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.

Content of Family Practice

To the Editor:

I began to read the study, "The Structure and Content of Family Practice: Current Status and Future Trends" *(Rosenblatt RA, Cherkin DC, Schneeweiss R, et al. J Fam Pract 15:681, 1982)*, with enthusiasm, but was shocked when I read the list of diagnostic categories used. It was a long string of predominantly medical complaints. Categories such as situational stress reactions were absent, as was any mention of family or psychosocial problems, except for the single cluster "depression/anxiety."

Where was the feel and texture of what I do every day? I wondered. Where was the flavor of family practice, the sense of the constantly shifting communication between patient and physician, the drama of "treating the whole person," or even (forgive the expression) "the family in family medicine"? Why did the study seem so neat and well organized, when my own daily practice felt so chaotic?

My consternation peaked when I re-examined the diagnostic cluster of "depression/anxiety." Its incidence was 2.9 percent. Of course, the figure was somewhat higher for residency-trained physicians, but still . . .

Epidemiologists have reported the prevalence of psychiatric disorder as anywhere from 50 to 80 percent among medical outpatients[1]; and Goldstein et al[2] report that 64 percent of patients in three family practice settings perceive one or more areas of psychosocial concern in their families, while close to 50 percent had concerns about themselves. Carmichael and Carmichael[3] have written that perhaps 80 percent of family practice falls into the "relational model," which is concerned not with the "cure or control of disease, but rather with the attention, support, and comfort the patient receives."

My own experience suggests that many patients' medical problems have a psychosocial core, which strongly affects their meaning and presentation. The presenting problem often screens a pressing psychosocial concern ("Why have you come to the physician now, at this point in your life?"), a notion that has been understood for generations and to which Balint referred in discussing the "deeper" diagnosis.[4]

Why is this missing from the "landmark" University of Washington study?

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References

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2. Goldstein HS, Snope FC, McGreehan DM: Family emotional health: A survey of family practice patients. J Fam Pract 10:85, 1980
3. Carmichael LP, Carmichael JS: The relational model in family practice. Marr Fam Rev 4:123, 1981
4. Balint M: The Doctor, His Patient and the Illness. New York, International Universities Press, 1957