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EDITORIAL

"Imagine a Clinical World Without Family Systems Thinking"

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Collaborative family health care acknowledges the importance of family and social context to yield a comprehensive understanding of health. In this editorial, we return to the concept of family systems thinking.

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Engel introduced the biopsychosocial model as an antidote to a dominant linear biomedical, disease-focused problem-solving approach. He argued that physicians should care for patients in their social context and demanded that clinicians step back from the narrowing focus on organs and cells to understand each component of life in a larger context: the person within a couple, the couple within the family, the family within the community, and the community as part of a culture (Engel, 1977). Systems theory requires that we recognize that change in any part of the system can be caused by changes elsewhere. This means that helping patients requires understanding the world in which they live.

Consider the following scenarios:

- A general internist invites an elderly woman's son into the visit to get his perspective on his mother's health and safety.
- A psychologist asks a middle-aged male patient what other people in the patient's family know about his desire to change genders.
- A licensed mental health counselor calls a patient's spouse at work to learn more about the family's eating habits and how the suggested changes to manage diabetes can fit into the family's established mealtime routines.
- A family physician ensures that a 12-year-old sibling is allowed to come to the maternity floor just after visiting hours to meet her newborn sibling, in a bending of the hospital rules.

The founders of family medicine, generalist physicians, had an intuitive understanding of systems theory and the biopsychosocial model, based on their daily work making home visits, delivering babies, managing chronic illness, and escorting patients through the end of life—all alongside family members.

There is no evidence of which we are aware that family systems thinking improves the process or the outcomes of health care for individuals or families. This is a paradox. Myriad clinical presentations demand that clinicians step away from linear problem solving and view the patient as part of a complex system.

What would it mean if we did not have this world view? Imagine a clinician in the following situations, not making an effort to learn about the patient in the context of his or her family, community, or culture.

- A child acts out a lot and has unexplained medical systems.
- A patient's glycated hemoglobin levels and her weight keep increasing despite repeated referrals to the diabetic education team.
- An elderly patient loses weight and develops bruises.

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- A patient's asthma and co-occurring anxiety gets worse despite evidence based treatments.
- A patient refuses to take medicine for high blood pressure.
- A parent repeatedly brings in a child for minor concerns.
- A dying patient is unwilling to let go of interventions, even though he acknowledges they are futile.
- A patient is repeatedly hospitalized for Crohn's disease and no one comes to visit.
- A patient resists accepting a referral for a colonoscopy.

Stop for moment and generate hypotheses for these scenarios. Are your theories absent of family system influence? We suspect not but believe that health care education has not honored the presence of this thinking.

What does it mean to use family systems thinking? Can one use family systems thinking to generate diagnostic hypotheses and not apply them in practice? Yes. We think this happens a lot because of significant barriers. Can one practice medicine without a family systems perspective? We think most clinicians possess tacit knowledge about family and contextual influences on patient health, but many do not apply these considerations in their clinical work. Is family systems a worldview or is it a treatment approach? We think it is both—but for most in health care, it is a stretch to acknowledge family thinking, let alone go the next step to designing interventions.

In Table 1 we list major barriers to using a family systems perspective in health care. We created this list after polling more than a dozen colleagues who are trained in family system thinking and clinical work and who teach physicians, behavioral health clinicians, and others about incorporating family systems approaches in practice.

A shared mental model of linear causality seduces us with its simplicity and the illusion of control. It is far easier to learn linear rubrics such as "If x, then y, and I do B to fix it" than to conceptualize a health care problem as the product of a surrounding family system. Systems thinking can be difficult to understand and conceptualize, especially for early trainees who grapple with the notion of "tell me what to do" and "tell me how not to hurt people." In many medical settings, family members are often viewed as in the way.

Most payment models reimburse for the care of a single patient at a time and do not cover the care of added family members. Typical office scheduling occurs in short preset blocks of time that do not allow the flexibility to lengthen a visit for a family consultation. The physical plant may not provide space for clinicians to comfortably meet with more than one or two people during a visit.

