The general practitioner as family doctor

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THE problem of finding and defining the ethos of general practice is not solved by giving a new name to the discipline. The search for a new name is rather a symptom of the uneasiness that general practitioners experience when they come to look for what is special or separate in their department of medical practice. One name in particular has gained currency—'the family doctor'. The purpose of this paper is to report some measurements of the extent of family relationships within his practice which the writer was able to make, and to explore some of the layers of ambiguity contained in the term 'family doctor'.

The family and the doctor

Professor Titmus[1] points out that, "In the past, 'family doctoring' only existed for a small section of the population, chiefly the inhabitants of relatively isolated rural areas and middle and upper middle-class patients". Among the historical causes of this division of medical care he lists the restriction from 1912 to 1948 of medical benefits under National Health Insurance to insured workers, the growth of specialized public health services based on personal categories (expectant and nursing mothers, school-children and so on) and disease categories (tuberculosis, mental illness and so on). It would seem, therefore, that general practice in this country has no strong tradition of family doctoring, which is rather a projection of the wishes of both doctors and patients on to medical history.

If tradition is against the rôle of the family doctor, so is the present day fragmentation of medical practice. Not only are doctors specializing in particular disease groups, but in the care of particular age groups and of patients who are grouped by their rôles (for example in industry, the universities and the armed forces). Against the grain of this fashion in medical care the general practitioner not only seeks to foster the holistic approach to the illness of the individual patient but to extend the purview of this approach beyond the individual to his family unit.

PART I

THE EXTENT OF FAMILY RELATIONSHIPS

1. *Defining the family*

Whatever academic definitions of family the sociologists may use, the doctor will regard the family unit strictly in terms of how the structure affects the illness situation that he is studying. The haematologist concerned with a case of haemophilia will be concerned with certain pathways through the genealogical tree of the patient's mother; the dermatologist treating a patient with scabies will look for a partner in the patient's bed, and the medical officer of health investigating diarrhoea and vomiting will look for a group who share the same board. In the nature of things, general practitioners are interested in all these relationships. From the practical point of view there is no need for him to define exactly what he means by the 'family', but if he is to systematize his observations by setting up a family index of the practice he must choose an arbitrary definition. The family index of the Edinburgh University Department of General

Practice is based on household rather than surname because this method happened to suit the social conditions of the Edinburgh practice best. The North Midland Faculty of the Royal College of General Practitioners[2] rejected the Edinburgh definition based on front doors, and chose their own based on the kitchen; a household was defined as "all those occupants of a dwelling who keep house as one unit". Kuenssberg and Sklaroff[3] developed the 'F' Book in which the family unit is composed of all the individuals with the same surname who live in the same household. All relationships, using the 'wife' as the key figure, are shown and each 'household' is cross-referenced with all other related 'households' in the practice.

As part of a study of contact behaviour[4] an 'F' Book was set up in my own practice early in 1964. The data which form the basis of this present study was, in fact, collected as a by-product of this survey and their collection were not originally organized to measure the total pattern of relationships within one general practice. The information which is available is accordingly limited and fragmentary but reflects the extent to which a general practitioner can become aware of the patterns of family relationships within his practice.

2. *The selection of material*

The practice is run by two partners, the writer and a woman doctor, in a residential district of a small town in south-east Essex. One of the first difficulties in measuring family relationships in a general practice is that practices themselves are not constants. Singlehanded doctors may amalgamate to form a partnership or partnerships may split up to form separate practices. Our own practice is one of four partnerships in the centre of the town which are directly descended, as a result of a series of fissions and fusions, from two two-doctor partnerships which existed prior to the First World War. We soon discovered, when we set up our family register, that there was a considerable richness of inter-related families and that inevitably many siblings and husbands and wives, especially of the older generation, tended to be split between the various partnerships in the town. It will be quite clear that there must be deficiencies in the cross-references which we have; however, the existence of family relationships is only useful to the doctor insofar as they are known to him. Since the purpose of the original survey was to study the intra-family patterns of morbidity and doctor contact, it became essential to abstract from the practice population as a whole, sub-groups which could be specially examined. The most obvious place to start seemed to be the nuclear family. Ronald Fletcher[5] describes this as being "of long duration since it is founded at an early age, small in size, separately housed, economically self providing . . . centrally and very responsibly concerned with the care and upbringing of children". This group (called the P Group) is defined as a nuclear family composed of either a mother or both parents, and at least one child under the age of fourteen. P Group 1 refers to nuclear families where the father is 'absent' from the list (and this includes a few families where the father is either dead or living apart), and P Group 2 to nuclear families with both parents present.

