Family Orientated care in Family Medicine Education-The Isreali Experience

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The Family History has been recently rediscovered, thanks to the breakthroughs in Genetics, with scores of papers, a US National family History day and a unique website, where one can compose your genogram and use it to get advice on familial predispositions(1,2) . In Family Medicine (FM) the importance of the Family is reflected in the discipline's name. A debate on the actual implementation of a family orientation can be seen in the title: The family in family practice- is it a reality? (3) , to which Medalie et al (3) answer positively by finding that 10% of visits in FM are devoted to family issues, in 32% other family members are present and in 18% another member problems are discussed . In this sample genograms are found on 11% of charts. In the present paper the focus is on educating for such a family orientation within the FM residency program.

Family medicine training in Israel

After a seven year Medical School (inc. a year of internship) the newly registered physicians that choose to specialize in Family Medicine (FM) go into four year training. They spend a year and nine months in FM settings, nine in a tutors practice under close supervision and a final year in their own practice with mentoring. In between they will rotate for two years and three months in hospital and outpatient settings (a year in internal medicine, six months in Pediatrics, three months in Psychiatry and six months electives). During the four years they will meet once a week for a day release course where large and mostly small group instruction occurs. The residents take an MCQ knowledge test half way through the four years and a final oral examination. Within the final, a family presentation session (one out of four testing portions, 40 minutes out of 3 hours and 20 minutes testing time and 25% of the final score) is allocated to evaluating the family orientation of the examinee.

Family orientation education in one FM Israeli Department

The Rappaport Medical School of the Technion University in Haifa, Israel is one of the four medical schools in Israel. 12 departments of FM are affiliated to these four institutions and in this section the training in the Haifa one (Chair: Dr Khaled Karkabi) is described. All departments teach according to a common syllabus, but translate it into a local interpretation of the particular instruction activities.200-300 residents are in training in any point in time. 50-60 train in the Haifa Department. They are divided into four groups by their seniority. The Family is a central domain of the day release course and the instruction includes the following (All small group obligatory modules):

1. A first year introductory session.(2 hours)
2. A second year personal family presentation (12 two hours meetings)
3. A third year family issues module (12 two hours meetings)

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Table 1: Intended learning Outcomes

Knowledge(cognitive)

1. The trainee will possess sociological knowledge of definition , different present compositions and the ethnic ,religious and social multiple faces of the family in Israel
2. the trainee will know the normative and non normative development of families (the family life cycle)
3. The trainee will learn about crisis and its influence on individuals and families.
4. The trainee will be able to describe and analyze the role of the family in its members health, and the impact of disease on the family.
5. The trainee will be able to use basic techniques of family description and analysis.
6. The trainee will know the different approaches to understanding, evaluating and intervening in families.

Attitudes (affective)

1. The trainee will be aware of the triangle Doctor-patient-family in the Patient-Doctor encounter and clinical care.
2. The trainee will demonstrate his commitment to" family –thinking" in his care of patients
3. The trainee will engage empathically and with deep listening in his communication with patients and families, including discussion of emotions.
4. the family physician is going through the same steps of information gathering , diagnosis, plan of intervention (therapy) , intervention execution and finally follow-up and assessment of effect as with any clinical problem . The difference is in addressing the clinical problem(s) within a contextual view. For each portion of the clinical method the family orientation adds the respective aspects.
5. The trainee will be aware of his own family history and his place in his own family life cycle and its' influence on his doctoring
6. the trainee will demonstrate comfort in working with individuals and families in different stages of the life cycle and in different crisis situations

Skills (psychomotor)

1. The trainee will relate to and engage the patient's family in the diagnostic and therapeutic plan.
2. The trainee will demonstrate capacity to collect, describe, analyze and integrate family data in the encounter with patients and families.
3. The trainee will maintain communication with the necessary number of family members in order to enlarge understanding, diagnosis and treatment , when appropriate.(hold family conferences when appropriate)
4. The trainee will, elicit the concerns and feelings of all the family members when appropriate and necessary.
5. The trainee will be able to identify a family dysfunction that impacts on the care of the patient and will skillfully refer when necessary.
6. The trainee will use ways to intervene in crisis situations as well as mobilize support systems

The trainee will be able to undertake multiple roles in family care from case manager to team member to just "on need to know" participant.

