Editorials

On Being "Pro Family" In Family Practice

What does it mean to be "pro family" in family practice? I take it as self-evident that all family physicians are, want to be, and imagine themselves to be uniquely interested in and qualified for the medical care of families. Yet I submit that in the 18-plus years since the official establishment of Family Practice as a modern specialty, our understanding of what this means has become increasingly problematic.

On one hand, there is a vocal minority, chiefly among our academicians, who believe fervently that we should expand and formalize our commitment to family systems theory and its various therapeutic applications in practice and teaching. On the other hand, there is a relatively silent and resistant majority, including most of our official bureaucracies, who seem stuck at the level of rhetoric of the Willard report,[1] which staked out our political and academic interest in the family but did not go much further.

Few will quarrel with a committee who believed "that the best medical care is provided if the patient has continuing relations with a family physician."[1(p 8)] But few can also fail to be intimidated by one who admonished us to "accept responsibility for the patient's total health care within the context of his environment, and including the community and the family or comparable social unit."[1(p 7)] The Willard Committee was big on ideals and role definition but wobbled a good deal on implementation. It took note of the mobility of the U.S. population (then, 20 percent changed residences annually) but bravely promised that "The family physician insures the ready availability of medical services, twenty-four hours a day and seven days a week, services that he [sic] either gives personally or arranges."[1(p 8)]

The Committee acknowledged that "It is not clear at this time how best to incorporate the behavioral sciences in education for family practice" but confidently affirmed that the social and behavioral sciences (sociology, social psychology, and anthropology) "should help the student acquire a holistic approach to health and disease and to recognize the interrelationships of cultural, social, psychological, and environmental factors with the psychological and biochemical processes of the body . . ." and ". . . to understand the causes and processes of family disorganization and its effects upon the family members."[1(p 27-8)]

In 1985, 16 years after its founding, the American Board of Family Practice reaffirmed the Willard Committee rhetoric in its official definition of family practice by saying, in part, "Training in Family Practice encompasses knowledge and skills which prepare the physician for a unique role as a personal physician who provides comprehensive health care to the individual and family."[2] Even this statement has more of the characteristics of a plank in a political platform than an assertion about professional competencies. It is more wish and hope than fulfillment. Like homesteaders in a nineteenth-century land rush, we seem more eager to stake our claim than to work the ground.

My hat is off to all who have tried, and still try, to teach us how to "think family," to understand family systems, and to do family work in our practices. Many of us have learned how to draw genograms, determine a family's APGAR, and use the language of dyads, triangles, enmeshment, the hidden patient scapegoating, and stages in the family life cycle. Still, in spite of all the publications, meetings, seminars, committees, and task forces, no theoretical or clinical orthodoxy about family medicine has emerged that can be incorporated readily into the day-to-day work of our residencies and practices. Much of the writing is polemical and exhortative, and the research base is remarkably thin.

We are left, it seems, in a state of confusion about what, to my mind, is the central intellectual issue in our discipline to have arisen at the academic grass roots. Put simply, does the word "family" carry any weight of cognitive meaning when used as a modifier for "medicine"? Is family as substantive as "Euclidean" attached to geometry, as descriptive as "Arabian" or "appaloosa" attached to horses, or is it more like "Republican" or "Democrat" attached to party? Is family ana-

logical or metaphorical, or does it correspond to some clinical reality? Is it merely a shibboleth, a catchword to be used propagandistically and sentimentally? There can be little doubt that the word has been cheapened by commercialization when connected to dentists, optometrists, chiropractors, podiatrists, pharmacies, "doc-in-the-box clinics," hair dressers, and even railroads; nevertheless, it is too important to be abandoned to those who, to borrow a phrase from Carl Sandburg, have "violated and smutted it."

Part of the answer to these questions is that we have fallen into the ditch on each side of the "royal road" of family-centered medicine. We have claimed both too much and too little; we have been, at the same time, myopic and farsighted. Mostly, though, we simply have been naive. "Family" has turned out to be a tougher and more complex subject than we supposed. It has dulled the swords of generations of social scientists, historians, economists, and politicians, and it continues to be denser and more durable than its experts have understood. Small wonder that family physicians, in our turn, should have been first charmed then frustrated by the ideals of family medical care.

For my part, I am willing, even eager, to see the debate about family-systems medicine go on, expand, and work itself out according to the rules of the academic and professional arenas. It is a legitimate and important controversy that ought to be settled by evidence and persuasion, not by committees, boards, or organizations taking votes and making authoritarian pronouncements. But there is something presumptuous, even absurd, in supposing that the health and well-being of families are primarily problems for medical professionalism, or any other kind of professionalism for that matter. The entire nation has an enormous stake in what is happening to its families, and there are more important ways of being "pro family" than whether or not one practices some variety of family therapy.

The "breakdown" of the family is a "hot" issue on the nation's agenda in the 1980s, though it has been decried, bemoaned, and predicted since the 1920s. We seem poised for another round of national "blaming the victim" as our attention is focussed on single-parent families, especially among minorities, as the root cause of poverty, unemployment, and other assorted ills. David Broder, a newspaper columnist, summed it up by quoting a 1980 Kettering Foundation study about single-parent children:

> They are poor students; 40 percent are rated low-achievers. They are sick more often, absent more often, more likely to be truant, and twice as likely to drop out before graduation. At which point they are far more likely to be unemployed—perhaps unemployable. And procreating another generation like themselves.[3]

This in a nation that, in comparison to other industrialized democracies, has failed to develop social, economic, and political policies to facilitate and strengthen family life. This sad story has been told in exceptional detail by Daniel Moynihan in his 1985 Godkin Lectures, published as *Family and Nation*.[4] Moynihan also documented the "feminization" of poverty that firmly establishes women and children as the underclass in our society.

Family physicians have a special obligation to be "pro family" in this larger sense, taking pains to become well informed, resisting the blind perpetuation of "welfare myths," and using their personal and collective political influences on behalf of rational and humane family policies. We should not be sanguine about where we stand on many of these issues, giving ourselves the benefit of the doubt because we often render services to poor people.

Physicians as a whole have a very spotty record on matters of family health. Peter Gay, in the first volume of his continuing study of nineteenth-century family life,[5] documented, all too painfully, the misguided and harmful influence of physicians as "authorities" on sexual behavior, reproduction, childrearing, and the relationships between men and women. Prominent doctors opposed medical education for women and chloroform as an anesthetic during childbirth. They misunderstood the causes of high infant mortality and the characteristics of normal female sexual behavior. They carried on a ghastly campaign against masturbation for decades and supported the Comstock laws, which criminalized birth control clinics. Some of the best and most respected nineteenth-century physicians contributed no small part to the hypocrisy, prudery, and guilt that hung like a pall over many Victorian families, whose descendents we are.

Let us set our priorities straight. Let us boldly become more "pro family," perhaps attending first

to ourselves in our own family roles. Then let us support policies that support families, not only middle- and upper-class families but also family life for all our varied citizenry, especially the poor. Finally, let us seek to be therapeutic with families in our practices, using all the means at our disposal, and keep family welfare always above and beyond our professional self-interests. Only then will family practice live up to its most cherished rhetoric and gain the respect we so diligently seek.

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