The family, like the individual, is in a state of flux. A young man and woman marry, produce children, the children grow up and eventually they leave the home and form new family units of their own. By selecting one group (the P Group) it is possible, as it were, to obtain a panoramic still photograph from the fast moving film of changing family patterns that the doctor sees in his daily practice.

The P Group provides a point of reference from which can be measured for each family unit how many members of the extended family are known to attend the same practice for their primary medical care.

3. *Dimensions of family-doctoring*

For the purposes of this survey the 'practice population' is defined as the static

population for the year 1 April 1965 to 31 March 1966—that is, those patients who were present on the practice list at the beginning and at the end of that period.

Table I shows that about half the practice population consists of P Groups. In approximately one third of these the husband is 'absent'—*i.e.* he is not present on the practice list. Backett *et al.*[6], reporting on a singlehanded urban practice in 1950, noted that in approximately two fifths of nuclear families the father was 'absent', while in Kuenssberg's practice, which consists largely of new housing estates, the husband is 'absent' in only one fifth of the nuclear families registered.

In the three years following the end of the survey year, only 24 of the 160 'absent' husbands in P Group 1 transferred to the practice list. The presence of so many 'split' families presents a challenge to our theorizing. Since both doctors and patients are presumed to want a family doctor, we need to know why a third of our nuclear families prefer to look to two separate practices for their 'family medical care'.

TABLE I

NUCLEAR FAMILIES PRESENT ON THE PRACTICE LIST FOR THE WHOLE OF THE OBSERVATION YEAR. (The total 'static' practice population for this year was 4,067.)

	P Group 1	*P Group 2*	*P Groups 1 and 2*
No. of units	160	363	523
No. of individuals	471	1544	2015

TABLE II

DISTRIBUTION OF P GROUPS BY NUMBER OF CHILDREN

No. of children in family	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*14*
P Group 1	62	64	22	8	3	0	0	1	0	0
P Group 2	91	158	78	23	7	2	1	1	1	1
Total P Groups 1 and 2..	153	222	100	31	10	2	1	2	1	1

Table II which shows the distribution of family size in both groups of nuclear families, shows a highly significant proportion of one child families in P Group 1 ($\chi^2=10.043$, $P<0.001$). This might suggest that following the birth of the first child a large number of young husbands, because they now regard themselves as having founded a family, change to their wife's doctor in order to have a 'family doctor'.

The table shows further that although the difference in the proportion of two children families in both groups is not significant, there is a significantly higher proportion of three children families in P Group 2 ($\chi^2=4.299$, $P<0.02$).

The range of years of birth of P Group 1 wives (1913 to 1948) and of P Group 2 wives (1908 to 1947) certainly gives scant weight to the idea that there is simply a time lag before a husband joins his wife's doctor.

Housing, or more precisely re-housing, must be an important factor. The two-fold difference in the proportion of 'absent' husbands reported by Backett and Kuenssberg respectively, may be explained by the fact that the practice investigated by Backett is described as a relatively poor urban area where much of the housing is scheduled for demolition, whereas that of Kuenssberg largely serves a new housing estate. It seems likely that when nuclear families are rehoused and have to change doctor, a majority re-register as a whole family unit.

