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.

The Family and Family Medicine

To the Editor:

The article by Merkel *(Merkel WT: The family and family medicine: Should this marriage be saved? J Fam Pract 17:857, 1983),* expressing his opinion that family-based medical care is undesirable and/or impossible, deserves additional comment to that of Ramsey,[1] so as to highlight Merkel's poorly developed and inaccurate conclusions.

As noted by Ramsey, Merkel seems to build most of his arguments against family-based medical care on professional role (''turf'') conflicts. Merkel seems not to realize that he is defending a piece of ground that is not wanted by family physicians. His arguments regarding logistical, conceptual, and educational barriers to family physicians becoming family therapists are analogous to those of a cardiovascular surgeon explaining why family physicians cannot perform mitral valve replacements. The objections are valid, but trivial. Family physicians do *not* wish to become family therapists; as described elegantly by Doherty and Baird,[2] family physicians merely wish to borrow a limited, but powerful, repertoire of group communication skills. As noted by Huygen,[3] Comley,[4] and Minuchin et al,[5] as little as two or three hours invested in clarifying family members' needs and expectations can pay truly remarkable dividends in the health of the identified patient.

Merkel misses the point in several other assertions. For example, he describes ethical barriers to caring for the family as a whole. This is another trivial argument because family physicians are not interested in caring for the family as a whole. Ransom[6] and Schwenk and Hughes[7] have clearly described both the undesirability and the impossibility of doing so for a variety of reasons in addition to ethical ones. As another example, Merkel describes the value of nonlinear, interactional systems thinking, then seems to castigate the field of family studies because its useful research and clinical work comes from a somewhat loose and complex *system* of unrelated disciplines. Finally, Merkel concludes that family physicians cannot provide family-based care because (1) it is too hard, (2) it evokes too much personal anxiety in the physician, and (3) it will cause disparaging remarks to be made by medical colleagues. These objections are not only spurious, but somewhat demeaning to a specialty whose members have shown considerable success in managing complexity, ambiguity, intimacy, and professional disenfranchisement.

The simple truth is that family physicians can and should provide family-based care because the family is both a source of diagnostic data and a medium for therapeutic intervention that makes for more

effective and efficient care of the individual patient. Further research is needed not to prove this truth, but rather to make future family-based medical care that much more successful.

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5. Minuchin S, Baker L, Rosman BL, et al: A conceptual model of psychosomatic illness in children. Arch Gen Psychiatry 32:1030, 1975
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To the Editor:

We very much enjoyed reading the provocative and well-written article by Dr. William Merkel in the November issue of the Journal titled: "The Family and Family Medicine: Should This Marriage Be Saved?" *(J Fam Pract 17:857, 1983)*. We agree that teaching residents about the family is a difficult task for medical and behavioral faculty alike. We also agree that further research is needed to document how a family orientation is beneficial to patients.

We do not agree, however, with the contention that the marriage of family medicine and family systems theory is ill-advised. In fact, it is a fundamental error in logic that presumes that there is a marriage at all. That family medicine is a distinct field of medicine that draws heavily on other fields is a well-worn cliche. Family systems is just another one of those other fields, albeit a very important one.

We believe that the family vs individual approach to family medicine need not be an either-or problem. It is the conception of how change occurs that is the distinguishing feature of a family approach rather than the method or techniques of intervention used. For family practice physicians the attitudinal shift from an individual to a family focus simply means that the family physician treats the patient within his or her social context. The family is an important part of that context.

The author contends that the founding fathers used the "family concept" primarily for political means to distinguish the "new breed" from the "old school" general practitioner. It seems ironic that these same founding fathers distinguish family practice from general practice primarily on the strength of the behavioral training they receive while in residency, even though none has suggested that it is reasonable to train residents to become family therapists. The need is not to train them in family therapy, but to encourage and model a conceptual shift from conventional medical training to an appreciation of the circular causality to which the author refers. A fundamental appreciation of the biopsychosocial model, an understanding of the relationship of stress and illness, and an appreciation of the impact of family and other support systems on health must all be a part of this process.

We strongly believe that it is advantageous and not necessarily a distortion to think "family" whether or not the family is simultaneously present. Even if "the system" is never fully conceptualized, the benefits of this approach keep the physician focused on the patient in his world rather than the patient that appears in his medical record; further, it increases the likelihood that the physician will be more attuned to the patient's concerns and more successful in building a successful relationship. While it is occasionally necessary to convene the family either for further assessment or for family therapy, it is not a common happening, nor should it be. It should simply be present in the family physician's armamentarium.

The author contends that behavioral scientists are the most likely people to bridge the "family" gap in programs. We doubt it! It has been our experience that the most effective way of bridging the gap is to present effective residency-trained family physician faculty role models who have witnessed the benefits of the "family approach" firsthand. The role of the behavioral scientist is to teach the fundamental skills necessary to do the job the faculty should be modeling.

As to Dr. Merkel's observation that family medicine will be out of step if it succeeds in practicing good behavioral medicine, most of us would proudly point out that family medicine has always been viewed as being out of step with traditional medicine, largely because of its commitment to the practice of family-oriented behavioral medicine.

Continued on page 524

Continued from page 521

Finally, we would emphasize that the kind of challenge Dr. Merkel presents is necessary and healthy for the continuing development of our field. It would have been especially timely six or eight years ago, but we must continue to examine the validity of the fundamental principles we are espousing—and, in our opinion, they are holding up rather well!

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To the Editor:

The article by Dr. Merkel *(Merkel WT: The family and family medicine: Should this marriage be saved? J Fam Pract 17:857, 1983)* is both excellent and timely. For many of us who completed our postgraduate training in the early 1970s, when the theorists of family practice seemed to outnumber the clinical teachers of that subject, philosophical arguments about family practice vs general practice seemed only to obscure the real crisis in postgraduate education in family practice, that is, increased competition for patients with concomitantly expanding postgraduate programs in internal medicine, pediatrics, and obstetrics-gynecology. As clinical opportunities accordingly diminished, the tendency was for the more behaviorally oriented members of our faculties to fill up that slack time in our schedules with still more of that ill-digested "family content" to which Dr. Merkel so courageously refers. Whatever subtle benefits such experiences conferred on us must be balanced against the disadvantaged position we were placed in upon applying for hospital privileges, credentials committees being, rightly or wrongly, more interested in the hard data of biomedical training and experience than in the extent of exposure to family theory.

Believing in family-centered primary care, I also believe that such care is best served by a sound education in broad areas of medicine and surgery. To cling, instead, to an ill-advised emphasis on family therapy no longer serves even a political purpose.

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Patients Seeking Family Care

To the Editor:

In the October 1983 issue of the Journal *(Wall EM, Shear CL: Characteristics of patients seeking family-oriented care. J Fam Pract 17:665, 1983),* Wall and Shear report that patients who were divorced were more likely to seek family-oriented health care than were single or married patients. Two possible reasons for this finding are presented by the authors, but at least one other should be considered. Apparently one-person households were not excluded from the analyses. Since divorced persons are more likely than married persons to live alone, they are, for this reason alone, more likely to live in households in which all members seek health care from the same practice. Hence, the finding that divorced persons are more likely to seek family-oriented care may be a statistical artifact.

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