The Family in Medicine, Process or Entity?

Lynn P. Carmichael, MD
Coral Gables, Florida

It has been ten years since the issuance of the American Medical Association generated Willard Report, *Meeting the Challenge of Family Practice*, and controversy over the meaning and definition of the terms "family physician," "family practice," and "family medicine" continues. I believe much of the confusion is due to ambiguity surrounding the meaning of the word "family." It can be used denotatively to refer to a particular group of persons or connotatively to the form of the relationship. It is my contention that the word "family" as used in the discipline of family medicine and the specialty of family practice refers to the form of relationship established between the physician and the patient. The family as a unit of care is relatively uninvolved in general medical care as currently practiced.

The Family as an Entity

The logograms of the Society of Teachers of Family Medicine (Figure 1) and of the American Academy of Family Physicians (Figure 2) depict a family, in both cases consisting of parents and offspring. These symbols imply that the focus of family medicine and the family physician is on the family as an entity. It is not simply that the physician will care for the young and old, male and female, but he or she takes care of a *family unit.*

Social scientists have long held that the family is the basic unit of living in our society, and socially oriented physicians have reasoned that the family should be the unit of medical care. While quite rational, this idea has only been adopted in psychiatry where the development of family therapy has made the family the object of treatment. Speaking to the Royal Society of Medicine in 1975, Professor Marshall Marinker correctly challenged the idea that the family can be the unit of medical care in general practice.[1] This is not to imply that the family is unimportant. A family is a system and what happens with one member affects other members. Medical care needs to be more family-oriented. However, to care for the patient in the context of the family is one thing; to turn the family into the object of care is another.

Characteristics of the Family

Vandervoort and Ransom have given us a definition of family that seems applicable to today's society. They refer to a family as "a significant group of intimates, with a history and a future."[2] I find this definition quite useful, and in my own studies I have identified four elements or characteristics of the family relationship. These elements are: affinity, intimacy, reciprocity, and continuity.

Affinity – A family is made up of two or more persons. An individual may need to carry out the *functions* of a family, but to *be* a family there must be two or more persons joined by an interpersonal bond.

Intimacy – This goes beyond eating, sleeping, or having sex together. Essential to this is a degree of openness and willingness to acknowledge one's vulnerability to others. Exposing one's unprotected parts in a family relationship is not submission but evidence of trust.

Reciprocity – In a family there is a reciprocal relationship, a sharing between members that gives rise to an interdependency. The reliance on each other is not from weakness but is accomplished to attain greater strength, just as a teepee is a stronger architectural structure than a single upright pole.

Continuity – In the family there is the expectation born out of past experience that the relationship will continue and endure. This assurance frees the individual from the necessity of constantly making contingency plans.

The Family as a Process

Persons who establish a relationship characterized by affinity, intimacy, reciprocity, and continuity may feel that they are a family. This feeling is not based on factors such as sharing a common household or being parents. Rather, it is based on the process or the relationship itself which has the above four characteristics. Primary care physicians will note that these four elements are familiar and are often found in the relationships they develop with patients in their practice. If they are unappreciated by the physi-

Figure 1. Logogram of the Society of Teachers of Family Medicine.

Requests for reprints should be addressed to Dr. Lynn P. Carmichael, Department of Family Medicine, University of Miami, School of Medicine, P.O. Box 520875, Biscayne Annex, Coral Gables, Fla 33124.

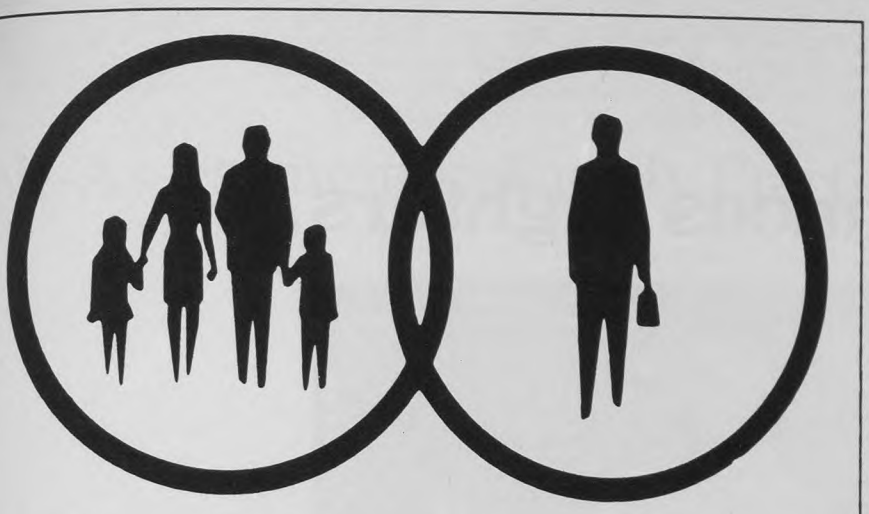

Figure 2. Logogram of the American Academy of Family Physicians.

cian while practicing, the overwhelming sense of loss he or she experiences when leaving practice confirms their existence. The existence of such relationships comes about because of the context of general medical practice. Only in a few of the encounters the physician has with a patient is there a progressive disorder in which the medical model is applicable. In the majority of encounters, the physician and the patient are participants in a social function that is based on process rather than outcome. Success rides on the rights and duties of the participants rather than on utilitarian value judgments such as what is the greatest good for the greatest number. The conceptual approach to management of these types of problems I have called the relational model.[3] The characteristics of the relationship in the relational model are the four mentioned above.

As I see it, the word "family" in medicine refers to the existence of these four elements – affinity, intimacy, reciprocity, continuity – in the doctor-patient relationship. That there is a family as a unit is moot. The meaning of family refers to the type or form of relationship that the physician and the patient establish. The meaning of family refers to the *how* or process, not to the *what* or entity.

