The Family and Family Medicine: Should This Marriage Be Saved?

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Although there have been many noteworthy attempts to integrate a family focus into family medicine, there is little evidence that this integration has occurred in either residency education or community practice. When the specialty was founded, a family emphasis may have been politically useful as a way to differentiate the new family physician from the old general practitioner. Now, however, it is unclear what specific family-related material should be taught or who should teach it since few family practice faculty are trained in understanding families. If a practicing family physician actually wants to see a family, practical problems concerning time, space, and money arise. Furthermore, the medicolegal system is structured to protect the confidential relationship between one patient and one physician. Other obstacles to the integration include the difficult epistemological shift required to apply systems theory, the current chaos in the family field, and family medicine's need to gain professional stature by being proficient in traditional medicine. It may be time for the family and family medicine to reconsider their well-intended but ill-advised relationship.

The last five years in family practice education have witnessed a renewed veneration of the family. Influential textbooks[1,2] have taken the position that family-oriented health care should be the sine qua non of family practice and predict that families will replace individuals as the most meaningful unit of health care. There is certainly a long, honorable history of interest in the family in general medical practice.[3,4] This interest was apparently well-founded; recent reviews have highlighted the scientific evidence for the importance of the family in virtually all aspects of health and illness.[5-7]

Family physicians have made a variety of efforts to integrate a familial perspective into the practice of medicine. For example, there have been attempts to introduce brief office questionnaires that assess family functioning[8] and efforts to initiate family charting systems.[9] Family practice educators have described a wide range of novel approaches used to teach family-related material.[10-13] In fact, the subject generated enough interest to inspire the creation of a special task force of the Society of Teachers of Family Medicine, which recently issued a report, "The Family in Family Medicine."[14]

Finding the proper place for the family in family

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practice, however, has not been easy. In spite of the stated goal that in "family medicine, the aim has been . . . to develop a body of knowledge that will allow physicians to approach the patient's family problems with the same competency they apply to biomedical problems,"[15] many are confused and frustrated. The same author, for example, notes that family care can mean (1) health care for all individuals in the family, (2) care of an individual patient within the context of the family, or (3) the "family as patient."[16] A recent report by the Task Force on Behavioral Science of the Society of Teachers of Family Medicine found that very few programs emphasize family-oriented training.[17] One review[18] found that fewer than 10 percent of family practice residencies surveyed had any systematic focus on the family at all. Louis LaBarber,[19] a behavioral scientist, thinks he knows why.

> 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, has defied most attempts at meaningful integration. . . . What, for example, is meant by a family orientation to patient care? What are the unique features of this approach?

The field of family medicine is left in an awkward position. Family physicians do not learn much about families, cannot clearly define family care, seldom keep family charts, and rarely treat all members of the same family.[20] What, then, do families have to do with family medicine? From afar, this union of "family" and "medicine" would seem to be a nearly perfect match. Yet behind the closed doors of the conference and examining rooms, they become quite incompatible. This essay is an attempt to understand how this unfortunate mismarriage came to be.

Contributing Factors

What Is the Difference Between a Family Physician and a General Practitioner?

When the family practice movement began in the 1960s, it was necessary to find some way to distinguish this new, well-trained breed of primary care providers from their predecessors. The old general practitioner, immortalized by Norman Rockwell, embodied all the small-town warmth and compassion the founding figures sought, but too obviously belonged to another era to practice modern medicine. The solution, in part, was a new specialty that was a lot like the old nonspecialty, ie, a physician who saw just about every kind of problem, in every age group, and who served as gatekeeper of the health care system. Simply requiring three years of postgraduate training, however, would not sufficiently differentiate the new specialist from the old generalist and could lead to confusion: "Are you one of those old-time general practitioners who went right into practice or one of those newfangled ones who's had three years of residency training?" One solution was to change the name of the field so that the newly trained and anointed were clearly distinguishable from the general practitioners of yesteryear. The emphasis on family became an early and potent rallying cry for those founding figures: Not only did family physicians have formal residency requirements and specialty boards, unlike general practitioners, but there was also a whole new orientation to health care. The emphasis on the family had great political utility for a young discipline striving to find a recognizable place under the medical sun.

