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Family Medicine

PRESIDENT'S COLUMN

Reimagining Family Medicine's Big Idea

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We are entering the holiday season (unless you have been in a department store or commercial pharmacy, where this started back in August or September). For many who celebrate, this means cherished time with family and friends. Advertising and popular culture convey the idea of family-centeredness at this time more than any other time of year.

It can also be a difficult time for persons and families, particularly those who have lost loved ones in the past year and may feel their absence more poignantly. This will be my family's first Thanksgiving and Christmas without my mother. My three sisters continue to inspire me and fill me with gratitude with their caring support of my father, now living alone, through their daily and unfailing acts of kindness. If you asked them, they would respond, "That's just what families do." This includes being lovingly attentive to his daily health-related needs; often advocating to, and sometimes seemingly against, his family physician's hospital-owned office practice or the insurer to get him what he needs, or as commonly dealing with what they need (this past week it was answering questions about a specialist office's billed date of service that was 3 days after my mother passed). We all know a supportive family is not available for all our patients. Do we really know, and do we encourage our learners to take the time to know the level of family support of the patient in front of them?

All of the above got me thinking about the concept of teaching about family in our specialty that we call "family medicine"—where it has been, where it is now, and perhaps where it could go with some thoughtful and intentional action. Our specialty's future, its own self-identity, its own efficacy, and its own differentiating marketability in a market-based system might depend on this.

For the remainder of this President's Column, "family" is used in a broad sense, as in this definition:

> Two or more persons related by blood, adoption, marriage, or choice and whose relationship is characterized by at least one of the following: (1) social and/or legal rights and obligations; (2) affective and emotional ties; and (3) endurance or intended endurance of the relationship.[1]

Regarding the role of the family context in care delivery, when adult patients are seen in a typical family medicine residency practice in these waning days of 2024, would they notice any difference between a group of family physicians, a group of internists, or a group of nurse practitioners delivering the care? Are we purposefully teaching this? Have we ever? Perhaps Norman Rockwell's depiction of a visit to a family doctor[2] in the 1940s is as hagiographic (and nondiverse) as his depiction of a family's Thanksgiving table.[3] Much like a Hallmark Channel holiday movie (which also seem to begin in August-September), perhaps family medicine's nostalgia for a focus on family remembers a time that never was. To better understand the historical context of the family in family medicine, I went back and read some of the early commentaries during the specialty's first decades.

The concept of a physician with family therapy skills was considered by many as one of the fundamental aspirational concepts of a new type of physician in our early years. "Family" was not chosen as part of the new specialty's name only to signal caring for both adults and children who lived under one roof. One early example from 1974 was Gayle Stephens' writing:

> The issue is not whether the theory and practice of family therapy should be an important component of the education of the family physician, but whether (their) education should be limited to that.[4]

Yet, a year earlier, a different commentator wrote:

> Where is the Family in Family Medicine?... Exploring many programs where family medicine is said to be taught and applied, we find that its essential subject matter, the family, is conspicuously absent... the

> individual, abstracted from his or her life-sustaining contexts, is still the significant and nearly exclusive unit of attention, and that families, or in the broader sense, groups of intimates and small human ecosystems, have virtually been ignored.[5]

The family medicine education literature of the 1970s and 1980s had much discussion of how to train family physicians with added skill sets in working with families compared with other primary care physicians and our general practitioner past. John Geyman in 1978 proposed viewing the family as the object of care[6] in addition to care of the individual, stating "both approaches are required for family medicine to realize its potential in the ongoing care of families." He discussed a "family life cycle with predictable crises" to assist with anticipatory guidance and problem solving as did Jack Medalie a year later.[7] Janet Christie-Seely in 1981 outlined five principles useful in teaching family system concepts including "the natural role of the family physician as first-line family advisor."[8] Thomas Schwenk wrote about family therapy skills for the family physician.[9] Gabriel Smilkstein proposed utilizing a family APGAR,[10] a 5-scaled item questionnaire that measured five areas of family function: adaptation, partnership, growth, affection, and resolve. William Doherty and Macaran Baird in 1983 wrote an entire textbook on family therapy and family medicine.[11] Susan McDaniel and colleagues in 1990 wrote a textbook on family-oriented primary care, stating: "Without considering the patient in his or her family context, the physician may inadvertently eliminate not only a wider understanding of illness, but a broader range of solutions as well."[12] M. Kim Marvel and colleagues provided a model for describing five levels of physician involvement that can be reliably measured.[13] As we continue advancing competency-based medical education in our programs, utilizing these frameworks (or adapting them) may be quite useful.