Although recognizing the barriers, we believe that all health care personnel should learn fam-

Table 1
Barriers to Learning and Operationalizing Family Systems Thinking

Cultural focus on linear problem solving and the single person		Problem solving seems easier	Training deficits
Charts are person focused, not family focused	Families often blame one person	Individual case conceptualizations are easier	Lack of role modeling in conceptualization and application
Billing systems and codes do not recognize family problems or treatment	Clinicians focus on one disease or person	Individual focus takes less time in day-to-day care	Clinicians do not see system thinking as problem solving and do not recognize their own capacity to think about family systems influence
Families seen as causing problems rather than as a resource	Curricula in medicine and psychology focus on one person Training focuses on skill training bypassing conceptualization	Logistically hard to convene family members	Emotionally daunting to meet with more than one person

ily systems and systemic thinking. What justifies teaching trainees to think systemically?

Consider the phenomenological evidence including your reactions to the clinical scenarios we offered above. The discipline of family medicine chose to include the word family in its name. The core Accreditation Council for Graduate Medical Education competencies of family medicine include system thinking. Of the 20 entrustable professional activities for family physicians, five directly reference family systems thinking (Society of Teachers of Family Medicine, 2017; see Table 2). Likewise, the Core Competencies for Behavioral Health Providers Working in Primary Care advocate that clinicians provide "culturally responsive, whole-person and family-oriented care . . . that includes family beliefs . . . uses the biopsychosocial model, as the intertwined biological, psychological, and social factors (social determinants of health)." (Miller et al., 2016, pp. 17–18) Imagine birth or death without concern for family involvement? If a family is supportive of behavior change in a member is that more or less predictive of change than if no family support exists? Perhaps the most potent evidence comes from the stories we read and live.

Narratives and poetry provide additional data about the importance of the family systems approach to caring. Kim Marvel, a behavioral science educator and family therapist in family medicine, recently wrote about a formative experience as a son in a family meeting regarding the care of his elderly father. In addition to his reflection that soft skills are undervalued in medical training and their acquisition difficult to measure, he described sitting in this family meeting and hearing rapidly presented clinical information from each staff member, without introductions, an agenda, or an opportunity for the family to ask questions and provide input. Marvel wrote that he eventually stepped into the facilitator role to summarize for his siblings, who were on the telephone, and to attempt to organize the presented information. In so doing, he helped his siblings better understand the salient issues regarding his father and also felt cheated of the chance to fully participate as a son in the meeting (Marvel, 2017).

Table 2
Entrustable Professional Activities for Family Physicians

Activities
Care for patients and families in multiple settings.
Develop trusting relationships and sustained partnerships with patients, families, and communities.
Use data to optimize the care of individuals, families, and populations.
In the context of culture and health beliefs of patients and families, use the best science to set mutual health goals and provide services most likely to benefit health.
Advocate for patients, families, and communities to optimize health care equity and minimize health outcome disparities.

In 55 words, Lisa Witkowski, a licensed professional counselor, shines a light on a stressful moment in primary care in which a teen and her grandmother anxiously await the results of a pregnancy test. The clinicians caring for this teen should know about the relationship between the two as well as anticipate and manage conflicts that might arise in this scenario (Witkowski, 2017).

We believe that using family systems thinking in health care exists on a continuum. At one end there is an absence of systemic awareness. The clinician thinks about and pursues a linear intervention without considering the family context: Take this pill; exercise more; decrease alcohol intake; recognize and change self-deprecating thoughts.

Some clinicians consider family systems influence on health status. "Does this patient's wife usually prepare high glycemic meals?" "How involved in child care is this child's father?" "Has this patient discussed end-of-life wishes with his family?" Some clinicians test family systems hypotheses by asking family systems questions, even if other family members are not present. "What does your wife know about the diet changes needed to manage diabetes?" "What does your family think about the connection between your drinking and your high blood pressure?"

