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.

Charlotte C. Levine, M.D.
Snead's Ferry, NC

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.[1,2] Otitis media with effusion (OME) is more common in children whose parents smoke.[3,4] Of particular concern, children with OME are more likely to require surgical therapy for this disease if their parents smoke.[5] 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.

James D. Legler, M.D.
San Antonio, TX

References

1. Committee on Environmental Hazards, American Academy of Pediatrics. Involuntary smoking — a hazard to children. Pediatrics. 1986; 77:755-8.
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?"[1] 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 genograms 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,

J Am Board Fam Pract: first published as 10.3122/jabfm.5.1.110b on 1 January 1992. Downloaded from http://www.jabfm.org/ on 16 November 2026 by guest. Protected by copyright.

drawn from anthropological field study, is especially attractive.[2] It deals with the premise that objectivity is difficult or not possible when the observer cannot be separated from the observed.

Some evidence in the SAGE-PAGE study implies that the research model used was not adequate to the task, i.e., the surprising (to the authors) disagreement on what happened during the encounter between physicians and patients and that patients were four times more likely than physicians to report that a treatment procedure had been performed during the encounter.

My own work doing genograms with medical students indicated the construction of their genogram, albeit in a less rigorous fashion than that described in the SAGE-PAGE trial, had a positive impact on their perception of the residency program to which they were applying.[3] My subjective experience was that I was able to make much more human contact with medical students than had been the case in more traditional interview styles. Additionally, I was surprised at the educational and even therapeutic impact of some of the encounters.

I trust the intuition of students of the genogram, e.g., Dr. Rogers and Dr. Rohrbaugh, for if we did not intuitively know it to be of value, it would have fallen by the wayside long ago.

John Blossom, M.D.
University of California, San Francisco

References

1. Rogers JC, Rohrbaugh M. The SAGE-PAGE trial: do family genograms make a difference? J Am Board Fam Pract 1991; 4:319-25.
2. Wilson HS, Hutchinson SA. Triangulation of qualitative methods: Heideggerian hermeneutics and grounded theory. Quant Health Res 1991; 1:263-76.
3. Blossom HJ. The personal genogram: an interview technique for selecting family practice residents. Fam Syst Med 1991; 9:151-8.

To the Editor: We found the study by Rogers and Rohrbaugh on the impact of the family genogram to be a valuable contribution in the evaluation of a tool that has been assumed to be helpful to family physicians in the care of patients and the training of residents. Their effort has strengthened the scientific aspect of family medicine by submitting a commonly used practice to the rigors of the scientific method. There are a couple of points, however, that we believe are appropriate to consider in weighing whether their study represents an adequate test of the value of the genogram in family practice.

By the nature of their study design, they were only able to measure the impact of the genogram at a single visit. In clinical practice, however, genograms are more often used as a longitudinal tool, having value beyond the visit at which the information was collected. This ongoing use of the genogram reflects the continuous nature of the family physician's relationship with patient families. In addition, by excluding new patients in their study, they may have been omitting the situation in which the genogram might have shown some impact on a single visit. It would be interesting to know whether patients who give information for a family tree on the initial visit have a more favorable impression of their physician than those patients who do not. Similarly, it may be that the family physician would realize greater value from the instrument at the original visit rather than later. The physician-subjects in the Rogers and Rohrbaugh study, for example, were already perceived by 70 percent of their patients before the study began as having asked questions about their families, possibly in taking the family and social histories. The genogram would seem to hold little additional value for them at a later point in their relationship with their patients.

Finally, we believe that one important finding reported by Rogers and Rohrbaugh deserves further consideration. They reported a significant inverse relation between completeness of the genogram and the physician's reporting of the prescribing drugs. This finding may demonstrate one positive impact of the genogram. It may have been that the physicians with more complete family information were less likely to prescribe needless or inappropriate drugs and satisfied patients in other ways, such as reassurance, education, understanding, or advice. Although alternative explanations can be offered for this significant inverse relation, it does seem to merit more attention, especially as it may relate to the value of the genogram.

Rogers and Rohrbaugh have reported on a carefully designed and executed study, which has provided a valuable service. Nonetheless we would conclude that it would be premature for the family physician to cease doing genograms.

Denis Lynch, Ph.D.
Harry Mayhew, M.D.
Toledo, OH

References

1. Rogers JC, Rohrbaugh M. The SAGE-PAGE trial: do family genograms make a difference? J Am Board Fam Pract 1991; 4:319-26.

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

To the Editor: We appreciate the comments by Drs. Blossom, Lynch, and Mayhew on the SAGE-PAGE trial. Both letters offer reasonable explanations for our negative findings. Indeed, the results *might* have been positive had we included relational data in the genograms (Blossom) or studied either initial visits or continuing doctor-patient relationships (Lynch and Mayhew). We hope these possibilities will be investigated.

It is also possible, as Lynch and Mayhew suggest, that the significant negative correlation between genogram completeness and drug prescribing might

J Am Board Fam Pract: first published as 10.3122/jabfm.5.1.110b on 1 January 1992. Downloaded from http://www.jabfm.org/ on 16 November 2026 by guest. Protected by copyright.