The Family in Family Medicine Revisited, Again

Gabriel Smilkstein, MD
Davis, California

In this issue of *The Journal of Family Practice*, a well-written paper describes an instrument that evaluates the level of physician involvement (LPI) with patients and their families. Marvel and Schilling, in collaboration with Doherty and Baird, the seminal authors of a model of physician involvement with patients' family issues, report on the LPI of 10 faculty family physicians who were videotaped during 200 office visits.[1,2]

I agree with the authors that "This model may be a useful tool for education and research . . ." as it relates to the medical interview that examines family content. My concern is that in this study of residency-trained family medicine faculty, the videotape evaluators found a biomedical focus (ie, levels 1 and 2) in individual and family assessment in 76.5% of the 200 interviews. Physicians reached level 3 of the LPI 23% of the time. Although level 3 recognizes a physician's sensitivity to patient and family stresses, physicians in this category were not considered to have an approach that represented ". . . a systematic assessment of the patient's or family's context. . . ."

Although the study of Marvel et al[1] does not reveal the level of family training or interest of the videotaped physicians, empirical evidence suggests that the physicians in the study were probably representative of the family physicians of the United States. As family medicine faculty, however, they might have been even more psychosocially oriented than are most family physicians. Such information suggests to me that family medicine should be concerned about whether its graduates are capable of an organized approach to the psychosocial problems of patients in the context of family.

Have educators and practitioners of family medicine relegated the family to a display piece that is trotted out for ceremonies and holidays? This question must be asked, for it seems to me that family in family medicine is fast becoming an anachronism not unlike the royal family in the United Kingdom. Family has retained its noble position, because, as in most sovereignties, it had functional importance in the establishment of the parent organization.

There is more to family, however, than historical significance. Whether royal or plebeian, family has the power of rallying the emotional energy of believers. This is certainly evident in the United Kingdom, where even though some members of the royal family are much maligned, any recommendation to dissociate the royal family from the government results in a national outcry of "God save the Queen." This same kind of devotion to family exists among members of the various family medicine organizations in the United States.

Although it is true that the founding members of the American Academy of Family Physicians recognized the political and social benefits to be gained from the cosmetic surgery that replaced "general" with "family," both teachers and practitioners in the discipline had hoped for more.[3] In the early years of the growth and development of this discipline, family medicine's publications proclaimed the family as a worthy subject for study and integration into practice. The drive to focus on family, however, seems to be losing its momentum far short of realizing family medicine's educational and research agendas.

To validate this impression, a study was conducted to assess the presence of "family" in family medicine journals in the United States. The study reviewed all articles published in *The Journal of Family Practice* between 1974 and 1993. A 5-year (1989 through 1993) review of articles related to family was also done on *American Family Physician, Family Medicine, The Journal of the American Board of Family Practice,* and *Family Practice Research Journal.* An empirical decision was made to establish six dominant themes under which each of the articles could be categorized: care of the patient in the context of family, family as the patient, instruments to measure family function, genogram and life cycle, care of family members, and family review papers.

The high-water mark for family-related papers in *The*

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From the Department of Family Practice, University of California, Davis. Requests for reprints should be addressed to Gabriel Smilkstein, MD, University of California, Davis, Department of Family Practice, TB 152, Davis, CA 95616.

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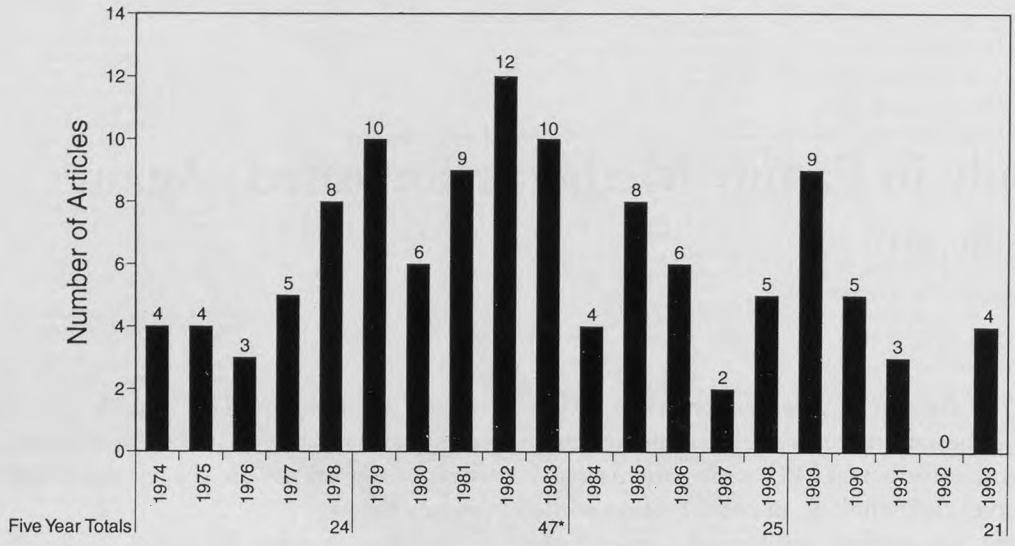

