Family Practice Forum

Family Content in Family Practice

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Several authors have concerned themselves with the delineation of boundaries between family practice and other primary care specialties on the basis of problems managed,[1] modes of inquiry,[2,3] consumer preference,[4-7] and other variables too numerous to mention, such as continuity of care and philosophy. All seemingly reflect an attempt to portray family practice as a unique and distinct discipline with its own goals, objectives, tools, and body of knowledge. In attempting to identify the "unique" scope and focus of family medicine, many authors have alluded to its emphasis on the "family" as the primary unit of care.[8-12] Despite this philosophical (or perhaps rhetorical?) commitment to the family as the unit of care, a wide discrepancy appears to prevail between what is "preached" and what is actually "practiced."[9,12] This discrepancy casts many aspersions upon the "uniqueness" of family medicine and summons its proponents to provide less verbiage and more documentation.

Further evidence for this discrepancy can be found upon reviewing a recent Society of Teachers of Family Medicine (STFM) publication in which the behavioral science curriculums of sampled residency programs are summarized.[13] Although smatterings of family content can be found in the curriculums of a few programs and may predominate in an even smaller number, the curriculum cited continues to reflect the traditional emphasis on "individuals."

Awareness of the relative obscurity of family content in family practice has stimulated an undercurrent of concern among family medicine educators who believe that knowledge of families should achieve a more prominent place in the training of family physicians.[9,12] This awareness, however, may be simultaneously causing others to question whether the "trees" of family content will ever bear "fruit." Just what exactly is this "content" and how should it affect the behavior of family physicians?

Interest in this problem was further reflected in the proceedings of the STFM's 13th Annual Spring Conference in which two seminars and two workshops concerned themselves with the dissemination of information about their respective family oriented curriculums. A common need among the participants at these sessions appeared to revolve around gaining exposure to varying kinds and types of family content. While information exchange among residency programs with regard to family content may indeed be necessary and beneficial, a cursory review of the literature pertaining to family assessment,[14-16] family types,[17-20] family development,[21-24] and the family in health and illness[11,25-27] reveals an abundance of information that is readily accessible. Examples of the integration and adaptation of this content for family practice residency programs are also available.[28-32] Although the articles cited above are in no way presented as exhaustive or sufficient in and of themselves, their existence does suggest that the problem with family content does not appear to rest with any apparent "lack of" content. Where, then, does the problem lie?

Simply stated, the problem with family content appears to rest with its immaturity, tentativeness, and more specifically, with its lack of clinical utility. The existing knowledge base with regard to the dynamics of family interaction resembles an "amorphous blob" of data which, to date, have defied most attempts at meaningful integration. While occasional subgroups of data have been amassed from the yeasty cauldrons of various

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disciplines, their transition from theory to practice remains sketchy at best. This state of affairs poses considerable difficulties and challenges for family medicine educators and researchers alike.

What, for example, is meant by a family orientation to patient care? What are the unique features of this approach? How does this differ from the "whole person" concept of medicine? Is it more advantageous? In what respect? What knowledge of families should be taught? With what methods? How should this knowledge change or influence the behavior of family physicians? Perhaps more importantly, given that these behaviors can be isolated, specified, and acquired, what impact will they have on patient care? Will they make any difference at all? If so, in what respect? Patient satisfaction? Compliance? Early detection? Family cohesion?

With respect to the clinical utilization of family content, the state of our knowledge remains in its infancy. As stated so aptly by McWhinney: "As a body of knowledge, family medicine still has many of the marks of an immature discipline. Whether or not it grows to maturity in the next decade or two will depend very much on the wisdom with which we choose the direction of our research."[3]

Family physicians, educators, and researchers are charged with an immense responsibility to describe and evaluate the tools that are peculiar to their trade. Upon developing and describing these tools, the true test of their clinical efficacy will demand painstaking answers to pragmatic questions. To put it more succinctly, "Do they work?"

Despite the obvious need for rigorous research, one must be cautious in not allowing the variables of family oriented care to be swept up in their entirety by the gram-centimeter-second traditions of the physical sciences. While various aspects of family oriented care must undergo empirically stringent tests, this must not occur at the expense of drastically altering the context in which these variables are believed to be operative. For whenever a phenomenon is investigated by means of dissecting its component parts, there is always an inherent danger that resulting observations may obscure the true nature of the whole. Within the tradition of empirical research, there is certainly a need for more disciplined investigations of family oriented care. Hopefully, this can be achieved without reducing the unique and personable features of family medicine to physics or phylogeny.

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