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## THE PATIENT IN THE FAMILY AND THE FAMILY IN THE PATIENT

**ABSTRACT.** The notion that the family is “the unit of care” for family doctors has been enigmatic and controversial. Yet systems theory and the biopsychosocial model that results when it is imported into medicine make the family system an indispensable and important component of family medicine. The challenge, therefore, is to provide a coherent, plausible account of the role of the family in family practice. Through an extended case presentation and commentary, we elaborate two views of the family in family medicine — treating the patient in the family and treating the family in the patient — and defend both as appropriate foci for care by family doctors. The practical problem that arises when the family is introduced into health care is deciding when to concentrate on the family system. The moral problems that arise concern how extensively doctors may become involved in the personal lives of their patients and families. The patient-centered clinical method provides a strategy for handling both problems. Thus, making the family a focus of care in family medicine can be justified on theoretical, practical, and moral grounds.

### 1. INTRODUCTION

The popular notion, at least among academic family physicians, that the family is “the unit of care” for a family doctor remains enigmatic and controversial. The editors of a recent volume on the concept of the family system in family medicine comment in their Introduction: “We, who worked on the book for two years, are now certain that *the individual patient is the unit of care* — not the family, as many writers on family medicine have proposed.”<sup>1</sup> This conclusion is problematic because it poses a simplistic dichotomy — it suggests that a family doctor must choose between viewing the individual patient or the family as *the* unit of care. The alternate claim that the family is *a* unit or *a* focus of care for family doctors can be defended in terms of systems theory and the biopsychosocial model of health that results when systems theory is imported into medicine.<sup>2</sup> The choice that confronts a family doctor, then, is not whether to consider the family in his clinical decision making, but when to focus on the individual patient, the patient’s family, or both in dealing with a problem.

Two kinds of difficulties arise when the family is introduced into health care. On the one hand, practical questions need to be addressed. What role should the family system play in a doctor’s problem-solving and management decisions? How and when should physicians decide to pay attention to the family system rather than or in addition to the organ

system or the individual person? The biopsychosocial model provides a conceptual scheme for understanding a patient's problem at a variety of levels and from several points of view, but it offers little guidance as to when one level or one point of view is more appropriate. On the other hand, the moral implications of making the family a focus of care are suspect. Managing a "family problem" effectively might require that a physician become involved in the personal lives of patients to an extent that is imprudent or unwarranted. To what extent is a family doctor entitled to intervene in the personal lives of patients? To what extent is a family doctor entitled to intervene in the personal lives of a patient's relatives when caring for the patient seems to require doing so? In addition, making the family a focus of care could conceal a substantive value judgment about the importance of the family as a social institution, a judgment that, again, might be either imprudent or unwarranted, in general or in a specific case.

Our aims are to elaborate two views of the family in family medicine and to defend the claim that both are appropriate foci for care by family doctors. The biopsychosocial model makes the family system an indispensable and important component of family practice. The emergent patient-centered clinical method<sup>3</sup> provides a strategy for dealing with both the practical uncertainties and the moral qualms that are generated by importing the family system into health care. With the patient-centered approach complementing the biopsychosocial model, the concept of the family as a focus of care can be firmly entrenched in family medicine.

Focusing on the family can involve both treating the family in the patient and treating the patient in the family. The former concentrates on the individual and the manner in which early experiences in the family of origin influence psychological development and recognizes that unresolved issues can be played out through relationships with other family members or caregivers or manifested in physical symptoms. The latter emphasizes that successful management of a patient's problem requires the involvement of the whole family: "The family is the unit of illness because it is the unit of living."<sup>4</sup> The individual is the "identified patient," who can serve as a symptom bearer and sometimes a scapegoat for a pathological family system. Here the unit of intervention is the family itself — the family structure and the rules that are inimical to the healthy functioning of one or more of its members.

Our defense proceeds by way of an extended case presentation that is intended to illustrate both what treating the family in the patient and treating the patient in the family can mean in concrete terms and what some of the dangers inherent in this approach are. The claim that the

family is a focus of care ultimately must be tested against cases, and such testing can provide strong evidence for it: "Single case reports . . . if they make the right kind of sense . . . can be enormously influential in promoting paradigm change."<sup>5</sup> The vignette is long, but it needs to be to capture the psychosocial dimensions of the patient's problems and the doctor's problems. The case is related by W. W., Hilda's family doctor.

