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Family-Centered Health Care

John W. Saultz

Since the birth of the specialty of family practice in 1969, a recurrent topic of controversy has been the degree to which our specialty should address itself to the family as a unit of care. A tenet of family medicine has been to provide comprehensive health care to the entire family, but what is meant by the "entire family?" The majority of physicians in family practice have interpreted this phrase to mean "all of the people in a household." In 1973, Ransom and Vandervoort[1] challenged the newly born discipline of family medicine to consider the family as something greater than the sum of its parts and to recognize that the family as a social system must become an integral part of understanding the context in which an individual becomes ill. Many health care problems that are seen by a family physician can be neither understood nor successfully dealt with when considered as isolated phenomena affecting only one person.

Although family physicians interact with families every day, the extent to which a family orientation is used as the foundation of practice varies. A practicing family physician can choose the degree to which he or she will develop a family oriented practice based on his or her personal interests, training, and experience. This chapter presents an overview of family systems medicine and outlines the way in which a practicing family physician can incorporate a family orientation into clinical practice.

Developmental Levels of Involvement

Doherty and Baird[2] have outlined five developmental levels of involvement in family centered care that can be used to assess the degree of family orientation in a practice. Each level includes and adds to the skills of lower levels. The following outline of these five levels provides a standard against which the degree of emphasis on the family in a practice may be compared.

Level One: Minimal Emphasis on the Family

The physician at this level deals with families only in situations where talking with family members is a necessary part of standard medical practice. Examples include talking with family members of a patient who is being admitted to the hospital.

Level Two: Providing Ongoing Medical Information and Advice

This level requires the physician to understand the importance of the family in the health care of the individual and to communicate effectively with families to obtain and share information. At this level of involvement, the physician must possess refined listening skills to facilitate the identification of family opinions and concerns and should attempt to involve family issues when providing care to individual patients.

Level Three: Feeling and Support

This level involves an understanding of the normal development and functions of a family and a knowledge of how families react to stress. In addition, the physician must appreciate his or her own role in the system and how the presence of a physician changes the ecology of the family. This level involves skill and experience in assessing family structure and function and identifying family dysfunction to allow referral.

Level Four: Systematic Assessment and Planned Intervention

This level requires a background knowledge of family systems theory and the patterns of family dysfunction. A physician at this level is able to assess the family, identify levels of family dysfunction, and refer families whose dysfunctions are beyond the skill of primary care treatment. A physician at this level also is comfortable with short-term counseling and organizing family conferences to address and work through minor family problems.

Level Five: Family Therapy

At this level, a physician is capable of assessing and defining major family dysfunction and planning an organized therapeutic approach to promote major change in the family system.

These five levels of involvement with family systems medicine clearly emphasize the variability in the degree of family orientation among practices. Today, family practice residencies are beginning to place increased emphasis on family systems in the residency curriculum to provide graduating residents with skills and experience necessary to communicate with families and identify family dysfunction.

Overview of Family Systems Medicine

A *system* has been defined as "elements in a patterned relation to each other."[3] This concept is not new to physicians who are accustomed to learning anatomy and physiology organized into body systems. When evaluating a patient with leg edema, a physician is accustomed to considering the cardiovascular system (heart failure) and the renal system (nephrotic syndrome) as possible contexts in which to understand and treat the problem. Family systems medicine simply extends this idea of interconnected contexts to systems that are larger than the individual. A patient who comes to the physician's office with a tension headache cannot be fully understood by considering only the pathophysiology of headache. Better understanding and, therefore, better health care result if family relationships (family system), socioeconomic and employment history (social system), and religious and cultural beliefs (cultural system) are also considered.

Medical students traditionally have been taught to obtain a family and social history when evaluating a patient, but little has been done to teach them how to use this information. Therefore, these skills often atrophy by the time a physician enters practice. Problems that are presented to a family physician are usually undifferentiated. A practicing family doctor must view the patient's problem in multiple contexts if efficient and timely health care is to be provided. Herein lies the central concept of family systems medicine. Consideration of these multiple levels of data do not represent an either/or phenomenon. Many problems seen by a family physician cannot be understood within the biomedical or pathophysiological model of illness, and problems that can be understood within the biomedical model invariably have impact on and are related to factors in the psychological, family, social, and cultural systems. Each system contributes to a better understanding of the patient and, therefore, to better health care.

