EDITORIAL

Return—For Good This Time—to Practicing in the Context of Families and Communities

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There are two wrenching stories in this issue of the *Annals*[1,2] that remind us why, when we family physicans are at our best, we should practice "in the context of family and community,"[3]—for as Khare knows from personal experience, "mental illness is not a patient illness but a family illness."[1]

At its inception, the discipline of family medicine was awash in considerations of the importance of the family in health and disease, and an early case was made that the family could be a primary source of health or illness.[4-10] The Society of Teachers of Family Medicine (STFM) sponsored an annual conference for 25 years called The Family in Family Medicine. Ransom developed exquisitely nuanced formulations about how the family could be regarded and approached in practice[11,12]; Medalie taught a generation of family physicians to seek and treat the hidden patient in families with chronic or catastrophic illnesses .[13] The field of medical family therapy was born, and still flourishes today.[14] Over the years, evidence has become more specific and compelling that family factors can be overwhelmingly important in health and illness.[15-17] Yet we family physicians seem to lose our way again and again, forgetting the family in the press of demands for productivity, burgeoning documentation requirements, the structured exclusion of family information in modern electronic health records, pressure to narrow the scope of practice, and individual privacy considerations. This must end.

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Kannai[2] and Khare[1] offer living examples of the pain that mental illness visits on "unaffected" family members—reminders that there are no unaffected family members. Under these conditions, of course our attention must focus on those most afflicted and symptomatic, but we must also cast our gaze on those bound to the identified patient by history, commitment, attachment, or other commonalities. Those others are the hidden patients who may be suffering outside the light of urgent clinical attention. In addition, we must remember that illness reverberates through a family for generations and that mental illness can distort normal family relationships, tax healthy coping, and evoke harmful compensatory behaviors. It can also bring out salutogenic behaviors, and a good clinician can sometimes tip the odds in favor of healthy coping.

Family medicine and primary care are in flux today, again. The news is filled with despair about ever-increasing demands on primary care without commensurate systematic support. This unsustainable situation is surrounded, however, by progress. We are better at managing chronic diseases; we have begun practicing in teams; we have more and better data with which to guide our care; we have learned to integrate behavioral health and primary care. We are also on the threshold of value-based rather than volume-based payment for health care.[18] We have begun to formulate and implement approaches to population health.[19]

The National Academy of Medicine reports that the social determinants of disease have assumed a new salience for primary care clinicians[20]:

"In an era of pronounced human migration, changing demographics, and growing financial gaps between rich and poor, a fundamental understanding of how the conditions and circumstances in which individuals and populations exist affect mental and physical health is imperative. Educating health professionals about the social determinants of health generates awareness among those professionals about the potential root causes of ill health and the importance of addressing

them in and with communities, contributing to more effective strategies for improving health and health care for underserved individuals, communities, and populations."[21]

This present-day environment is a sea-change in which a leap forward can be made by family medicine and primary care into a world of clinical practice that actually improves individual, family, and population health in an affordable way. As Dickinson reminded us in 2011,[22] there is room for the family in our medical home. It is time for family physicians and other primary care clinicians to return, for good, to care that is comprehensive, coordinated, continuous, and practiced in the context of families and communities. Only then can we serve our communities "at our best." Only then will our friends, neighbors, patients, and own families get proper care.

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