The number of P Groups who are known to have relatives of either the husband or the wife, or both, on the practice list, is shown in table III. Although, as would be expected, there is a very high proportion of relationships through the wife, as opposed

to the husband, in P Group 1, it is interesting that in 11 of these families, although the husband has close relatives who are registered with the practice, he himself is not. The figures for P Group 2 show a fairly equal distribution of relationships through both the husband and the wife, suggesting that there is no particular descent of medical care through either parent. These figures would support what Ann Cartwright[7] found that, "It does not seem that the tie between mothers and daughters stressed by Young and Wilmot (*Family and kinship in East London*) influences married women to stay with the doctor of their family of origin any more than it does married men".

TABLE III

DISTRIBUTION OF NUCLEAR FAMILIES BY PRESENCE ON THE PRACTICE LIST OF RELATIVES OF EITHER PARENT

	P Group 1	*P Group 2*
Wife has at least one relative	64	76
Husband has at least one relative	8	70
Both have at least one relative	3	24
Neither has any known relative	85	193

Table III throws further light, however, on the composition of the P Group 1. As would be expected, there are comparatively few relationships shown through the 'absent' husband in P Group 1—since the relationships of these P Group 1 husbands must be underscored, no conclusions should be drawn from them. In comparing the ratios of families with relationships through the wife in P Group 1 and P Group 2, therefore, we have to subtract from the totals shown in table III those families with relationships through the husbands only. The ratios of families with relationships with the wife in P Group 1 and P Group 2 is therefore $\frac{67}{152}$ to $\frac{100}{293}$ so that we see a significantly higher proportion of P Group 1 wives with relatives on the practice list than P Group 2 wives ($\chi^2=4.226$ $P<0.02$).

Table IV gives the distribution of nuclear families by the number of their relatives known to be registered with the practice. In both P Groups 1 and 2 approximately half of the nuclear families have no other relatives known to be registered in the practice. These may be migrant families, they may be families who have a need to separate themselves from the family doctors of their families of origin, or they may simply be people whose family connections are not very strong and have therefore not reported to us the relationships within the practice that actually exist.

TABLE IV

THE DISTRIBUTION OF NUCLEAR FAMILIES BY THE NUMBER OF KNOWN RELATIVES ON THE PRACTICE LIST

Relationships with other patients	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*	*16*
P Group 1 ..	85	14	15	12	6	4	2	5	2	2	4	2	2	1	1	2	1
P Group 2 ..	193	37	30	16	14	18	14	14	5	3	6	2	3	3	4	1	0
P Groups 1 & 2	278	51	45	28	20	22	16	19	7	5	10	4	5	4	5	3	1

(i.e. 278 families have no other known relatives in the practice, 51 families have one other relative and so on.)

Table V shows the distribution of relatives of the P Group, known to be registered with the practice, taken as far as the great grandparents and first cousins once removed of the P Group children. It is noticeable that in P Group 2 the wife's mother and father

is 'present' in almost exactly the same number as the mother and father of the husband. For this group therefore, these figures again support Ann Cartwright's findings.

TABLE V
DISTRIBUTION OF KNOWN RELATIVES OF BOTH P GROUPS

	P Group 1	*P Group 2*		*P Group 1*	*P Group 2*
Children unmarried ..	311	818	Husband's mother ..	7	65
Daughters—married ..	1	15	Husband's father.. ..	2	39
Daughter's spouse ..	0	8	Husband's siblings ..	8	80
Sons—married	0	9	Husband's sibling's spouse	5	41
Son's spouse	0	5	Husband's sibling's children..	20	92
Grandchildren	4	18	Husband's grandfather ..	0	2
Wife's mother	60	68	Husband's grandmother	1	2
Wife's father	25	41	Husband's parents' siblings	3	9
Wife's siblings	76	97	Husband's parents' sibling's spouse ..	2	5
Wife's sibling's spouse ..	29	51	Husband's parents' sibling's children ..	4	12
Wife's sibling's children ..	66	103			
Wife's grandfather ..	0	0			
Wife's grandmother ..	2	8			
Wife's parents' siblings ..	14	26			
Wife's parents' sibling's spouse	10	9	Total	680	1641
Wife's parents' sibling's children..	30	18			

However, if we compare the ratio of wife's mother in P Group 1 $\frac{60}{160}$ and P Group 2 $\frac{68}{363}$, there is a highly significant increase in the proportionate 'presence' of the wife's mother in P Group 1 ($\chi^2=21.2$ $P<0.001$).