The following patient encounter may serve to illustrate this concept:

A 16-year-old male is brought to the family physician's office by his mother, who requests that the physician order an x-ray examination of the young man's leg. While the patient sits quietly in a chair, his mother explains that he was struck in the thigh at football practice 2 days ago and since that time has frequently complained of pain in the leg. She relates that this pain has prevented him from performing several of his usual tasks around the house and that she wants the matter resolved once and for all as to whether the leg was seriously injured or not. She quite adamantly insists on an x-ray being taken to rule out fracture of the femur. In questioning her son, the physician learns that the young man has very little to say concerning his leg pain and indicates in short sentences that his leg is okay and that this is all silly. Physical examination of the leg reveals that the young man walks normally without a limp. There is no evidence of any ecchymoses or induration of the thigh. There is no tenderness on palpation. The physician's clinical assessment is that the leg appears to be normal. Two issues immediately face the physician in this case:

1. It is unlikely that there is any serious injury to this young man's leg, and an x-ray examination does not seem indicated. The pathophysiological model seems inadequate to understand what is happening here.
2. The mother is adamant about having an x-ray taken and appears to be in conflict with her son. A key question arises about who is the real patient, since the son seems fine.

The family consists of mother, father, and three children. This son is the oldest of three children and is currently a junior in high school. His father left approximately 6 weeks before this visit on an extended business trip that will require him to be away from the family for 6 months. During the father's absence, his mother has assumed most of the household responsibilities of the father. She is concerned that she is not getting the help she needs from her son and relates that his unwillingness to help with additional household chores creates an extra burden for her. Upon hearing this, the son becomes considerably more vocal and relates that he resents being ordered around by his mother and feels that she is not allowing him to grow up just because his father is gone.

Additional data about the family clarify the situation. This mother is alone as a parent because of dad's absence and does not feel she is getting the amount of help and respect she deserves from her son. In his father's absence, the son considers himself the man of the house and resists being bossed around by his mother.

The key question now becomes: How should the family physician handle this situation? Clearly the son's leg is not seriously injured. The traditional solution using the biomedical model would be to explain to the mother that the leg is fine and leave it at that. A systems approach to this problem would redefine the problem as a conflict between the mother and son. The two principal parties in this situation are attempting to triangulate the physician, meaning that they would like their physician to resolve the disagreement. The physician can avoid this triangulation by encouraging the mother and son to work together to resolve their conflict. This allows the physician to model a way in which future problems between them can be resolved in a similar manner.

This case is one example of how a family systems approach to a common clinical situation can facilitate a new level of understanding of a patient's problem. Clinical examples like this are familiar to all family physicians and occur frequently in practice. The actual patient in this example is neither the son nor the mother but the relationship between them. Although many aspects of this case appear to be common sense, a family systems approach clearly changes the physician's understanding of this clinical situation in a profound manner.

Incorporating a Family Systems Approach into Clinical Practice

Developing a family systems approach to patient care requires understanding some basic concepts about the structure and function of a family. Some authors have suggested that these concepts are common sense and have always been a part of the general practice or family practice tradition. Others have emphasized the complexity of systems theory to the extent that the practicing family physician may become frustrated trying to understand its applications. In fact, developing a family orientation is neither self-evident nor hopelessly complex.[3–5]

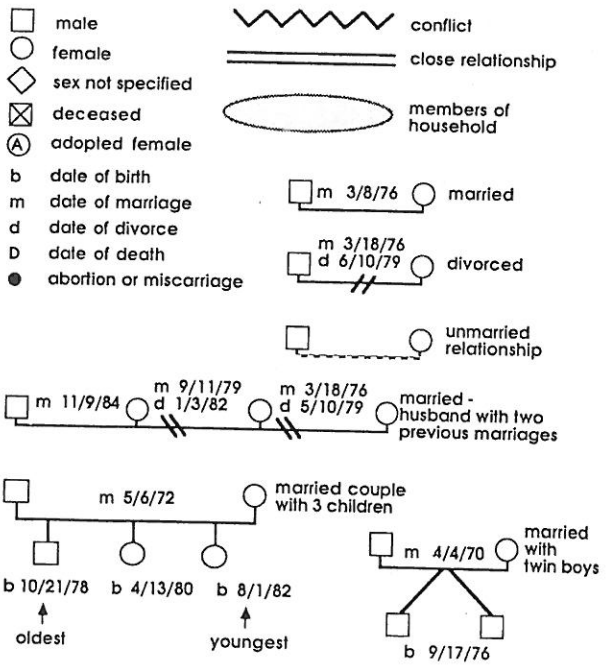
Step One: Recognize Family Structure

The first step in understanding the family is to know the individuals in the family. What are their names? Where do each of them live? What roles do each of these people play in the family? Which family members have chronic illnesses? Where is the family in the family life cycle (Chapter 5)? What are the significant dates for this family (marriage, birth, death, and so on)? Family physicians learn the answer to many of these questions in routine day-to-day practice, but a family orientation is best achieved by establishing this background family information as early as possible in the interaction with them.