4. A fourth year tools in Family orientation course.(12 two hours meetings)
5. Live and video enhanced personal mentoring (range 6-30 hours).

The intended Learning Outcomes for the "family "course are spelled out in the three customary categories of Knowledge, skills and attitudes (4, see table 1)

The recommended teaching methods are small group discussions, supervised reading, extended workshops, role play, supervised experiences and house calls.

The teaching team includes a Family Physician and a behavioral sciences person, who have knowledge and interest in the family – centered approach in Primary Care. (Such as a Family Therapist, Social Worker or Health Psychologist).

Features of the above-mentioned curriculum that we feel strongly about (yet, have not empirically demonstrated) are:

-Working on your own family stuff (second year) centers on assessing learners' family patterns using their genogram. The extreme variations of ethnic and family patterns in Israel (in every group Jews and Arabs are represented as well as immigrants from the former Soviet Union) are the backbone of a diversity that serves as a strength and developmental enhancer. Participants also engage with the question why did I become a physician? (Family influences?)And what do I bring to the clinical encounter from my family?

The semester long sharing fosters group bonding and a cross-cultural sensitivity that is quite unique.

Table 2: Family examination score sheet

1. The patient and family narrative (data collection)
2. Genogram ,psychofigure, life events
3. Stage in life cycle, family system, cultural influences, support system(s), psychosocial influences condition. (data analysis)
4. Diagnosis, problem list (working hypothesis)
5. Treatment plan and prognosis
6. Intervention (D&B III)
7. Evaluation of intervention
8. Theoretical background
9. Collaboration (team work, supervision, consultation, community resources)
10. Overall evaluation and self-awareness

10 points for each entry- tot: 100 points.

-A gradual introduction of constructs and tools that is elaborated upon as the group progresses from triangulation (5) to area of questioning that promote family-oriented approach in Primary Care (6)
-Combined with the third and fourth year modules the curriculum spans a spectrum of diversity and family narratives that enhances awareness and reflection. These senior years are also characterized by emphasis on longitudinal care of families.

The final family examination

The author was instrumental in drafting this syllabus, is actively teaching and chaired the re-formulation of the final examination family portion (7).This rendition is intended to normalize family orientation and facilitate its integration into the daily FM work. The family orientation is emulated on the usual clinical method of data gathering (history), examination, diagnosis, plan, intervention and evaluation /follow-up. Thus, part of information gathering will be asking about data that enable the construction of a genogram, part of diagnosis is a family diagnosis and interventions are in the sphere of facilitating family change. This is naturally manifest in the examinations' score sheet (table 2). This approach was broken in through focused workshops that span the entire examiners body and are implemented in the last 4 years already.

Assessment

Nevertheless, fundamental questions are left relatively unanswered, including:

What do the trainees transfer from the classroom to patient care in the real world? Does family teaching make a difference?
When posed with Launer's questions (Where are you on the individual-family axis? Are you using genograms? How do you do with more than one patient in your room? Would you like to expand the family dimension in your work? How? (8)) graduates of the residency program voice a perspective of difficulty in implementations (sparse use of genograms as a marker) and a gradual attrition of skills.

Conclusion

A feature of a living profession is its ability to reinvent itself and redefine its' own role according to changes in the environment. The domain of the family in FM seems to be an arena where the vitality of FM is enacted. As this paper demonstrates while a strong educational agenda exists and is taught its implementation, retention and impact remain to be documented. Thus, in Israel and elsewhere an emphasis on documentation, evaluation and constant adaption is called for. The unique opportunity of the growing interest in the family history and genograms should be seized for enhancing the cause of a family-orientation in Medicine at large.

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