One is tempted to look for psychological explanations for the 'absent' husbands, and indeed Michael Balint has suggested that this division of medical care within the family should always be regarded as a *possible* sign of other deep divisions within the family unit. Conclusions cannot be firmly drawn, but the suspicion remains from the figures presented here, that P Group 1 has a somewhat matriarchal structure, and that the 'absence' of the husband from a matriarchal family's doctor is a kind of defence by the man against a complete takeover by the women in his family. It would certainly seem worthwhile to compare the epidemiology of ill health in these sub-groups.

PART II

THE MEANING OF FAMILY MEDICINE

Ann Cartwright points out that one of the difficulties in assessing the importance of family medical care is its elusive character. Perhaps the problem is that the simple term 'family doctor' contains a complex of subsumed notions which require individual examination.

1. *The family as a pattern of diatheses*

Nora B, a 17-year-old girl, presented with a history of recurrent pains in the right iliac fossa. The symptoms had lasted for some weeks, there was no nausea or vomiting, and physical examination revealed no abnormality. The consultant surgeon who saw

her wrote, "I agree that this may be recurrent appendicitis but I feel she should have an IVP to exclude any right renal pathology . . .", and later when both IVP and RGP proved negative, "I will . . . consider interval appendicectomy if further pain occurs".

Figure I shows Nora's family history as far as it is known to her own doctor. This is a three-generation family, and typically the family tree within the practice is very far from complete. The information contained in figure I is by no means a full record of all the pathology of the individuals represented, but it records the major observations contained in the existing medical record envelopes, the majority of which date back with varying degrees of accuracy to about 1950. Whatever the theoretical background of family patterns of illness may be—whether we talk in terms of chromosomes or learning theory or psychoanalysis—we should ask ourselves as general practitioners, "What do we need to know about the family history?" Perhaps, even more pertinent, we should ask, "To what use can we put this information?"

There are various ways of looking at Nora's family history. The diagnosis of ureteric colic in her mother Dora is made firmly in the hospital notes of the time, although the results of the IVP were inconclusive. One could therefore advance the theory that her grandmother Mary had many years of abdominal pain due to an undiagnosed renal lesion, that her mother suffered similarly, that an aunt suffers from recurrent cystitis and that there is a family pattern of renal disease which is genetically determined.

It could also be said that Nora's grandmother, her mother, and two of her mother's sisters (at least) suffered over long periods from recurrent bouts of abdominal pain, none of which were ever ascribed to a particular pathological process, and that two first cousins had appendicectomies without any clear evidence that they were in fact suffering from acute appendicitis. A theory could be put forward that children learn from their parents, in their first matrix of illness, how to be ill; in other words we could say that this family tends to express its illness experience as abdominal pain.