An ideal way to obtain and record this information about family structure is to complete a family genogram.[6] A genogram is a graphic representation of the family structure using standardized symbols (Table 3.1). The use of genograms in family practice has been advocated by numerous authors during the past 10 years,[6–8] and it has become a standard tool for recording information about family structure in medical records. Figure 3.1 is a genogram depicting structural family data about a young family with preschool children. It records the names and roles (father, mother, oldest son, and so on) of each family member and separates the extended family into several households. It documents the medical problems of each family member and significant dates in the family's history. This genogram also reveals more subtle information about the family. Alcohol abuse and divorce are a pattern among the men in John's family. Both John and Mary grew up in single parent families as the middle of three children. Mary has a younger sibling (Andrew) who has cerebral palsy and was born after her mother had two miscarriages. This experience may affect Mary's attitudes and health beliefs concerning her daughter Jane, who is also a youngest child and has seizures.

The family genogram is a concise and reliable tool that is useful in obtaining and recording family structural data. Once included in the medical record, 91 to 96 percent of the data on the genogram can be correctly interpreted by a physician reviewing the chart, even if that physician has never met the family.[6] This interobserver reliability has established the genogram as an essential part of the medical record in clinical family practice. A genogram can be completed in 10 to 15 minutes by an experienced family physician and will then provide a long-term database in the record. Some family physicians have trained their office nurses to complete a genogram as a standard part of the database on new patients in their practice.

Table 3.1. Standardized symbols used in family genograms.



Step Two: Understanding Normal Family Function

Once a family physician understands the family structure, the next step is recognizing how the family functions. A term commonly used in clinical practice to describe a family is "dysfunctional," but dysfunction can be understood only within the context of an understanding of the normal functions of a family. It is important to maintain a sense of cultural tolerance in working with families because there is a powerful tendency to assume that all families function the same as the physician's family. There is a wide range of normal in assessing family function.

In evaluating the structure and function of a family, there is an initial tendency to view the physician as an outside observer of the family system who is searching for a framework of objectivity. In fact, there is no such thing as objectivity in family systems medicine. The presence of the physician inevitably affects the family, just as the family affects the physician. In the practice of family medicine, the doctor becomes part of the family system, and the entire social interaction becomes a constantly changing, fluid mass. There are no bystanders or uninvolved observers. The primary goal of the physician is to approach the family with an open mind and an understanding that the physician is part of the system that is being observed.

Several models have been established to explain the normal functions of a family. These models vary in complexity and in the manner in which different aspects of family life are emphasized. The clearest and most understandable of these models

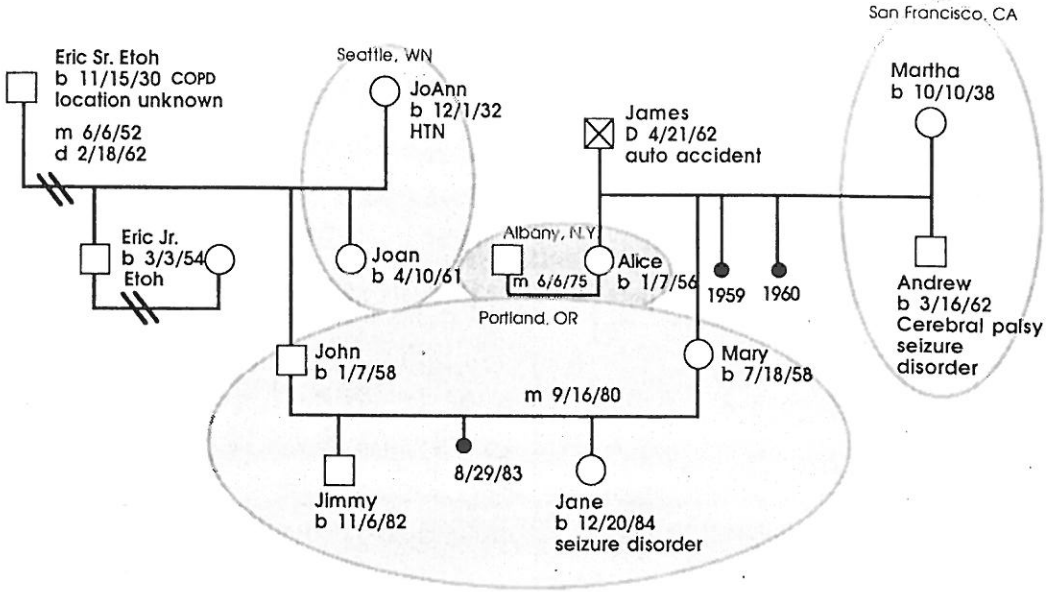


Fig. 3.1. Family genogram of a young family from Portland, Oregon. The family is separated into four households, which are identified by shaded circles.

is the family circumplex model, which was described by Olson et al.[9] An adaptation of Olson's work, simplified in the interest of clarity, follows.

There are five basic functions that are performed by all families. An outline of these functions will serve as a basis for a discussion of how to assess family function.

