

### Management Problems in Otitis Media

*To the Editor:* Dr. Legler's article on "Otitis Media" (*JABFP* 1991; 4:331-9), exhaustive as it was, missed one key point — tobacco smoke in the child's environment.

Smoke-filled rooms are considered "normal" in North Carolina. Tubes are scheduled before any attempt to isolate the kids from the cigarettes.

Perhaps this is intended under "compliance" problems, but in our part of the world, middle ear disease and smoke have not been discussed adequately.

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The above letter was referred to the author of the article in question, who offers the following reply:

*To the Editor:* I thank Dr. Levine for her pertinent addition to the ideas contained in my recent article on otitis media in children.

Parental smoking has indeed been shown to exert a detrimental effect at all levels of a child's respiratory system. Bronchitis, pneumonia, bronchiolitis, and asthma have all been found to be worsened by parental smoking.<sup>1,2</sup> Otitis media with effusion (OME) is more common in children whose parents smoke.<sup>3,4</sup> Of particular concern, children with OME are more likely to require surgical therapy for this disease if their parents smoke.<sup>5</sup> Accordingly, counseling the parents to avoid smoking during the time that their child is being observed for spontaneous resolution of an episode of OME is warranted in an effort to decrease the chance of requiring later surgical management of the OME.

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### References

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2. Weitzman M, Gortmaker S, Walker D, Sobol A. Maternal smoking and childhood asthma. *Pediatrics*. 1990; 85: 505-11.
3. Hinton A, Buckley G. Parental smoking and middle ear effusions in children. *J Laryngol Otol* 1988; 102:992-6.
4. Reed B, Lutz L. Household smoking exposure-association with middle ear effusions. *Fam Med* 1988; 20:426-30.
5. Hinton A. Surgery for otitis media with effusion in children and its relationship to parental smoking. *J Laryngol Otol* 1989; 103:559-61.

### Family Genograms

*To the Editor:* I commend Rogers and Rohrbaugh for their article "The SAGE-PAGE Trial: Do Family Genograms Make A Difference?"<sup>1</sup> Like many family physicians who have used the genogram, I continue to be convinced of its value as a diagnostic and therapeutic tool, even though supportive evidence is elusive.

The authors addressed the following questions: (1) Does doing or having a genogram available influence what a physician thinks or does; do geno-

grams make physicians more sensitive to psychosocial issues and affect the process of clinical care? (2) Does the presence of the genogram affect the physician-patient relationship or the patient's sense of rapport, satisfaction, or immediate relief? (3) Does how or by whom the genogram is constructed — patient or physician — make a difference about its impact on physicians or the physician-patient relationship?

Data on quality of family relationships were not included in the study; genograms focused on genetics (biological level), not family interaction (familial-social level). The medical records provided physicians a space 1 3/4 inches by 4 inches for the genogram.

According to the authors, the results failed to support the hypotheses of the study. Physician and patient agreement on what happened during the encounter was "surprisingly low." Physicians reported fewer "treatment procedures" took place when there was construction of a genogram; patients reported four times more often than physicians that a treatment procedure "had been performed." The authors speculate that physicians and patients thus must have different perceptions of "treatment procedures." Physicians found genograms to be more relevant when they performed them themselves. The authors observed that genograms may be of greater value in selected cases but affirmed the cost-effectiveness of routine performance of the genogram because it is neither expensive nor dangerous.

I believe that the following points are relevant to the SAGE-PAGE study: (1) The performance of the genogram can simultaneously be a diagnostic and a therapeutic intervention. (2) The performance of the genogram gathers information at several different levels; it captures genetic information (biological level) and it captures psychosocial data (familial-social level). (3) The performance of the genogram by a clinician can dramatically transform perceptions of the relationship by the two individuals involved. The impact on the relationship logically could be expected to decrease to the extent that the gathering of psychosocial data is excluded from the construction of the genogram.

Genograms have their greatest value when applied selectively. Routine use of many medical diagnostic and therapeutic tools is unjustified. The confinement of genograms to the biological level limits the information that can be gathered. The act of gathering an indicated genogram by the family physician in an interaction that includes all important psychosocial data is a most powerful diagnostic and interventional tool for physicians. (That this can be of therapeutic or even healing value is supported by the view of SAGE-PAGE patients that the genogram sessions included a "procedure.")

The study of the genogram as a diagnostic and therapeutic tool in this expanded and obviously more ambiguous sense is not easy; newer qualitative research modes may be appropriate. Hermeneutical analysis, a phenomenological research paradigm,