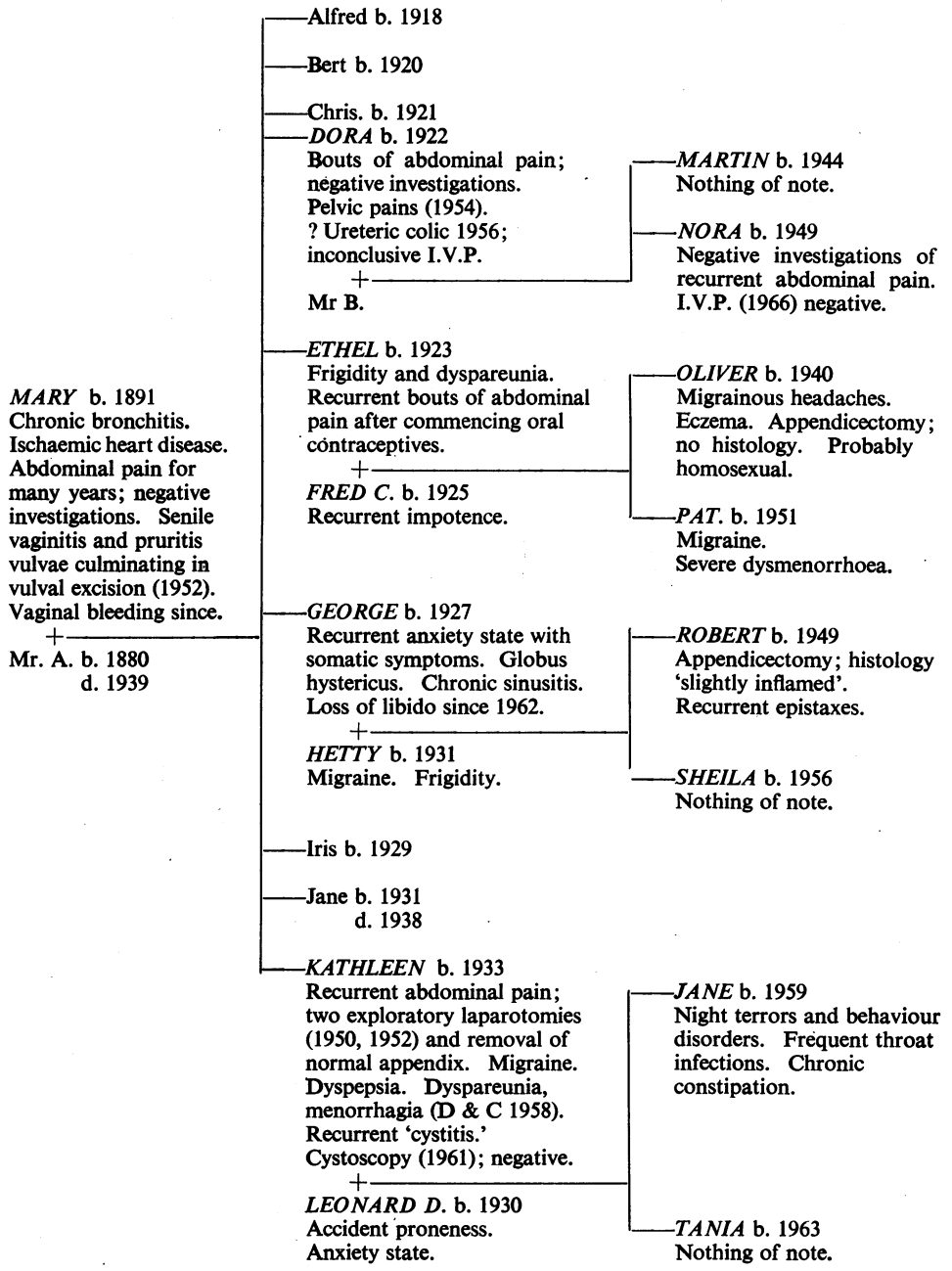
Thirdly, we can say that although there is not much information about grandmother Mary's history as a young woman, she was ill for years with lower abdominal pains, and she suffered from pruritus vulvae to such an extent that she needed to have a vulval excision. Of the four of her children who continued to be patients of the practice, three are known to have made marriages which exhibit major sexual difficulties. The theory could be advanced that Nora's abdominal pain represents the anxieties of a teenage girl about her body whose sexual identity, in terms of the family history, can only be expressed in pain and unhappiness.

2. *The family tradition*

As the general practitioner becomes acquainted in depth with his families of patients, he comes to see how each has a unique family tradition, a family culture which seems to influence not only the attitudes of the members of the family to illness, but also the nature of the illnesses themselves. An understanding of this tradition can not only lend depth and colour to the doctor's diagnosis, but can give him, as it were, certain map references to guide his therapeutic endeavours.

In the case of Pat C the gynaecologist may understandably elect to do a dilatation and curettage in view of the severity and persistence of the dysmenorrhoea; only the general practitioner is in a position to see clearly the dangers and the inappropriateness of this sort of move.