In 1989 the STFM Task Force on the Family in Family Medicine published a 190-page document[14] that included forewords from the chairs of the task force from 1981-1989 (Roy Gerard, Jack Medalie, and Macaran Baird). For anyone desiring to know in greater detail the long-standing tension and debate within the discipline about the role of the family in family medicine and how it was being taught in residency programs of the 1980s, this is well worth reading. Teaching methods integrating family included didactics and case conferences, video reviews, the genogram (which still has never recovered from the graphical limitations of electronic health records), family instruments, family systems studies, chart review, and retreats. There was some optimism that the specialty would continue to grow in integrating family as a unique niche differentiating us from others in primary care. As was stated in this report,

> as a medical discipline, family medicine can now demonstrate an expanding literature integrating family systems theory and medical practice, an array of family social science and family therapy professionals with whom we collaborate for teaching, research, and patient care, and widespread attempts to integrate family issues into our training programs. No other medical specialty has demonstrated this interest in the family and related contextual issues.

However, by 2008 the STFM Conference on Families and Health was experiencing limited enrollment, and the STFM Board of Directors subsequently asked the Group on the Family and the separate Group on Behavioral Science to define a new direction to advance family systems and behavioral science in the discipline with a focus on collaborative care. The last STFM Conference on Families and Health occurred in 2009 with a desire to welcome this subcommunity into the larger behavioral health community and to develop new initiatives together. This has had only mixed success in highlighting the role of the family physician in family systems-oriented practice.

Proponents of teaching family-centered care do have some graduate medical education regulatory support. The 2023 Accreditation Council for Graduate Medical Education Program Requirements for Family Medicine explicitly require that residents are able to provide family-centered care and specifically require that they can

> demonstrate competence to independently integrate the family medicine approach to patients of all ages and life stages including ...understanding family dynamics, ... and family influences on the health of patients... identify and address significant life transitions ...for patients' families... and address suffering in all its dimensions for patients and patients' families (Core).[15]

It is not clear based on the family medicine education literature whether this is actually occurring on anything more than a superficial level in most programs. There does not seem to be widespread emphasis on how to assess these competencies. It seems the field currently addresses these program requirements incidentally through generalized, global assessments of resident communication skills without specific and robust curricular attention to family assessment and effective family physician interventions.

To this point, a 2014 national study of family medicine program directors, chief residents, and behavioral science faculty showed that 47%-66% believed integrating family concepts and skills into family medicine training "is very important," but only 19%-23% believed their own programs placed this level of importance on this curricular area, with less weight given to family topics when compared with other behavioral science subjects.[16] It is unlikely that intentionally teaching the family in family medicine has improved in the past decade.

There is good work being done in this space that can inspire and inform others to better train residents in family systems and family-oriented care. In a 2024 study in this journal, Rebekah Schiefer and colleagues found that graduates who completed a family systems curriculum in postgraduate year 3 liked the curriculum, felt it helped them in their care of patients, and notably, 83% felt that it helped them maintain empathy.[17] An earlier paper by this same author also noted improvement in empathy and rapport-building, but also noted evaluation is challenging and qualitative analysis of narrative reflection demonstrated value not captured by quantitative assessment tools.[18] Schiefer also provided in 2017 an excellent summary of the historical context of family systems training in family medicine.[19] A different residency program implemented a Family-Centered Observation Form (FCOF) in direct observation pre and post a 20-week psychosocial medicine curriculum, showing an increase in family-oriented attitudes and skills.[20] For those interested in collaborating to enhance and research family systems education in family medicine training, STFM's Family and Behavioral Health Collaborative[21] is a good starting point and networking opportunity.

One specific area of curricular opportunity is teaching how to interact with patients' family members during the office visit, including assessing family dynamics. These informal assessments are covered in a useful *American Family Physician* article.[22] Also, although most would agree the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule enacted in 2002 has been a good regulation overall, perhaps an unintended consequence has been an overreaction in the minds of some clinicians to not discuss anything going on in the family with their patients. Educating students and residents on not only what HIPPA is but as importantly what it is not, as it relates to discussing the family, could be helpful.

What about community medicine's role in this? The family has been described as a social determinant of health.[23] There is a growing appreciation in public health circles[24,25] that the family unit may be an overlooked facilitator of health-promoting or preventive medicine activities rather than putting all efforts into only community-level approaches. Families differ widely within the same community; approaches utilizing these differences could yield better health outcomes. This sensibility could inform our community medicine curricula as well—specifically how families are supported and how they can best support individuals.

After 55 years, we remain in an unresolved existential crisis of identity as a specialty. Better integrating family-centered skills into family medicine training and practice is a worthwhile aim that can help resolve this issue. The family has changed and become less visible in our practices and training programs. Yet the family is always present in the psyches of the individual patients we see, whether living in the same household or not, or even living or not. How we are different and need to be different as the primary advocates for relationship-based medicine is worth openly discussing. Reorienting to the family in our own educational house may be a good place to start.

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