. . . and Again

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In the accompanying editorial, Dr Smilkstein[1] argues that Family Medicine has turned its back on the family. Perhaps this is true if family care is measured by the volume of research on the subject or the biomedical focus of education. However, I cannot agree that our discipline has abandoned the family. Having just returned from Saturday rounds at the hospital, I am empirically reminded that families and the clinical practice of family medicine are inseparable companions.

Mrs Clark is a 93-year-old matriarch whose obedient "children"—four sons and one daughter, all themselves in their late 60s and early 70s—gather at their mother's bedside to quiz me about her dehydration and urosepsis. During the 10 years that I have treated Mrs Clark for GI bleeding, pneumonia, heart failure, an odontoid fracture, and diabetes, the six of us have met regularly at her side to talk about both her misfortune and her indomitable will to recover.

Mr Duncan, the son of an influential physician in town, was a new patient to me this morning when he presented with several days of the "flu." He had some abdominal tenderness and I noted melena on his rectal exam. "Oh, I forgot to mention that" was his sufficient explanation. Later, outside his hospital room, I meet Mrs Duncan, who has come to evaluate her husband's new physician. "I threatened this morning to go out and buy a fancy new black dress so I would be the best-dressed woman at his funeral," she reports. "I knew he was sick, but he never listens to me."

Mrs Santini, age 62, is dying, and not very gracefully. Her astrocytoma was discovered just 6 months ago. I began caring for her last month when she entered a nursing home, after her daughter, in exhaustion, realized she could no longer care for her at home. This hospital admission is for fever and dehydration. She refuses to drink. The three of us talk about her options—all of them bad: PEG tube, hospice, or frequent readmissions. Guilt. Tears. Fear.

Mrs Stillman is 82 years old. On her way to my office for her regular visit, her daughter's car was demolished in a head-on collision. Mrs Stillman had emergency surgery that night for a ruptured rectus, small bowel, and colon. She has done remarkably well postop. Her two daughters have been at the foot of her bed day and night, like guardian angels. We talk today about going home. The elder daughter will be taking the next month off from work to nurse Mrs Stillman back to her feisty self.

Family may be suffering from neglect in the scientific literature and the classroom, but it is alive and well in clinical practice. There is no way to escape it. There is no place to hide from it. If you care for patients, you will end up caring for their families. Ask any busy practitioner.

How does this assertion measure up against Dr Smilkstein's observations about the "dearth" of papers about family in the family medicine literature? I believe that the problem lies not with the practice of family medicine, but rather with the inexact science of families. We all come from families, yet no one understands how they operate. In particular, there are no formal tools or conceptual models that have survived the ultimate test of practicality: adoption by busy clinicians.[2] Most of our family skills are learned by trial and error. We draw on what we have seen in our professional practices and what we have learned as sons, daughters, husbands, wives, fathers and mothers.

Given the importance of families, why has there not

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been an explosion of research on this subject? Although emotionally appealing, family research is extremely complex. It is rooted in numerous competing fields, including psychology, sociology, anthropology, and psychiatry. While each of these fields can claim some success, none has demonstrated a sufficiently comprehensive approach nor developed tools that can be effectively used in clinical practice.

In addition to being complex, family research is largely unfunded. Kidneys, corneas, cancers, nurses, and alternative medicine all have neatly packaged homes at the National Institutes of Health. No one funds family research. This will likely continue to be true until a serotonin equivalent for family dysfunction is found. When family function can be explained chemically, it will be funded adequately.

Finally, I believe it is a mistake to hold family as the unassailable center of our discipline. There are times when I am at my best clinically because I have focused on family, but at other times, it is because I have attended to a patient's job stress, his wedge pressure, or his views about God. Our British equivalents still wisely and proudly refer to themselves as General Practitioners.

Because we are *family* physicians, we often assume that we have a monopoly on family. This is as absurd as assuming that cardiologists take care of all patients with heart disease or that only pediatricians care for children. Some of the real wizards of family therapy I have worked with have been surgeons who "finish their case" by going in their surgical greens to the OR waiting room to talk with three generations of a single family, all nervously waiting to hear about Grandpa's operation.

What then is the state of family in medicine? Marvel et al[3] observed 10 family physicians and found that they often addressed family issues but never in the in-depth way typically associated with formal family therapy. We learn about patients' families on the run and over time. This is an imperfect process, but who has time for genograms?

Families are important to everyone. We are therefore probably correct in assuming that the more effective physicians pay closer attention to family issues and use family interventions more often. What do they actually do? How did they learn this? Are the best teachers of family medicine our faculty, our patients, or our mothers?

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