Kathleen D was five years old when her sister Jane died. Both children crossed the road in front of an on-coming car, and, as Kathleen remembers it, her sister pushed her forward and died saving her life. The father Mr A, died a year later from carcinoma and it is part of the family tradition that the growth started when he saw the body of his



(Patients on practice list shown in italic capitals)

Figure 1. Tradition of illness in 16 related patients.

favourite child lying in the road. Kathleen named her first daughter after her dead sister.

In 1964, Mrs D had brought Jane to see me on 17 occasions. This piece of family history came to light when I turned from the symptomatic treatment of Jane's catarrh and constipation and talked to Mrs D about her anxieties as a mother. As a result, all sorts of mysteries began to make sense; the anxiety about Jane's health was explained, the feelings of guilt that caused Kathleen, although her cottage was far smaller than those of her siblings, to provide a home for her cantankerous and punishing mother, Mary A.

3. *The family as a pathological state*

The study of the families of schizophrenic patients reveals a typical constellation of dominating mother and weak distant father. Peter Lomas[8] describes, "The alienated family . . . [which] avoids penetration from the outer world, wrapping itself in secrecy and mystification". It is not only among the schizophrenics and the homosexuals in his practice that the general practitioner is confronted by patients whose experience of family life is clearly making them ill.

Mr E is 48 years old and has been wearing a lumbar support for ten years. He attends the surgery frequently with exacerbations of his 'disc' with various aches and pains and feelings of depression. Mrs E is a year older than her husband and has been having treatment for dyspepsia for at least 18 years. Eighteen years ago she had an appendicectomy as a last ditch effort to make a surgical response to her abdominal pains. Since then, numerous investigations of the gastro-intestinal tract have proved negative until, more recently, she developed menorrhagia which culminated in a hysterectomy a year ago. There is one child, a daughter, born in the year of the marriage.

The couple had been childhood sweethearts. In 1940 Mrs E had married a sailor while Mr E was a POW. The sailor soon ran off with another woman and after the war, when Mr E returned, the two were married. A child was born but sexual contact between them was infrequent and soon petered out. Mrs E could never really live in her body as a woman and the medical history culminating in the hysterectomy states more eloquently than any psychiatric formulation, the nature of her problems. Mr E who saw his docker father as an aggressive, domineering drunkard, could never really stand up to his father in childhood and perhaps now feels that he needs a lumbar support in order to stand up to the rest of the world.

Their 21-year-old daughter married two years ago. She had already had a dilatation and curettage for irregular menstrual bleeding and is now acutely depressed over her failure to become pregnant.

What the general practitioner as family doctor sees is the unity of family pathology. Seen as separate entities, as the gynaecologist, the general surgeon and the orthopaedic surgeon must see them, the illnesses which the three members of this family have experienced are rather puzzling. Years of abdominal pains in Mrs E's adolescence and young womanhood culminate in an appendicectomy—for what seems to be no very good reason. Far from ceasing, the pains become worse and are punctuated by a series of repeated investigations. The abdominal pain eventually gives way to menorrhagia and this in turn is terminated by hysterectomy; the pathologist reports the presence of a few small fibroids. With hindsight now, not only can the general practitioner see how the appendicectomy adumbrated the hysterectomy that occurred 16 years later, but he is able to see, in terms of the family's 'tradition', how the daughter's dilatation and curettage and her present depression are part of the same family experience of illness which produced her mother's two surgical crises, and perhaps her father's need to wear a lumbar support.

The perspective of family medicine allows the doctor, as it were, to see super-

imposed upon the individual patient's experience of illness, the illnesses of the patient's parents and the patient's children. If we have not yet been able to submit the patterns of family morbidity to the same kind of reproducible formulations that we can apply to morbid anatomy and histology, it is only because we are still groping for the language with which to express these aspects of illness and because we do not yet know the spatial and temporal framework in which we must make our measurements.