References

1. Marinker M: The family in medicine. Proc R Soc Med 69:115-124, 1976
2. Ransom DC, Vandervoort HE: The development of family medicine: Problematic trends. JAMA 225:1098-1102, 1973
3. Carmichael LP: Competencies in the relational model. Presented at the Annual Meeting, Society of Teachers of Family Medicine, New Orleans, Louisiana, April 2, 1976

The Medical Doctor and the Physician

Hiram B. Curry, MD
Charleston, South Carolina

What is the difference between a medical doctor and a physician? Society has given certain educational institutions authority to examine an individual after a period of study and to award a degree called a Doctor of Medicine. This follows the acquisition of a certain amount of knowledge and accompanying skills concerning the science of medicine. This is a Medical Doctor. When the word "physician" is used, a slightly different meaning is connoted. The person of the Medical Doctor is implicitly involved. It is the person of the physician that utilizes and makes available the knowledge and skills of medicine to the patient, resulting in a humane service. The physician soon learns that his personhood is the most important and dependable diagnostic and therapeutic tool he will ever use.

Even though a college student has a good vocabulary and can carry on an intelligible conversation, he requires special training to carry out a good medical interview. Likewise, individuals in medical schools are generally well-adjusted, normal individuals. This is not to say that their person is optimally differentiated for meeting the personal demands made on a physician. Indeed, like any tool, they need to be treated in the heat and cold of human emotions if they are to withstand the work of their profession. Through behavioral science training we endeavor to give a young Medical Doctor insight in order that he might understand himself and his patients. We support him in accepting his own faults and biases in order that he be able to tolerate the shortcomings of his patients. And lastly, in accepting him as he is, we model the unconditional positive regard that allows him to accept the patient in a nonjudgmental fashion.

This type of work directed toward the person of the physician is basic to the establishment of a satisfactory doctor-patient relationship which encourages the patient's trust. This trust will permit the patient to share sensitive information with the doctor. In addition, this trust will allow the patient to accept the comments and suggestions of the doctor and wish to implement them. A trusting attitude, when built upon this kind of interpersonal relationship, is a lasting one and essential for the optimal functioning of a physician.

Requests for reprints should be addressed to Dr. Hiram B. Curry, Chairman, Department of Family Practice, Medical University of South Carolina, 80 Barre Street, Charleston, SC 29401.

This section of the journal is designed to present clinical problems which focus on patient management, problem-solving, and other elements integral to family medicine. It features reinforcement of major teaching points through further discussion and supplemental references which appear on the following pages.

Self-Assessment in Family Practice

These materials have been prepared by members of the Self-Assessment Panel of *The Journal of Family Practice*. Membership: R. Neil Chisholm, MD, Chairman (University of Colorado, Denver), B. Lewis Barnett, MD (Medical University of South Carolina, Charleston), Paul C. Brucker, MD (Thomas Jefferson University Hospital, Philadelphia, Pennsylvania), Laurel G. Case, MD (University of Oregon Medical School, Portland), Ian R. Hill, MD (Plains Health Centre, Regina, Saskatchewan), Kenneth F. Kessell, MD (MacNeal Memorial Hospital, Berwyn, Illinois), John A. Lincoln, MD (University of Washington, Seattle), Richard C. Reynolds, MD (University of Florida, Gainesville), Gabriel Smilkstein, MD (University of California, Davis), William L. Stewart, MD (Southern Illinois University, Springfield).

Question A

A 40-year-old white man reports to your office with the chief complaint of right shoulder pain of three weeks' duration. He cannot remember injuring his shoulder, but he does play tennis three times a week. His health in general has been good, but he has been taking hydrochlorothiazide for mild hypertension for eight months. The patient denies any recent trauma to his shoulder. Examination of the shoulder reveals discomfort over the lateral portion of the shoulder with abduction of the arm.

1. Name four conditions that you would consider for your working differential diagnosis.
2. Further examination of the shoulder reveals full range of motion. Pain is produced only with abduction past 90 degrees. Popping and crepitation are present on movement. What do these findings signify?
3. You elect to continue your workup. Name three basic studies you would order.
4. The patient's uric acid level is markedly elevated. Although it is most likely due to the diuretic, you decide to consider other causes for hyperuricemia. Name five causes for hyperuricemia.

Question B

The following questions are to be answered true or false. The correct answers and references are indicated on the next page.

1. Deterioration of intellect, memory, self-care, judgment, and orientation in most elderly patients is now thought to be due to progressive degenerative changes in the brain itself, and usually not to faulty circulation through atherosclerotic blood vessels.
2. Well-controlled studies have demonstrated that some oral vasodilators improve the mental or physical state of selected elderly or senile patients.
3. Dihydrogenated ergot alkaloids frequently relieve the dizziness that is complained of by elderly patients.
4. Improvement of social and occupational circumstances is more likely to relieve mental and behavioral symptoms of the elderly or senile patient.
5. Dihydrogenated ergot alkaloids may produce a sinus bradycardia in elderly patients.

Question C

The following questions are to be answered true or false. The correct answers and references are indicated on the next page.

1. Nitroglycerin causes general venous dilation and peripheral pooling of blood.
2. Nitroglycerin reduces venous return, which diminishes the work of the heart and myocardial oxygen consumption.
3. Nitroglycerin has no effect on ST segment abnormalities in patients with acute myocardial infarction.
4. Nitroglycerin has been shown to decrease collateral coronary resistance and increase flow in collateral coronary arteries.
5. The rate of absorption of sublingual nitroglycerin is usually fairly predictable.
6. It is now known that nitroglycerin reduces the mortality and morbidity in patients with acute myocardial infarction.