What You Do Not Know, You Cannot Teach

Family medicine is an embryonic field. Like any young discipline, it is groping to find its core, its boundaries, and its methods. One of the reasons educators are having trouble teaching family-oriented medicine is that the field has not yet generated much to teach. This is compounded by the fact that all of the family practice founders and many of the current senior educators came either from general practice or from one of the older medical specialties before passing family practice boards. These leaders have had very little formal training in family theory, family therapy, or family anything—which is not surprising, since the current dominant clinical views about families are primarily products of the last 15 or 20 years. As Christie-Seely[13] points out, family practice residency programs need a critical mass of faculty who understand families and systems theory to

develop and maintain that orientation in a training center. Untrained or ill-trained educators may actually retard the spread of this perspective. After all, "everyone knows all about families." Most physicians grew up in them, knew many families in their neighborhoods, and see people of all ages and backgrounds in their practices. However, not only is the myth that everyone knows about families untrue, but it also actively hampers attempts to teach contemporary concepts. Few busy physicians would devote much time to learning—or teaching—things that are allegedly common-sensical or based on a nearly universal human experience.

The educators who might be the most likely candidates to bridge the gap from family theory and therapy to family medicine are the behavioral scientists. Unfortunately, as Hornsby and Kerr[21] note, behavioral scientists are a heterogeneous bunch with a kaleidoscopic diversity of background and professional preparation. Very few behavioral scientists in family medicine are particularly well trained to work clinically with families. They too, however, grew up in families and know all about them. What they do not know, they cannot teach either.

The Problem of Logistics: Sometimes More Is Less

Question: How do you fit a family of five, and a doctor, into a room for two?

Answer: Leave the family at home.

Current opinion seems to be divided on the advisability of interviewing a family all together at one time. Some contend that this is an unlikely and unrealistic expectation for a family physician,[12] while others argue that sometimes the family physician should interview the family en masse.[22,23] Many physicians' offices, however, do not have rooms that can accommodate more than three people in a sitting position. Hallways, reception areas, and employee lounges are not suitable substitutes for a good, comfortable room that can seat a family and a physician. Without adequate space in which to see families, families will not be seen.

Family physicians who do see whole families will quickly appreciate two other problems—time and money.[14] How much should one charge for seeing a family or gathering a family data base? If a family member comes for treatment of an individual medical problem, and if the physician wants to gather a family data base firsthand, should the family pay for that interview at all? If so, how much should it cost? In addition, more people, saying more things, encourages more interaction, which consumes more time. How will the busy family physician fit in these new demands? The Society of Teachers of Family Medicine has a solution: Work nights.[14] That is when families are most likely to be available anyway. But then, who takes care of the family physician's family when the family physician is out taking care of someone else's family?

Family charting is another useful idea that is hard to put into practice. Should one note all visits by all family members in one chart? If so, it is impossible to extract individual medical records on individual patients. Some offices file family members' individual charts together under a family name. Although this seems like a helpful plan, it is essentially putting old charts into new places. When charts are needed, they are simply extracted as individual charts. In actual practice, this modus operandi affects family chart placement, not family charting. Further, what about those family members (eg, stepchildren) with different last names? How shall they be known, found, filed, and cross-referenced? As yet, there is simply no widely accepted method for integrating individual and family health care records into one meaningful, easily accessible system.

A Little Confidentiality Goes a Long Way

The patient-physician relationship is an ancient sanctuary protected by vast legal barriers from uninvited curiosity seekers and other misanthropes. The patient is entitled to privacy, the physician is committed to confidentiality. These "rights" are so rigidly held that legislation has been required to prod health care givers into revealing information about child abuse and potential homicide. Patients may be understandably reluctant to give up this cozy arrangement: "Why do you want to involve my whole family? Don't you believe me? I won't be able to talk with all those people there."