1. Families *provide support* to each other. This includes physical, financial, social, and emotional support. This support occurs through an organized framework of interdependent family roles and is based on emotional relationships among members of the family. Families eat their meals together. They console and comfort one another in times of stress. Families do things together as a group and have a sense of belonging to one another. These are all examples of the support function.
2. Families *establish autonomy* and independence for each person in the system, which facilitates personal growth of individuals within the family. Each person in the family has a set of defined roles that establishes a sense of identity and serves as the foundation of a larger role of that person in society as a whole. Each family member has an individual personhood that extends beyond the boundaries of the family. When a child first starts to school, he struggles to establish a role separate from his family with his teachers and friends. In effect, families do things together, but they do other things separately. This ability to maintain the integrity of each individual is the essence of the autonomy function.
3. Families *create rules* that govern the conduct of the family and of the individuals within the family. These rules of behavior are largely unwritten and are established by an informal decision-making process that is often difficult to define, even for the family itself. This system of rules becomes most apparent when an outsider visits a family. The outsider has a different set of rules, learned in his or her own family, that contrast with the family's rules. Among other things, rules deal with privacy, interaction patterns, authority, and decision making.
4. Families *adapt to change* in the environment. This ability to adapt, change, and grow is essential for the long-term progression through a family's life cycle. Family therapists distinguish between first and second order change. A first order change involves an adaptation by the family to changes in the environment that do not require extensive change in the family structure. An example is the change that occurs when a family moves to a new city. A second order change involves a fundamental change in the basic family structure. These changes involve not only what the family does but, in a sense, also who they are. An example of a second order change is the birth of the first child in a family.
5. Families *communicate* with each other. This communication involves a complex tapestry of verbal, nonverbal, and implied messages, many of which are unintelligible to outsiders. Communication is the key function without which the other functions become impossible.

Olson et al.'s circumplex model envisions a reciprocal relationship between rules and adaptability, placing these two functions on a linear continuum that they call the "adaptability scale." They consider support and autonomy to be reciprocal functions in their "cohesion scale." The adaptability and cohesion scales can be combined into a two-dimensional model of family function (Fig. 3.2).[10] An interesting aspect of this model is that any of these functions, taken to the extreme, interferes with the reciprocal function and thereby can be considered dysfunctional.

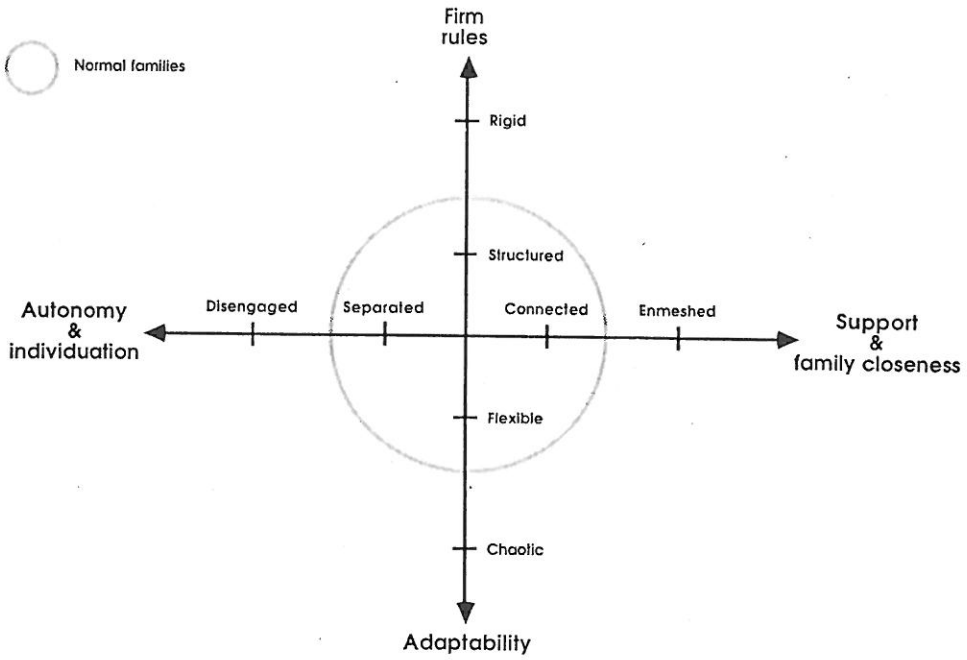


Fig. 3.2. Modified two-dimensional model of family function. Normal families tend to fall within the shaded circle.

Having described five functions performed by all families, it now becomes easier to define normal family function. Each family will establish a balance between these functions that meets the needs of each person within the family. Any of the functions can be emphasized inadequately or excessively at a given time, and this imbalance can cause the needs of individual family members to be unmet. Communication is a central function in initiating change in the balance of other functions in response to environmental stress. Families are constantly changing this balance in order to cope with stress. Stress and change are, therefore, part of normal family function. It is only when the family's ability to cope is overwhelmed and the needs of family members are chronically unmet that family function breaks down. The definition of a dysfunctional family then becomes a family with a chronic inability to respond to the needs of its members or cope with changes and stress in its environment.