## 2. CASE PRESENTATION

"Hilda is a 44-year-old woman who immigrated from Holland many years ago with her husband. Their two children are in university and recently moved away from home.

"Hilda has had an irritable colon syndrome for many years but generally has coped very well by watching her diet and using antispasmodic medication. She presented to the office one day with severe, constant, burning lower abdominal pain. She was exquisitely tender over her lower abdominal wall but had no muscle guarding, and a bimanual examination was normal. Her urine was clear. I was puzzled by this sudden exacerbation of her pain. She denied any changes in her life situation or stress. I felt satisfied that I had ruled out any serious organic pathology and concluded that her symptoms were related to her irritable colon. Her unwillingness (or inability) to connect her symptoms to any life stress suggested to me that I should back off, defer further probing, and treat her symptomatically with additional antispasmodic medication.

"Two weeks later she called, imploring me to give her something to control the pain. She felt 'out of control.' I sent her some acetaminophen with codeine. One week later she appeared in the office with her husband. They were both desperate! The pain was getting worse and was unremitting. Now she also had severe pain in her right upper quadrant similar to what she had before her cholecystectomy ten years earlier. At that time she had been in and out of hospital numerous times for investigation of abdominal pain, and she ultimately had a normal gallbladder removed. Following that she settled down again. She and her husband were convinced she had an organic problem and wondered about having her admitted to hospital. Again, there was little to find on physical examination. I probed once more for sources of stress in her life, and she denied any problems. She seemed almost panicky that this pain was never going to let up. It was greatly interfering with her ability to do her jobs around the house and with starting a book she wanted to write. I reassured her that there was no evidence of any serious organic problem, arranged some

investigations, and promised to stick with her until I had the problem sorted out.

"She returned three days later and reported that the pain in her right upper quadrant had quickly disappeared after her last visit. But she continued to have the lower abdominal pain that she presented with initially. I was still puzzled and wasn't sure which way to go next. But in exploring the effects this pain was having on her functioning, she mentioned she had some trouble sleeping because of vivid dreams. At last, here was a clue! She was reluctant to discuss the dreams at first but finally told me about a recurrent dream of five European cathedrals. She finds herself inside one that is dirty and full of soot from the burning candles. She struggles to discover a way out and finds herself in one of the other churches. It seems that she can never escape from them. She then told me that the first five years of her life were spent mainly in bomb shelters during World War II. She reports that she was raised very strictly as a Roman Catholic by a mother who was extremely rigid; the nuns at school were not much better. Eventually she rejected the church, but she continues to feel guilt and confusion about her decision.

"A few years ago her mother came from Europe and lived with Hilda and her family. After two years of fighting, Hilda finally sent her back home, where she lives in a nursing home. Hilda felt very guilty about this but could think of no other solution. Ever since then Hilda has phoned her mother every week, although most of what she hears from her is complaints. I suggested to Hilda that she had 'a belly full' of her mother. She readily agreed and asked if I thought her abdominal pain was related to her inner conflict. I suggested it might well explain her chronic pain better than any other theory and asked her to think about this possibility and return to see me in one week.

"On her next visit she was dramatically improved. Although she still had some pain each day, she had pain-free periods from four to six hours on many days and in fact had been able to write a forty-page chapter of her book. She told me about her mother. Hilda is an only child, and she has always felt that her mother wanted her to be more like herself. In so many ways Hilda chose different values and consequently felt her mother's disapproval. She crossed the Atlantic to try to escape the oppressive criticism. She dreads the day when she is well enough to go back to Holland to visit her: 'As long as I am sick, I have an excuse not to go.' As Hilda put more and more of the pieces of the puzzle together, she realized that the recent flare-up of pain coincided with Christmas. It was just after Christmas two years ago that she put her mother on the plane and sent her home.