What *is* remarkably reproducible is the pattern of family unhappiness. The failure to communicate, the failure to show love, the failure to make the child secure and to allow the adolescent to achieve independence, these are the basic pathological changes of the unhappy family. In *Anna Karenina*, Leo Tolstoy says, "All happy families resemble each other, each unhappy family is unhappy in its own way". The experience of general practice suggests that Tolstoy was wrong. Family happiness is an individual and idiosyncratic part of each family's culture. There is, in contrast, a terrible sameness about the pathology of unhappy family life.

4. *The family as the patient*

R. D. Laing's[9] study of the families of schizophrenics suggested that the psychopathology of schizophrenia was a family experience and the schizophrenic patient, that member of the family who was chosen to be mad. Again, in general practice, the doctor is aware of this double meaning (personal and family) in the general illness situations that he sees. When Mrs D brought Jane in to see me because of her chronic constipation, although I had to deal with the mass of faeces in the rectum because this was the immediate problem, it was quite clear between the mother and myself that Jane's refusal to go to the lavatory was, so to speak, a variation on the theme of her mother's abdominal pain and dyspareunia. When Mrs D brought Jane to see me because of her night terrors, it was also not hard to see how the child's sleeplessness either kept Kathleen out of the connubial bed or precipitated Jane into it—both excellent devices for avoiding painful intercourse.

It is tempting from this kind of example to talk about the whole family as though it were a composite patient, and as though its individual illnesses need only be seen as symptoms of some unit of family pathology. It is true that while the child remains very young the doctor is able to treat the mother and child as a kind of unit, as in the case of Kathleen and Jane D. But Nora B, whose abdominal pain can now be seen in terms of the tradition of abdominal pain which her mother Dora and her grandmother Mary both experienced, and Pat C, whose severe dysmenorrhoea has a similar background in the family culture, must both be treated as individuals. The basis of medical practice is a relationship between patient and doctor. It is, as we have seen, imperative for the general practitioner to see the individual and his illness in the context of the family tradition. Uniquely, he is privileged to experience something of the family's inner world. That experience is no less important to him in the practice of medicine than the possession of the senses of sight, touch and sound. The illnesses, for example, of Dora and Nora B, of Ethel and Pat C, of George A and Kathleen D, make a cohesive sense, but only if they are seen as part of the same pathology that floods the whole life of this family no less completely than any other disease process which has been shown to have a family pattern, like asthma or diabetes or tuberculosis. There is, however, no short descriptive label for this kind of illness.

Discussion

Even the fragmentary measurements, made from the standpoint of the nuclear family, presented in Part I of this paper, suggest that the general practitioner has an enormous amount of family material available to him. I have tried to demonstrate in Part II how this material can sharpen the doctor's focus on the patient, so as to make

comprehensible, isolated experiences of disease which, seen out of the context of the family tradition, might otherwise seem meaningless.

In summarizing family histories, Kuenssberg and Sklaroff quite understandably opted for 'hard' data. "We decided to limit ourselves to the clinical conditions which produce a pathology with permanent changes, viz., mainly all chronic conditions, congenital abnormalities". As a research tool the 'F' Book is excellently fashioned to answer the question which its inventors set themselves: "Do diseases run in families?"

The fact that much of the information contained in figure 1 would not satisfy the criteria for recording in the 'F' Book, underlines again that a great deal of the real morbidity that we see has to go unrecorded because we have not yet invented a scientific language in which to make the recording.

The so called 'soft' data, the anecdotal fabric of the patient's family tradition, may be the vital key to the understanding of the patient and his illness. Any future system of recording family morbidity, not so much as a research tool than as an *aide memoire* for the doctor in his consulting room, ought to include this kind of material. The task of inventing such a system will be a formidable one, and I suspect that it will have to be preceded by a fundamental rethinking of the ways in which we talk about illness.

Summary

In Part I of the paper, the recording of nuclear families within a general practice is described, and some measurement of the size and extent of their relationship with other patients is made. In Part II, some of the ideas subsumed in the term 'family medicine' are examined, and the importance of the family's tradition of illness is discussed.

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