*Significantly different from other 5-year groups ($P < .05$).

Figure 1. Number of family-related articles published in *The Journal of Family Practice,* 1974–1993.

Journal of Family Practice was 1982. In that year, 12 papers on family were published. When divided into 5-year blocks, from 1989 through 1993, only 21 family-oriented papers were published in *The Journal of Family Practice* (Figure 1).

It could be assumed that a change in editorial policy in *The Journal of Family Practice* accounted for a reduction in acceptance of family papers for publication. Yet, an examination of the publication record of four other family medicine journals shows not only a dearth of family papers, but the absence of any trend suggesting a growth in interest in issues related to family (Figure 2).

In a categorical examination of papers on family, it was heartening to note that a steady interest has been maintained in studying "the care of the patient in the context of family" and "care of family members" (Table). These two content areas probably reflect most traditional values in family medicine. It is unclear why the number of published reports on "family as the patient" has declined.

A debate on educational policy between "patient in

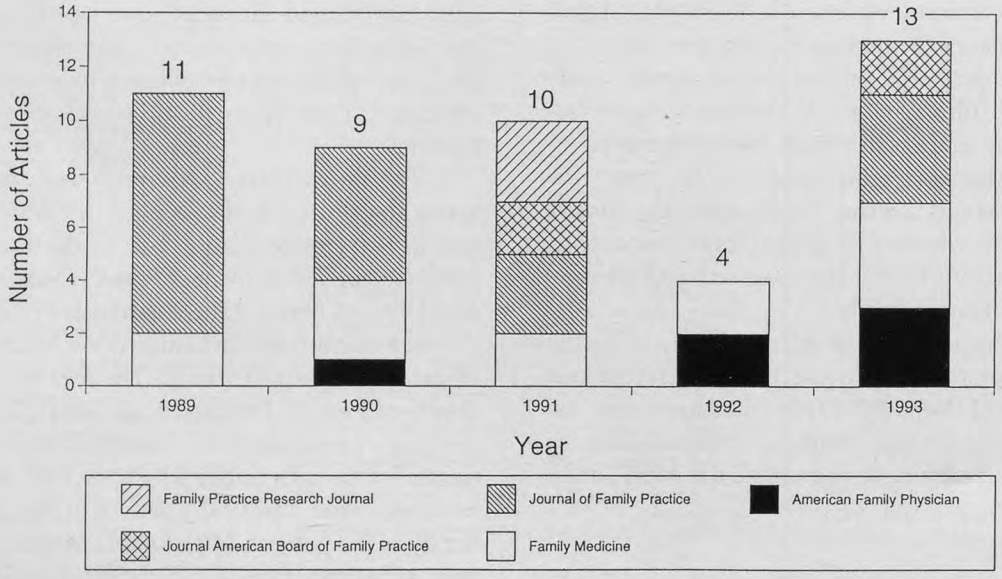

Figure 2. Number of family-related articles published in five family medicine journals, 1989–1993.

Table. Number of Family-Related Articles Published in Five Family Medicine Journals, by Year and Topic

Journal	Care of Patient in Context of Family	Family as Patient	Instruments to Measure Family Function	Genogram and Life Cycle	Care of Family Members	Review Papers Related to Family
The Journal of Family Practice						
1974–1978	6	13	1	0	1	2
1979–1983	10	16	4	4	3	10
1984–1988	10	5	2	2	3	4
1989–1993	10	3	0	0	3	5
American Family Physician, 1989–1993	3	1	0	0	2	0
Family Medicine, 1989–1993	3	3	2	1	2	2
The Journal of the American Board of Family Practice, 1989–1993	1	0	0	2	1	0
Family Practice Research Journal, 1989–1993	1	0	2	0	0	0
Total	44	41	11	9	15	23

the context of family" and "family as the patient" captured the attention of educators during the first decade of family medicine's development.[4–16] Since both have a place in the education of family physicians, it is a debate that should not have occurred. In the first issue of *The Journal of Family Practice* in 1974, Curry[17] proclaimed that "The Family As Our Patient" should be a basic tenet of the discipline. Curry's view was influenced by his role as a physician who cared for individuals as members of a family. Even in Richardson's[18] landmark publication "Patients Have Families," the emphasis was on relating a patient's illness problems to the family with whom the patient lived.

