Family Practice Forum

The Unit of Care Revisited

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Much discussion has revolved around the role of the family in family medicine. Sometimes the debate seems academic, simply semantic gymnastics irrelevant to the everyday practice of medicine. At other times the rhetoric seems the very center of clinical practice.

Several views have recently been expressed in the literature: (1) treat the patient "in the context" of the family, but not the family as the "unit of care" for fear of compromising care to the individual[1]; (2) treat the family as the "unit of care" for the purpose of improving treatment of the individual[2,3]; (3) treat the family as the "unit of care"* for the purpose of maintaining the family itself[4]; (4) treat the family as the "unit of care"** for the purpose of improving the family as a unit of society[3]; and (5) do not treat the family as the unit of care because it is too difficult, too complicated, too impractical to do.[5] The view expressed by this paper supports treating the family as the unit of care because the individual and family are, in fact, inseparable.

While most physicians are aware at some level of the impact they have on family through the patient, many fail to recognize the determining influence the family has on the illness with which the patient presents. Awareness of this two-way relationship is the basis of treating the family as the "unit of care." While many who question the role of the family in family medicine also recognize this essential point, one must question how fully this concept is integrated into practice unless the next logical step in this process is forthcoming. That is, if (1) the family affects (or even determines) the individual's illness experience, and if (2) the individual's illness and treatment affect the family, then (3) it is often necessary to "diagnose" or treat the family (as a unit) in order to fully treat the individual. It is not enough to recognize a vector in the development and transmission of disease unless intervention is then attempted. When Dr. John Snow discovered contaminated water as a cause of cholera, he took the handle off the Broad Street pump. To recognize family as a determinant of disease is empty unless the family physician also learns to "take the handle off the pump," or alter "environmental toxins" that can exist in families.

Treating the family as the unit of care is, in essence, searching in an anticipatory fashion for the reciprocal effect of family on health and health on family. Whether this approach is done by addressing the family directly (by convening the family) or indirectly (by communications with and through the individual) depends on the degree of family involvement, the seriousness of the family

*Author's interpretation of Schwenk and Hughes
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and individual problems, the willingness of the family members to participate in their own health care as a group, and the skill and comfort level of the physician in dealing with family. Examples range from treating both members of a couple for trichomoniasis, although only one was seen, to informing an individual of the interaction between family dysfunction and angina pectoris, to recognizing depression in a mother who has brought her child in ostensibly for a mild cold, to convening the family to discuss the potential problems of a newly diagnosed diabetic. The physician can (and does) "treat the family" without each member's physical presence, regardless of whether the entire family is enrolled in the practice. He can treat the family as the unit of care without offering or having training in "family therapy."

Once comfortable practicing this style of medicine, it is often difficult to think of the individual without also thinking of the family. One looks at the patient, but sees the family, listens to the patient, yet hears words collected from the family as interpreted by the patient. The family is not simply equal to the sum of its parts; nor is it necessarily greater than the sum of its parts. To say that the family is unequal to the sum of its parts is true, but not enough. Rather, the family should be treated as the unit of care, as the "patient," because *each part of the family is a "sum" of the whole.*

Because of the nature of the relationship between family and individual, it would be as inappropriate for physicians to try to separate care of the individual and the family, as Merkel[5] has suggested, as it would be to attempt to separate care of each cell from care of the whole body. To make this separation simply because not enough is known about the family would be comparable to our scientific predecessors ignoring the cell because it was a mystery to them. Rather than separate the family and the individual, one might take the current lack of knowledge as a challenge to investigate their relationship in a scientifically acceptable way. Such research might focus on the process of integrating family into medicine, as expressed by continuity of care or the physician-patient relationship, or on the outcome of such care in terms of improved health, decreased mortality and morbidity, or cost benefit.

Though treating the family as the unit of care is central, it is by no means simple. The practice of family medicine raises issues of assessment technique, treatment tools, and ethical conduct that are foreign to traditional medical training. The complexity of these issues and the unfamiliarity with skills necessary to address them often seem a larger stumbling block to their implementation than any philosophical disagreement over their importance. Physicians lacking training in these skills are often resistant to the integration of behavioral and biomedical because of anticipated difficulty in changing from a style of practice with which they are comfortable.

Ransom[3] correctly points to the danger of inappropriately applying the biomedical model to "diagnose" the family, but the widely used problem-oriented format asks not for diagnosis, but rather for assessment. While labeling or categorizing the family may not be appropriate at the current level of understanding, a descriptive assessment of how the family interacts with the illness episode is. Both assessment and treatment, though at an early level of understanding, are becoming more clearly developed, as illustrated by such texts as *Family Therapy and Family Medicine* by Doherty and Baird.[6]

The ethical dilemmas are basic and encountered with increasing frequency.[7] The difficulty begins when the assumption is made that, since family and individual are inseparable, what is good for one is also good for the other. Clearly the well-being of the individual and the family are interdependent but not identical. Further, while the well-being of society and the family are interdependent, again, they are not identical. How then are physicians to make the tough day-to-day ethical decisions when the best interests of individuals, family, and society conflict? Several guidelines are implicit in the model of understanding the relatedness of individual and family discussed here.

First, though the community, the culture, the society contribute components to the individual and to the family, none of these systems is contained within the parts of the subsystem. For this reason it seems inappropriate to treat the family "for the sake" of its community, its culture, or its society.[3] That is, treatment of families should not be conducted for the purpose of molding them to conform more closely with societal or cultural conception of what a "normal" or "good" family

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is. While treating the family may indirectly result in societal benefits, treating the family for the benefit of society implies that a "healthy" family is one that conforms with societal norms. Treatment in this manner does not respect family autonomy.

Further, treating the individual for the benefit of the family unit, as Schwenk and Hughes imply,[4] too often dictates that the individual conform to family norms or demands that may not be in the individual's best interest. On the other hand, treating the family for the sake of the individual[3] endeavors to encourage families to be flexible to individual idiosyncracies and needs and respects individual autonomy. It is clear that the physician needs both to treat the patient in the context of the family and to treat the family in the context of the patient. The family physician must shift as comfortably from family to individual and back as he does from geriatrics to pediatrics to gynecology.

The argument is simple. Every time a physician treats an individual, he affects the family. Every time the physician is confronted with an individual's illness, the presentation and nature of that episode is heavily influenced by the family environment. To believe one can understand the illness as perceived by the patient and its causal and exacerbating factors without examining family issues is erroenous. To attempt to treat the individual without affecting (and therefore passively "treating") the family is impossible. If our current lack of knowledge inhibits intervening in an optimal way for both the family and the individual, then it must be part of the agenda of family medicine to address this knowledge gap.

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