provides for such objectives and goals and that it is our educational charge to realize their attainment within family practice residency programs. Once objectives and goals have been achieved, research logically follows to determine if such training results in greater preventive medicine and better patient care. Indeed, as Geyman stated: "The development and continued evolution of the academic discipline of family medicine, including an active emphasis on research, is the major task of Phase Two. . ."[2] in the development of family medicine. Implied in such a statement is that Phase One is comprised of developing family medicine in terms of objectives and goals, which are necessary before progressing to family medicine as a more clearly defined academic discipline, part of which requires the establishment of a more solid research base.

Research demonstrating family pathology already exists (eg, the relationship of genetic predisposition to such medical problems as diabetes, hypertension, and heart disease). Other family problems have also been described and defined. As Schmidt reports: "There is a considerable volume of evidence that documents how important to the individual's health is his family. This material has been organized into four categories: (1) the family's contribution to the 'cause' of disease, (2) the family's contribution to the 'cure' of disease, (3) the family's response to serious or chronic disease, and (4) the family's desire and/or need for family oriented care."[3]

To reiterate such elementary points concerns us as it demonstrates that, for some, family medicine is still in the "premarital phase." Therefore, while some are still planning the wedding, current thinking suggests the wedding between family medicine and whole person medicine has already been consummated and a family begun, and we are ready to "foster" research to further stabilize the family system. Family medicine has made and continues to make tremendous progress. It is in a dynamic state of growth, developing its body of knowledge, practice skills, and research base, and placing a more systematic emphasis on the family. The time has come for those involved in the field to actively participate in the further development of family medicine and to generate research to ensure the discipline's continued survival.

Jerry Authier, PhD
Associate Professor/Clinical Psychologist
Trudy Land, ACSW
Instructor/Medical Social Worker
Section of Family Behavior
Departments of Family Practice and Psychiatry
University of Nebraska Medical Center
Omaha, Nebraska

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1. Carmichael LP: Introduction. In Medalie JH (ed): Family Medicine: Principles and Applications. Baltimore, Williams and Wilkins, 1978, p xvii
2. Geyman JP: On entry into phase two in family practice development. J Fam Pract 4:15, 1977
3. Schmidt DD: The family as the unit of medical care. J Fam Pract 7:303, 1978