Step Three: Learn to Assess Family Structure and Function in Clinical Practice

Having established a vocabulary with which to discuss the family system and its relationship to health care, the next step to incorporate a family orientation is to learn how to assess the family system. Family therapists assess families by observing family interactions. This requires the physician or therapist to meet with several or all family members and observe the style and content of their interactions to arrive at a family assessment. This method of assessment requires training and experience and is often difficult to accomplish in an office practice. There are, however, several clinical situations in which physicians are accustomed to meeting with the family as a group. When a patient develops an acute illness and is hospitalized, especially if the illness is life threatening, it is common to meet with the family to discuss the diagnosis and plan of care. Likewise, in the context of a patient with a terminal illness or the death of a family member, meeting with the family unit has become standard medical practice. In these situations, the emphasis in a family meeting tends to be on a flow of information from doctor to family. Convening a family to assess family function primarily involves a flow of information from the family to the physician. To assess the family in this manner requires that physicians talk less and listen more. It also requires a different set of skills in dealing with group dynamics. The presence of these skills serves to differentiate the third, fourth, and fifth levels of family involvement in Doherty and Baird's model.[2]

Because many family physicians are uncomfortable and inexperienced with convening families for family assessment, several family assessment instruments have been devised that simplify the process.[11] Each instrument has its own set of advantages and disadvantages. A common disadvantage of all these instruments is that, as a rule, they obtain data from only one family member. One member's view cannot assess accurately the entire family, but because these techniques help the physician to "know what to say," they have become popular among practicing family physicians. A brief discussion of several of the most frequently used instruments, including their differential advantages and the clinical situations in which each is useful, follows.

The Family Genogram

The genogram, discussed earlier in this chapter, has become the gold standard method of obtaining and recording data

about the structure of families. Many authors now advocate that all charts in a family practice should contain a family genogram. Although the genogram is an excellent tool to use in learning about family structure, its use in assessing family function is more limited. Table 3.1 lists symbols that can be incorporated into a genogram to characterize conflict and close relationships in family dyads (two-person subsets of the family). Characterizing dyad relationships in this way tends to facilitate a discussion of the interactions of family members and, thereby, functional family assessment. The genogram is far from ideal as an instrument to assess family function. It requires 10 to 12 minutes to complete a basic genogram, with additional time required to obtain data about family function. This makes the genogram impractical in routine office visits where time is at a premium. Ideally, the basic structure of the genogram will already be on the chart, thereby shortening the time demand. Genograms are more useful in extended office visits and in working with the family of a patient who has been hospitalized.

An excellent overview of the clinical uses of a genogram has been published by McGoldrick and Gerson.[12] This useful book uses the genograms of famous families to illustrate basic concepts.

The Family Circle

Thrower et al. have described a family assessment technique that they call the "family circle."[13] Family circles are most often collected on individuals, but the technique can be used with couples or small groups as well. The physician simply draws a large circle on a piece of paper and instructs the patient as follows[13]:

As a family physician, I am interested in you, your family, and what is important to you. Let this circle stand for your family as it is now. Draw in some smaller circles to represent yourself and all the people important to you—family and others. Remember, people can be inside or outside, touching or far apart. They can be large or small depending on their significance or influence. If there are other people important enough in your life to be in your circle, put them in. Initial each circle for identification. There are no right or wrong circles.

The physician can leave the room while the patient completes the exercise. This ideally suits the family circle technique for use in a busy office practice. The physician can see another patient during the 10 to 15 minutes that is required for the patient to complete the family circle. The actual assessment of the family occurs when the physician asks the patient to explain the diagram. The physician can then listen to the patient's explanation and collect information about the family. Variations of this method involve observing a group of family members collectively completing a family circle or comparing the family circles of several family members.

The primary disadvantage of the family circle technique is that it is difficult to standardize and much more difficult for an outsider to interpret than is the genogram. Its time efficiency, however, makes it a useful instrument for the practicing physician.

Objective Family Assessment Instruments

The genogram and family circle are useful tools for the practicing physician, but they are subjective. To perform research on the family's impact on health care and the effects of illness on the family, more objective instruments are required.[14] Several such numerical scales of family functions and stresses have been developed in an attempt to quantify family functioning. The family APGAR was originally described by Smilkstein.[15] This instrument is a simple scoring system in which an individual family member rates five family functions on a scale of 0, 1, or 2. Normal family function is indicated by a score of 8 or higher out of a possible 10. The family APGAR has been validated in several patient populations and seems to correlate well with other instruments of family assessment. It is simple to administer and requires little time to complete. Although the APGAR has not been widely used in clinical practice, it appears to be useful in differentiating a subset of families within a practice who would benefit from a more careful assessment.[16,17]

The family environmental scale (FES) is a 90-item questionnaire developed by Moos.[18] Results of this scale include numerous separate scales of family parameters. The FES has been used as a research instrument to compare health care outcomes with family variables.

