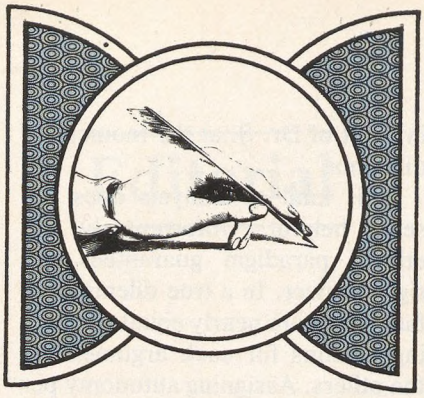
Letters to the Editor



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 Health Tree

To the Editor:

The article "The Family Health Tree: A Form for Identifying Physical Symptom Patterns Within the Family" by Prince-Embury *(J Fam Pract 1984; 18:75-81)* stated: "The application of genograms suggested thus far, however, has been predominantly genetic and relational, and has not yet been integrated into family practice." As I stated in a previous communication *(The genogram as an aid to diagnosis of distal renal tubular acidosis. J Fam Pract 1983; 17:707-708),* the genogram is completely integrated into our practice (every chart) here at the University of South Alabama. It gives all the information of a family health tree plus the genetic, relational, and social history at a glance. The family health tree is no new invention, but is merely a subset of the data we have been collecting in this fashion for years.

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Care of the Poor

To the Editor:

In the October issue of *The Journal* Robert Drickey in Family Practice Forum discusses the role of family physicians and family practice training programs in providing health care services to the poor of our country.[1] Dr. Drickey comments that residency training should include a "systematic approach . . . so that family physicians are recognized and trained to meet the medical needs of the growing number of people who are unable to afford care." I wish to comment on an important attitudinal and philosophical point Dr. Drickey does not make, that any training of physicians to care for the poor must include awareness of the isolation in which these physicians may find themselves once they leave the "protective" setting of residency training and enter into practice. I would like to quote from a letter I recently received from one of our residency graduates who is practicing in an urban community.

> There were some things that we took for granted. We could barely conceive of any other way to practice medicine. What is so novel about listening to a patient, or understanding that a person's environment and family have a bearing on his/her health, or eliciting the patient's view of things, or that culture and economic status have major influence on health and health behavior? Apparently such things are not generally appreciated by the medical profession. The other thing is that hardly anybody cares about the poor. Maybe it is just that in the past I was working with people who do care that my new environment is such a shock.
>
> Fortunately my colleague who is 71 years old and has worked in this community for 41 years is a true role model. He will tell you what a privilege it is to serve people by being their doctor.

Current changes in medical economics are putting additional pressures on systems to provide health services to the poor of this country.

This letter raised some additional questions for me regarding the general support in the medical community for physicians who are interested in providing services to all patients and about the methods we use to prepare our residents for the transition to practice. Even if we train physicians as advocated by Dr. Drickey, does the community of family physicians support a philosophy that includes care for patients in situations where fiscal reimbursement may not be forthcoming? Can the American Academy of Family Physicians propose and develop a creative system for providing care regardless of socioeconomic status? Can the Society of Teachers of Family Medicine propose a curriculum module for use in training family physicians about this aspect of practice?

This is an opportunity for family medicine to act upon its populist and reformatory nature and take a leadership role as advocate for the welfare of all our patients. I laud Dr. Drickey in raising this issue at this time and hope that its presentation in Family Practice Forum serves to stimulate and formulate a unified position on the part of the discipline of family practice.

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Reference

1. Drickey R: Family medicine and the poor. J Fam Pract 1983; 17:726-728

Medical Ethics

To the Editor:

In a recent guest editorial,[1] Howard Brody took major issue

with an article in the same issue of *The Journal* in which he argues that Williamson and colleagues[2] demonstrate a lack of due concern with patient autonomy. We feel compelled to reply. What, after all, is the role of the family physician? Clearly, the family physician feels competent to care for various members of a family. As such, he or she feels comfortable with the role of facilitator, helping various family members to negotiate and communicate about any number of health issues with the hoped-for outcome being consensual, mutual agreement. But if mere negotiation does not lead to a solution, as occurred in the case that we presented,[2] what then? That case described an elderly patient who wants to stay at home to help care for a retarded son, while the married son, on whose shoulders much of the burden for keeping the family afloat has fallen, wishes to have both of them institutionalized, especially in light of the mother's worsening cardiac status. Dr. S., the family's physician, did indeed facilitate an examination of the beliefs and attitudes of all family members, but without resolution of the basic conflicting wishes of the elderly patient and her married son.

How then should Dr. S. have proceeded? If patient autonomy is the dominant principle, how should Dr. S. choose among conflicting autonomous individuals? It is a chance fact that the patient sitting in front of him is the identified patient (in this case the elderly woman happened to be hospitalized at the time, although both she and her married son were patients of Dr. S.). Is autonomy to be based on a first-come, first-served basis? It strikes us that Brody's analysis could have been applied with equal effect had the son been the primary patient who happened to be sitting in front of Dr. S. at the moment of dilemma.

This kind of analysis does not seem helpful. Unfortunately, no ethical paradigm guarantees the right answer. In a true dilemma, in fact, there are nearly equal conflicting reasons for each argument vs the others. Assigning autonomy per se does not guarantee good decisions. One must hope to be sensitive to all of the relevant factors without obscuring some, and then proceed to a choice one can live with. (After reviewing several articles on medical ethics, as well as the paradigm presented in Brody's book, we wholeheartedly agree that the Potter Box is not optimally useful. Far more articulate is Brody's own method,[3] which not only allows a separation of facts from values and principles, but presents effective guidelines for reaching decisions in ethical conflicts.)

Let us look more closely at Brody's argument that the presenting patient deserves regard for his autonomy at almost all costs. Brody implies that one can take the family into observation without taking those observations into account, since the patient's autonomy is the final responsibility of the physician. Is it practicable for the family physician to send family members somewhere else whenever there is a conflict among them?

This sounds good but, we feel, does not bear close scrutiny. How about the patient who is not acting in his own best interests or in the interests of his family? The patient who abuses his child and the patient who abuses alcohol come to mind. Clearly one cannot champion patient autonomy when the patient is seriously harming someone else. Is it ethically feasible for a family physician to witness severe family dysfunction and to support it in the name of patient autonomy? We think not.

We end up, not with answers, but with questions about the role of the family physician:

1. If the family physician is caring for more than one patient in a family and is aware of other family members' needs, can he ignore them?

2. The family system is recognized as a major stabilizing force in the life of family members; can the family physician ignore the power of this?

3. The impact of simply dealing with a single family member can produce dysfunctional changes in the family system as a whole. To do this would be not to do a good consequential job of decision making. Is this what should be advocated?

4. At times, such as in the case of child abuse, the rights of the person who happens to be sitting in front of you are clearly less important than the ones who are being harmed offstage. What should the role of the family physician be in situations such as these?

These are not easy issues to resolve. As Brody himself points out, ultimately one must be able to reach a decision with which one can live.

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References

1. Brody H: Ethics in family medicine: Patient autonomy and the family unit. J Fam Pract 1983; 17:973-975

2. Williamson P, McCormick T, Taylor T: Who is the patient? A family case study of a recurrent dilemma in family practice. J Fam Pract 1983; 17:1039-1043

3. Brody H: Ethical Decisions in Medicine. Boston, Little, Brown, 1978