Some physicians may try to piece together an understanding of family functioning from talking with individual family members. Information gath-

ered in this way is likely to be distorted, however, since it represents a single vantage point. Furthermore, it cannot be validated without violating the informant's confidentiality. As a result, the family is often brought into the act only when individual patient care cannot proceed without it. Even then, no one is quite sure who should be told what, or who should do the telling.

Thinking in Circles vs Thinking in Lines

Most conventional medical thinking utilizes the time-honored Aristotelian model of linear causality, ie, A causes B, which causes C. This model has been enormously successful in finding, isolating, and treating infectious diseases or any condition with a specific pathogen. Environmental or contextual factors are primarily viewed as complications or confounding variables. This is not to suggest that traditional medicine has ignored everything except germs, but it is to suggest that traditional medicine has achieved its most dramatic and widely practiced successes by sticking to this perspective. Although there has been a recent rash of carefully researched and reasoned writing about the "biopsychosocial model,"[24] the bottom line in 1983 continues to be the laboratory report and the hospital consultant's technical or pharmacologic recommendations.

The dominant model of clinical thinking about families emphasizes circular causality. In this view, based on systems theory and cybernetics, events are continuously and reciprocally determined, ie, A is associated with B, which feeds back to modify A, which influences B, which modifies C, which feeds back to influence A, etc. The search for an original cause is both futile and irrelevant. The very basis of the Western scientific method is questioned, since "objectivity" implies a dualism between observer and observed, and phenomena and context, which this model does not recognize. Other goals and methods of traditional science—predictability, replicability, reductionism, and inferring causes from effects—are simply immaterial.[25,26] The systems view, then, involves a major conceptual and epistemological shift.[27,28] In a linear world, life is simple, straightforward, and predictable; in a circular world, life is everchanging, inescapably complex, and populated by irreducible, interacting patterns.

Thinking in systems terms also leads to new perspectives on the meanings and implications of health and illness.[29,30] This shift creates major problems for physicians, ie, what to do with the old, familiar perspectives that have served so well in the past. Common responses to reorganizing one's reality are uncertainty and anxiety. Common responses to uncertainty include a rapid return to past habits and devaluation of new, unsettling information.

Learning Systems Theory Is Hard; Applying It Is Harder

Systems theory is complex; systems theory applied to a quickly changing, fully interacting, and occasionally screaming family is bewildering. The basic conceptual shift required to think systemically, especially under pressure, requires years of apprenticeship and practice. It is naive to expect this perspective to be adopted by a busy family physician who sees an occasional family in the office. If fully trained family therapists have trouble maintaining a systems focus in the heat of the clinical moment, how can one expect family physicians to?

Is There a Family Field?

It is inaccurate to imply that there is one family field; there are many family fields. Although systems theory provides a common thread for clinical family therapists, there are numerous variants, all competing for both theoretical sublimity and adherents. Currently, there are at least six major schools of family therapy: structural, strategic, behavioral, psychodynamic, experiential/existential, and communications-based. Although there are certainly similarities among the perspectives, each has many unique features. Some family therapists, for example, insist that all members of all generations be seen, whereas others focus on the nuclear family or on the marital dyad, and still others see individual patients while working in a "family framework." Some orientations highlight the critical influence of family history, whereas others ignore history and focus exclusively on the here and now. There are approaches that emphasize the personality and experiences of the thera-

pist, and there are approaches that claim the personality and experiences of the therapist are irrelevant.

In part, the confusion may be accounted for by family therapy itself being a young endeavor. The first serious family therapists began their work in the 1950s, and the field has only recently attracted a large following. There are other reasons, though, why the "family field" has not jelled into a manageable whole. Families have been treated by psychologists, social workers, nurses, psychiatrists, family physicians, ministers, and drug and alcohol counselors. Academic interest in families has emanated from departments of education, home economics, social work, psychology, child development, family studies, sociology, anthropology, systems analysis, and others. From this chorus of dissonant vantage points, research methodologies, and theoretical vicissitudes, the one clear chord of truth has not been struck. If there is no coherent family field, how can it be integrated into family medicine?