Olson's circumplex model of family function, discussed earlier in this chapter, is the theoretical model for the family adaptability and cohesion evaluation scale (FACES). This instrument has been through two versions, and FACES III has been developed recently.[10] Because the circumplex model is understandable and the FACES instrument has been extensively tested, this instrument may have the best potential as a future tool in clinical practice. FACES is a self-reported scale, which means that a patient rates his or her own family on 30 items on a 1 to 5 scale. The instrument is easy to score, and data are available from a large population to interpret results.

At the present time, there are no objective family assessment tools that have gained widespread use in clinical practice, although several instruments have proven to be useful research tools.[11,14] One of the difficulties with these instruments is their failure to take into account the multidimensional effects of the family system on health care or the effect of an illness on the family system. Family function cannot be quantified into a numerical scale without significant distortion. These instruments are limited also because they assess family function only from the point of view of the person who completes the test. Future uses of these tools may involve comparing the scores of several different family members. The best method of assessing family function is to develop the knowledge and skills that are required to convene family groups and evaluate them within the context of family systems theory. The family assessment instruments discussed in this chapter are helpful tools for family physicians who are interested in developing such skills.

Working with Families

Health care in the context of the family is a fundamental part of the definition of family practice (Chapter 1). Until recently, however, only a small percentage of family physicians had received the formal training required to assess and work with family units. Instead, these skills have been learned by trial and error in the day-to-day conduct of a busy practice. Fami-

lies influence health beliefs, patterns of contagious disease, frequency and pattern of physician visits, compliance, and disease inheritance. It seems obvious that family centered primary care leads directly to higher quality of care and greater patient satisfaction, but objective proof of these contentions is not yet available. Because family physicians are the only providers of primary care who care for the entire family, research to establish the benefits of this approach represents a high priority for academic family medicine.

For practicing family physicians, developing a family orientation to practice creates a special bond with patients. It allows a physician to develop a deeper understanding of patients and their problems and increases both physician and patient satisfaction. These advantages are the most compelling arguments in favor of family centered health care.