Some clinicians design family-focused interventions. "I would like to meet your husband during our prenatal visits." "Consider discussing with your wife how you plan to change your diet." "You, your siblings, your mother, and your father might consider meeting with a palliative care team member to discuss your father's end-of-life preferences." Some clinicians recommend or practice family therapy. "I suggest that you, your husband, and your son meet

with a colleague of mine to discuss how to deal with your son's repeated school absence." "The conflict in your family may be contributing to your mother's worsening asthma. I would like to discuss this with all of you and involve a colleague of mine who knows how to help families work together."

Educators of biomedical and psychosocial clinicians have a tall order to teach family systems thinking to their trainees. Is it possible that educators steeped in family systems training might move too quickly to teach family interventions or family therapy techniques while glossing over basic concepts in family systems?

We are reminded of the seminal paper by Doherty and Baird examining developmental levels of family involvement in medical care (Doherty & Baird, 1986). Rereading this paper, we see a focus on incremental skill development. Doherty and Baird wrote the paper because they observed residents using family skills but not recognizing these actions as family focused. In their paper the development of family systems thinking is not directly addressed. How important is it for trainees to recognize their own capacity to form family systems hypotheses?

For the reasons listed above and in Table 1, we suggest educators focus on the recognition of family systems thinking that may be taken for granted by educators and their trainees. Most primary care clinicians probably think about patient problems within the family context but for important reasons may not operationalize this perspective within their practices. Help trainees see the tacit knowledge they possess from life experience. Teach basic concepts and principles (e.g., circularity, homeostasis) that can form a base for further cognitive exploration. Show trainees, through their own family experience and patient care, how a contextual understanding of a patient might make care easier, more logical, and more effective. Help trainees undo some of the hidden curriculum (Hafferty, 1998) that values linear thinking and devalues a systems approach. Help trainees learn to ask questions that test family systems hypotheses. Teach ways to incorporate questions about family context in single patient encounters. Develop tools to assess the use of family-interviewing skills, such as the Family Centered Observation Form and online training developed by Dan Felix (Felix & Mauksch, 2017). Before teaching how to incorporate family interventions, ask trainees to consider barriers to using these interventions.

Imagine a clinical world devoid of family systems thinking. We hope this reflection, and perhaps some discomfort, motivates the reader to help trainees and colleagues expand their world views. What can we do to help clinician trainees and their faculty value family systems thinking? As Kim Marvel did, reflect on your own experiences with chronic or serious illness. What supervision and precepting questions encourage family thinking in our trainees? We welcome your comments.

References

Doherty, W. J., & Baird, M. A. (1986). Developmental levels in family-centered medical care. *Family Medicine, 18,* 153–156.

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196,* 129–136. http://dx.doi.org/10.1126/science.847460

Felix, D., & Mauksch, L. (2017). *Improving family interviewing skills using the Family Centered Observation Form: An online training module for healthcare providers*. Retrieved from http://www.fcof.us

Hafferty, F. W. (1998). Beyond curriculum reform: Confronting medicine's hidden curriculum. *Academic Medicine, 73,* 403–407. http://dx.doi.org/10.1097/00001888-199804000-00013

Marvel, K. (2017). Teaching family meeting skills makes a difference. *Family Medicine, 49,* 734–735.

Miller, B., Gilchrist, E., Ross, K., Wong, S., Blount, A., & Peek, C. (2016). *Core competencies for behavioral health providers working in primary care*. Retrieved from http://farleyhealthpolicycenter.org/wp-content/uploads/2016/02/Core-Competencies-for-Behavioral-Health-Providers-Working-in-Primary-Care.pdf

Society of Teachers of Family Medicine. (2017). *Entrustable professional activities for family physicians*. Retrieved from http://www.stfm.org/NewsJournals/STFMNewsEntrustableProfessionalActivitiesforFamilyPhysicians

Witkowski, L. (2017). Two minutes. *Families, Systems, & Health, 35,* 512. http://dx.doi.org/10.1037/fsh0000286

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