“As the abdominal pain receded into the background, Hilda began to complain of right elbow pain. It was associated with vague numbness along the ulnar border of her hand but no objective neurological signs. She commented that she was going to have great difficulty carrying suitcases on her trip to Holland to visit her mother. I wondered if there were a connection — she desperately wanted to avoid giving in to her mother again when she visited, but she feared she would not have the courage to stand up for herself.

“Hilda fulfilled her own prophecy — the visit with her mother was devastating, and she reported she was ‘back to square one.’ But with the passage of time and further ventilation, she seemed to recover again.

“A few months later she phoned me between visits and was in tears because the pain in her elbow had become intolerable and she needed to have something done. But I had run out of things to do and was beginning to feel desperate, too; I knew I couldn’t keep giving her stronger analgesics. Out of my sense of failure came the realization that perhaps the problem was not just in her elbow. Maybe this pain, like her previous pain, was expressing some unspeakable conflict. I mentioned this possibility to her and arranged to see her one week later. I had no conscious realization of what this conflict might be and wondered to myself if I were simply stalling for time.

“She came to see me one week later markedly improved. She brought me a lengthy typed note describing her long-standing dissatisfaction with her marriage and her deep loathing for her husband. She had been dimly aware of her feelings for years but had always pretended, even to herself, that she had the best she could expect and all that she deserved. Now her pain and my prompting had suddenly unleashed a flood of ideas and feelings. Her elbow pain was still present but was now quite tolerable; instead she was desperate about her marriage.

“I urged her to speak to her husband about her concerns and ask him to return with her for marital therapy. I suggested indirectly that she not read her note to him — it was such a nasty attack on his character that I felt it would be destructive of him as well as their relationship. I am unsure why I didn’t make my point more strongly.

“Upon returning home she read the entire note to her husband! She described his reaction as calm and deliberate, and she sensed he seemed relieved. He indicated that they should separate. Within a few weeks they sold their home and moved into separate dwellings. Both of them seemed quite satisfied with the separation. For Hilda it was the first time in her life that she felt free to be herself rather than constantly striving to satisfy the wishes of others, first her mother and then her husband and children.

“During this time her 19-year-old daughter was seen with severe unexplained abdominal pain. She was in engineering school but was very unhappy there and wanted to enter teachers’ college. She believed her parents would not accept this, however, and felt pressure to do what she thought they wanted. I urged her to speak openly with her parents about her wishes and encouraged her mother to stop overprotecting her daughter and to allow her to be more self-sufficient. As a result, everyone was happy with the changes the daughter wanted to make — she switched to teachers’ college, began dating for the first time, and became more independent.”

### 3. DISCUSSION

Where is Hilda’s problem? Is it in her body — painful spasms of her gut caused by some as yet unexplained physiological mechanism? Is it in her mind — the unresolved developmental issues which we have labelled “the family in the patient”? Or is it in her family — the fragile alliance between Hilda and her husband may have been held together only by a rigid authoritarian structure, with the consequence of Hilda having abdominal pain to cope with her dissatisfaction rather than openly expressing her frustration in a manner that could endanger the marriage? The answer to these questions depends largely upon the theoretical orientation of the observer. We all tend to see what fits our conceptual frameworks and either to ignore what does not fit or construe it as the exception that proves the rule. Specialists in a field tend to have a selected group of patients referred to them for problems that match their orientation, thereby reinforcing their belief in their particular approach. Family doctors, in contrast, see a relatively unselected population of patients, so they need to be able to look at problems from several perspectives and find the one that is most likely to work for the individual patient. This practice may not reflect the theory that best matches the physician’s orientation, but rather the theory that fits the patient’s point of view or utilizes the resources available. As Engel says, “The value of a scientific model is measured not by whether it is right or wrong but by how useful it is.”<sup>6</sup>

#### 3.1. *The Family in the Patient*

Hilda came to see her family doctor alone, except for one visit when her husband accompanied her (a clear message to take this problem very

seriously). But in another sense Hilda never came alone — she was always accompanied by the family within her. While it can be invaluable for a family doctor to see the patient within his whole family, it is much more common to see the family within the individual patient. Laing challenges us to understand the family in the patient this way:

The family as a system is internalized. . . . The family may be imagined as a web, a flower, a tomb, a prison, a castle. . . . The 'family' set of relations may be mapped onto one's body, feelings, thoughts, imaginations, dreams, perceptions; it may become scenarios enveloping one's actions, and it may be mapped onto any aspect of the cosmos.<sup>7</sup>

This “family” is always present if the family doctor will look for it. Sometimes it is like a Chinese puzzle. Hilda first presented her family doctor with her pain and asked him to take it away. Then she shared with him an image of her experience of “family” — being trapped inside a European cathedral full of soot. Finally she gave him her confession — she had not been a proper daughter to her mother, whom she experienced as rigid and rejecting. Her abdominal pain was rich with meaning: it represented her unbearable pain in her relationship with her mother; it was punishment for not fulfilling her mother's expectations and finally rejecting her by shipping her home; it gave her a legitimate excuse for not visiting her mother; and it was a way to defuse her anger at her mother. She truly had a “belly-full” of her mother.

Keeping Hilda's emotional problems submerged would have been difficult. Referring a patient in this situation to a specialist is fraught with peril. Referral to a psychiatrist would be experienced as rejection; referral to a surgeon or internist would lead to a series of investigations and perhaps hospitalization and even needless surgery, as had happened to Hilda before. Patients with problems like this are usually best helped by a physician who can look at body and mind together within the broader context of the patient's life history and family circumstances.

### 3.2. *The Patient in the Family*

This case also demonstrates the extent to which family problems and symptoms are communicable. Hilda learned her rigid style of dealing with matters from her parents, and Hilda's daughter strove to please her parents in the same way that Hilda had. When the effort became too great, Hilda's daughter acquired her mother's symptom.

Recognizing the family in the patient allows the doctor to treat the patient in the family. When Hilda's daughter presented with stomach pain, the doctor had a good idea of what the cause might be. He was able to

enlist Hilda's help in solving her daughter's problem. The timing undoubtedly was propitious. Having appreciated how her own mother's attitudes affected her life, Hilda had to be receptive to allowing her daughter to begin to live her own life. The daughter's problem needed to be addressed in the context of the family. Dealing with it in isolation — forcing the daughter to continue to struggle against the perceived values of her parents — would have been much less likely to succeed.

### 3.3. *Family Therapy*

Hilda's doctor wanted her and her husband to engage in marital therapy because he wanted to try to repair the rift for which he felt partially responsible. He interpreted her cues as indicating the problem was dyadic — involving both of them — so he offered a strategy for dealing with that kind of problem. Hilda rejected his offer of marital counseling, though, because she wanted to work on her own problem, not the problem between her and her husband. A family doctor has to be reactive, trying to do the best he can for the patient within the constraints imposed by the patient. Unlike a specialist, who can legitimately say, "Do it my way or seek help elsewhere," a family doctor is obligated to "hang in" with his patients and provide the help they will accept.

Moreover, unlike a family therapist, who has one type of help to offer, a family doctor has a variety. Hilda and her husband would not have gone to a family therapist had that option been offered to them. Therapists who deal with families as their primary job see a different category of families, namely, those not hostile to family therapy. This highlights why it is inappropriate to try to impose upon family medicine a model of the family derived from family therapy. Such a model is generally inappropriate, moreover, because it is based on the theoretical foundations of a different discipline and is directed towards clinical problems of a different nature.<sup>8</sup>

### 3.4. *The Patient-Centered Approach*

Even if a physician believes strongly in making the family a focus of care, this theoretical commitment must be tempered in practice. Not every patient and not every problem is amenable to such an approach. Doctors need to adopt a pragmatic stance that matches their problem-solving to the nature of the problem and the wishes of the patient. The best strategy for achieving this meld is a patient-centered search for cues that is tailored to each individual patient. Using this clinical method the physician follows

the patient's lead and gently probes the cues the patient presents about the nature of his problem. If the patient indicates he cannot or will not follow the physician's line of reasoning, the doctor backs off and tries another approach. This is what happened initially with Hilda. She refused to relate her abdominal pain to any personal problems or sources of stress, so her doctor withdrew from that line and treated her symptomatically. If patient and physician reach an impasse, the doctor may need to confront the patient, but more often he will accept that the patient is not ready to tackle the problem or he has failed to understand the patient. Either way he will bide his time and try again on another visit. Too strong a confrontation may simply increase the patient's defenses and perhaps scare the patient off. Sometimes the patient will give up on the doctor and go elsewhere to find someone who understands his plight in a way that makes sense to him or is acceptable to him.