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Fig. 1

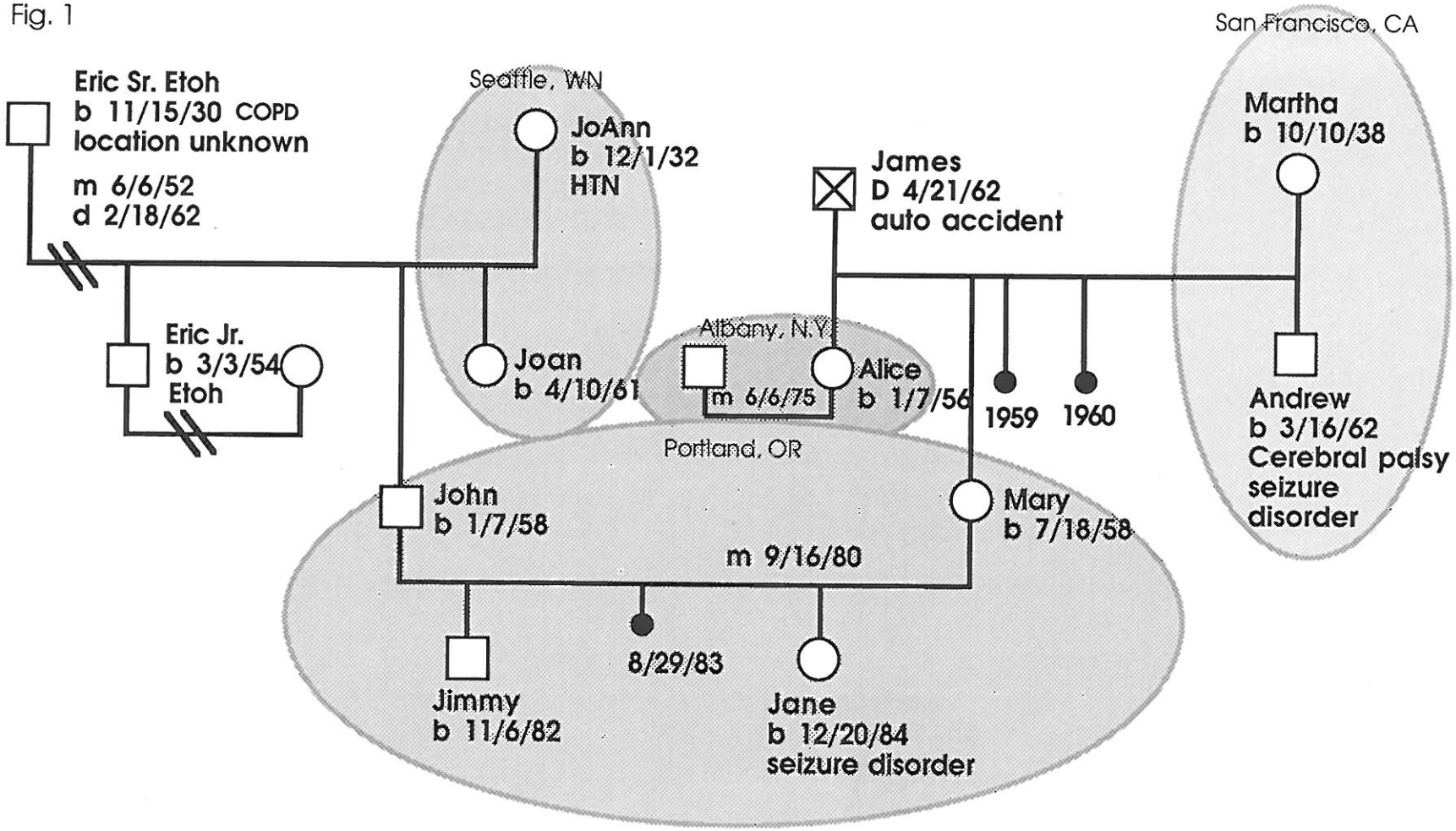
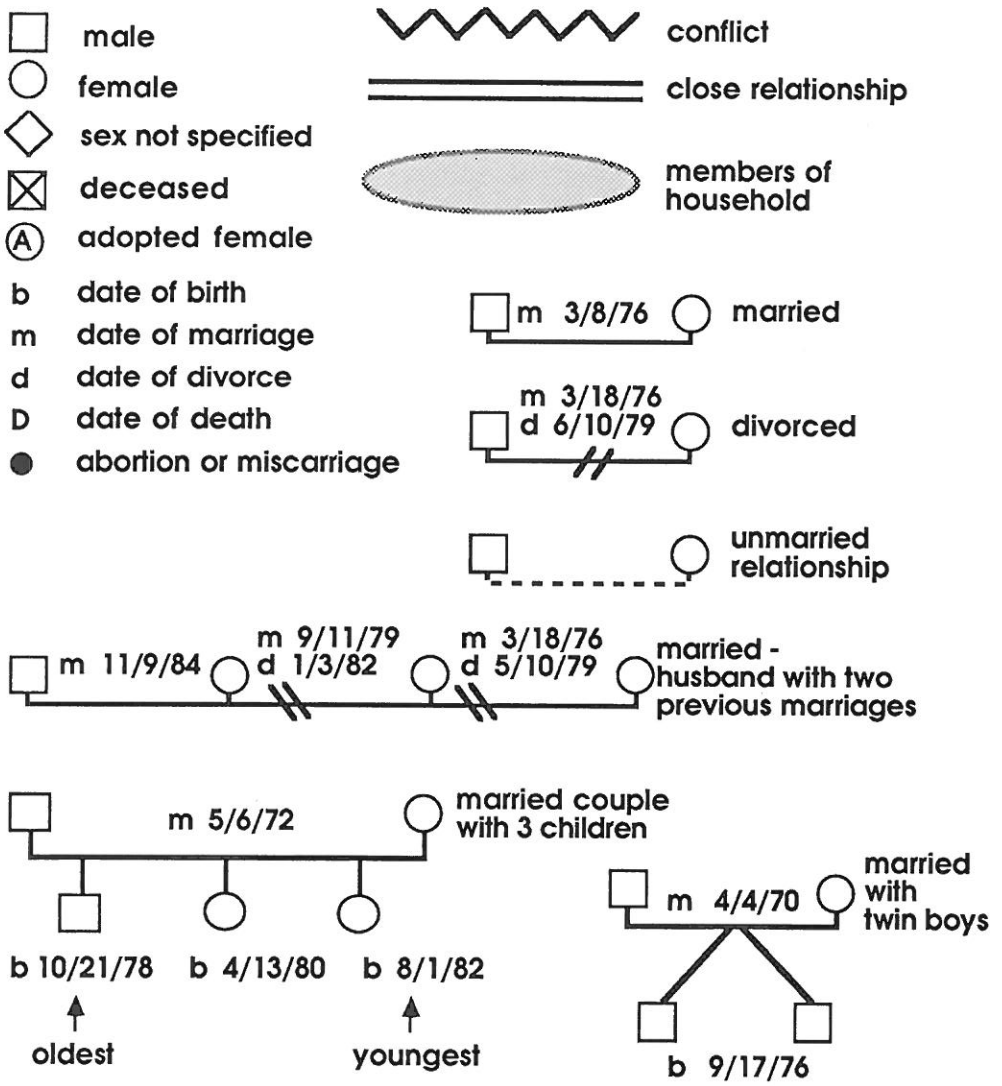