The Family Physician's Own Unfinished Family Business

It is commonly accepted in psychotherapeutic circles that the psychotherapist's own unresolved conflicts are often activated during the treatment of patients.[31] The same is true of family therapists. Working with families or thinking about patients from a familial perspective can trigger uncomfortable, anxiety-provoking feelings about unfinished family conflicts.[32] One convenient, easy-to-rationalize alternative is to stick with an individual focus. If psychotherapists can resist a family-oriented approach because of the conflicts it induces, so can family physicians.

Family Physicians and Family Therapists Do Not Know Each Other

Family physicians and family therapists come from different backgrounds and professions. Very, very few practitioners are trained in both. Further, the two disciplines are young and working hard to consolidate both their professional identities and their turfs. This focus on internal solidification makes it all the more difficult to begin useful interactions with other, related fields. For beneficial collaboration to occur, each discipline will need a critical mass of accepted leaders who are genuinely versed in both specialities. As for now, family physicians and family therapists are content to nod at each other politely across the room while avoiding greater intimacy.

Discussion

There are other reasons for family theory and family medicine being in a questionably compatible and mutually distant relationship. From a more general perspective, it is only within the last few years that mainstream medicine has become seriously interested in behavioral science at all.[24] As Balint[33] has pointed out, it is usually more gratifying for a physician to diagnose an organic problem than to diagnose psychosocial difficulties. The physician who finds a rare, verifiable disease that his colleagues have overlooked or dismissed as "probably emotional" is a diagnostic hero, acclaimed by peers and teachers. A psychosocial diagnosis (including familial considerations) is usually made after clinical hunches are played out and high-tech medicine has failed to produce significant findings. Even then, the diagnosis and explanations are likely to seem soft and tentative since psychosocial processes are rarely subject to confirmation by "scientifically acceptable," objective data.

In traditional medicine rewards go to those who can astutely isolate linear chains of causation and whose nimble fingers produce procedural masterpieces with difficult cases. The premium placed on proof (as defined by physical findings) and proper technique led to the belief in the existence of one correct answer and the illusion of linear certainty. Family physicians grew up in the same milieu and practice under the same pressures as all physicians. However, the old mind-body debate is particularly conflictual for family practice since the field so enthusiastically espouses the interactive relationship between physical and psychosocial factors in health care and disease.[28] When family physicians try to practice a behaviorally oriented, family-based brand of medicine, though, they are likely to be out of step with their colleagues. Other specialities do not understand the relation of the

family to health care and are even less willing to try the epistemological shift that systems thinking requires. The family physician, then, can subscribe to the dominant high-tech values of the medical majority or to a new, hard-to-grasp and difficult-to-communicate view of the world that colleagues are likely to find frivolous or simply irrelevant. To gain credibility and status for a discipline that is still struggling for specialty hospital privileges, family physicians must be good at natural science and traditional medicine. At this time, an emphasis on families might even be self-defeating.

There is another nagging question about this hoped-for union of family and family practice: Is the marriage really worth the investment for either party? Family therapists may gain some stature by affiliating with the prestigious field of medicine. The nonclinical family theorists and academicians gain a ready-made laboratory for their theories and proposals. It is less clear what family medicine will gain. Perhaps the family physicians who could benefit most from a family orientation are those small-town family physicians who really do provide ongoing care for a large number of families. Unfortunately, these same physicians often have such heavy demands for acute care that they have little time or inclination to try something new. One benefit might be economic: A family-oriented practice may make family physicians more marketable in a quickly approaching era of physician overabundance.

For this marriage of the family and family medicine to succeed, research will have to answer a critical question: What specific advantages will understanding family systems or adopting a familial perspective have for the practice of general medicine? Right now it is politically useful and ideologically gratifying to keep the family in family practice. Yet this family therapist, having seen many a couple begin with unmitigated passion and limitless forgiveness, is cautious about the prospects for these two unlikely partners. It is rather like the marital prognosis for two well-intentioned but obviously inexperienced adolescents: Everyone hopes it will work out, but no one is quite sure they can survive together beyond the honeymoon. As the differences become more apparent, more frequent, and less resolvable, the family and family medicine may sadly, but wisely, go their separate ways.

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