When Geyman's[4] paper "The Family As The Object of Care" was published in 1977, there were those who believed that care of the family should be a focus in family medicine training. More recent literature probably reflects the direction taken by those who teach "family" in predoctoral and residency programs. In five family medicine journals published between 1989 and 1993, 18 articles addressed "care of the patient in the context of family," 8 related to "care of family members," and 7 dealt with the "family as the patient" (Table).

Fujikawa et al[19] alerted the discipline to one of the problems inherent in family practice when assumptions are made without research support. His study suggested that in many instances, not all members of a family seek care from the same physician. Schwenk[16] expanded our understanding of caring for the family as the patient by noting the complex challenges faced by family physicians who attempt to assess and manage family problems.

Despite the difficulties encountered in addressing family problems in a practice setting, the need to understand family dynamics as it relates to health care and to apply this understanding to the care of patients and their families has been documented in papers published through the years. The following is a partial listing of family health problems that have been identified as family issues in our discipline: impending divorce,[20] runaways,[21] cancer patient,[22] post-suicide,[23] atypical children,[24] chronic illness,[25,26] the dying child,[27] cardiac rehabilitation,[28] bereaved parents,[29] neonatal death,[30,31] teenage pregnancy,[32] depression,[33,34] family violence,[35] death in the family,[36,37] ethical issues,[38] terminal care,[39] hypertension,[40] cerebral injury and brain death,[41] infertility,[42] paraplegia,[43] child with handicaps,[44] developmental disabilities,[45] infant illnesses,[46,47] and pregnancy outcome.[48]

This list emphasizes the relationship of family to patient problems. Curry [17] in 1974 and Stephens[49] in 1988 have called for the discipline to be "pro family." Predoctoral and residency-training directors should respond to the sage advice of these founding fathers of family medicine by examining their curriculum to see how far they have drifted from family.

After 20 years of trying to teach a family approach to health care, it must be clear to all that it remains a difficult task. The easy part of teaching "family" is the biomedical component. Medical students are constantly reminded to include biomedical family history in their comprehensive writeups. Attending physicians often remind students and house officers that genetic relationships must be sought to clarify health problems. The difficult instructional challenge is to train future generations of family medicine

faculty to recognize and to teach the biopsychosocial risks that influence health outcome.

Marvel et al[1] hypothesize that the failure of physicians to reach higher LPI (levels 4 and 5) ". . . may indicate that such interventions are rarely needed during routine patient care." A more likely scenario is that the physicians involved in their study had not been adequately trained to recognize and address the issues related to psychosocial problems. Thus, they probably responded in the way they had been trained, ie, with biomedical protocols.

I believe that all family physicians should be capable of functioning at a minimum of level 3 of the LPI, which I consider the entry point for the biopsychosocial model[50] in medical interviewing. All family physicians should be capable of being responsive to the cues and clues that allow for a sensitive and responsive patient-centered interview,[51] and family medicine faculty should recognize and support students and residents when they use patient-responsive techniques, such as empathy and the explanatory model.[52] Students will learn to respond in a caring way when they discover that their instructors value such behavior.

A stronger partnership between behavioral scientists and family physician clinicians is central to the success of such a venture.[53] Unless physicians serve as models for students and residents of what they have learned from their behavioral science colleagues, little progress will be made in the arena of psychosocial assessment in routine patient interaction. Finally, our behavioral science colleagues have developed methodologies that allow for systematic and time-limited approaches to the examination of psychosocial issues related to family and other social support.[54–56] We should be studying and teaching the principles of such gems as the "15-Minute Hour."[57]

Our roots are in family. It is not enough to do homage to the royal symbol of our discipline. Marvel et al[1] have given us an instrument for assessing how skilled we are at medically interviewing patients and their families. Now is the time for family medicine to reenergize the educational and research programs that validate the worth of family-oriented care.

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