San Francisco, CA
Eric Sr. Etoh
b 11/15/30 COPD
location unknown
m 6/6/52
d 2/18/62
Seattle, WN
JoAnn
b 12/1/32
HTN
James
D 4/21/62
auto accident
Martha
b 10/10/38
Eric Jr.
b 3/3/54
Etoh
Joan
b 4/10/61
Albany, N.Y.
m 6/6/75
Alice
b 1/7/56
1959
1960
Andrew
b 3/16/62
Cerebral palsy
seizure
disorder
Portland, OR
John
b 1/7/58
Mary
b 7/18/58
m 9/16/80
8/29/83
Jimmy
b 11/6/82
Jane
b 12/20/84
seizure disorder

Table 1


male
female
sex not specified
deceased
adopted female
b date of birth
m date of marriage
d date of divorce
D date of death
abortion or miscarriage
conflict
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members of household
m 3/8/76
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m 3/18/76
d 6/10/79
divorced
unmarried relationship
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d 1/3/82
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d 5/10/79
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married couple with 3 children
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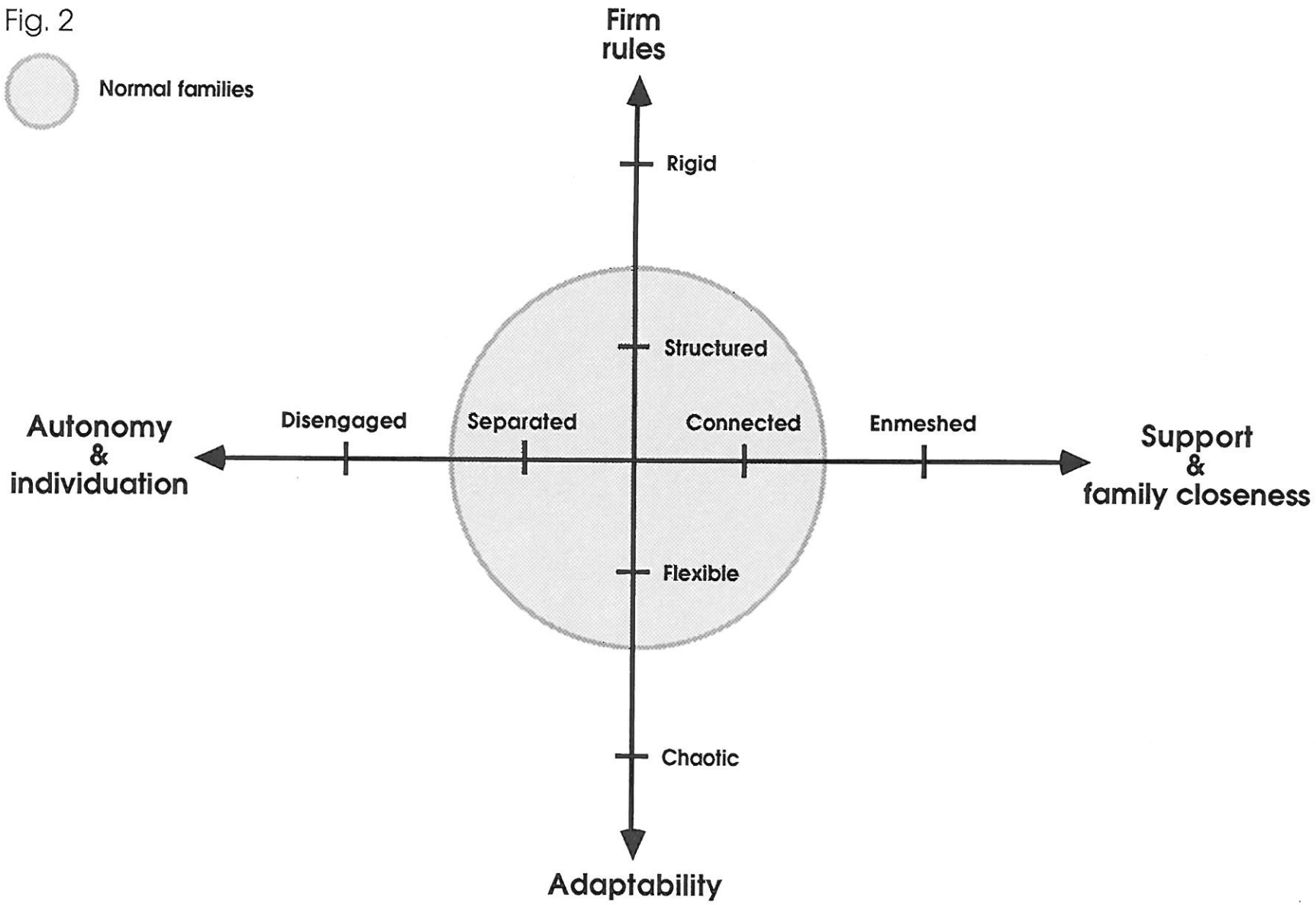
married with twin boys
b 9/17/76

Fig. 2


Normal families
Firm rules
Rigid
Structured
Flexible
Chaotic
Adaptability
Autonomy & individuation
Disengaged
Separated
Connected
Enmeshed
Support & family closeness