Searching for and interpreting cues is a slippery business, however. In Hilda's case the doctor was deeply involved before he even knew what he was involved in. He suspected that her elbow pain might be a manifestation of an underlying emotional problem, but he did not know the exact nature of the problem, and he certainly had no idea of the depth of animosity that existed between Hilda and her husband. The history of Hilda's right upper quadrant pain and stomach pain supported the hypothesis that the elbow pain also was caused by an emotional problem and the attempt to uncover and confront this problem. Hilda's doctor was surprised by the result of this investigation, though, because, again following his experience, he looked to the past — Hilda's relationship with her parents — rather than to the present — Hilda's relationship with her husband. He was still dealing with the patient's family, but an unexpected part of it.

This case illustrates that the focus of care is not determined after all the facts have been collected but rather evolves from a patient-centered interaction between doctor and patient. Despite being their family physician for a number of years, the doctor had no inkling of the desperate state of the spouses' relationship. He did not know where the patient's cues were leading. The patient also had been unwilling to confront the problem in her marriage, so perhaps even she did not know where her cues were leading. Her children's recent move out of the home might have made her more aware of the emptiness of her marital relationship, though, and prompted her to assess her life and relate her physical problems to her personal problems. The case does point out that if family doctors are dedicated to following a patient's cues, they must follow them wherever they lead. They cannot set arbitrary boundaries on the kinds of problems

with which they will deal. Only in this way are family physicians faithful to the commitment to the patient that McWhinney has articulated so well:

The kind of commitment I am speaking of implies that the physician will "stay with" a person whatever his problem may be, and he will do so because his commitment is to people more than to a body of knowledge or a branch of technology. . . . Very often in such relations there is not even a very clear distinction between a medical problem and a non-medical one. The patient defines the problem.<sup>9</sup>

Appreciating the nature of the physician's search for and interpretation of cues emphasizes the power that doctors possess to intervene, sometimes unwittingly, in the lives of their patients. Yet doctors may have only an intuitive sense of the importance of this burden and may be unaware of their power in this regard. Adopting the biopsychosocial model forces an explicit recognition of this power, and utilizing the patient-centered approach is a way of exercising this power responsibly.

### 3.5. *Ethical Issues*

Treating the family in the patient raises moral issues whenever important values intrude in a doctor's judgment or decision making.<sup>10</sup> This can happen in a number of ways. The value a doctor attaches to the family as a social institution can influence the interpretation of patient cues. The value that the family holds for Hilda's doctor became clear through his suggestion of marital counseling after the problem in the marriage was revealed. In a situation unlike Hilda's where the potential for marital breakdown is perceived, however dimly, in advance, the physician might not probe deeply into or might recoil from personal problems, for fear of precipitating a marital crisis. In such instances the doctor is making a judgment about whether it is better to remain married and continue to suffer or to separate and possibly be relieved of pain. Recognizing the nature of this judgment is important because it exposes a limitation to the moral notion of respecting patient autonomy. In this kind of situation it is practically impossible to respect patient autonomy in the way that many commentators recommend, namely, by posing the issue explicitly to the patient and telling the patient to decide. Putting the question of whether it would be better to remain oblivious to the marital problem that is causing physical symptoms or to explore the possibility that severe, perhaps irreconcilable, difficulties in the marriage are being manifested in physical symptoms effectively precludes choosing the former. Simply raising this question would tell the patient that the doctor thinks an organic problem is emotionally caused and open up the realm of personal problems. Again, the patient-centered method offers a solution. The patient-centered

approach tries to deal with this dilemma by encouraging the doctor to explore any cues the patient throws out concerning his own thoughts and feelings about his illness. A doctor who follows the patient's lead in this way is less likely to impose on the patient insights for which he is unprepared.

The value of respecting individual autonomy provides a moral reason for a patient-centered search for cues. A doctor's problem solving and management decisions should be guided, as far as possible, by the patient's wishes. That the patient brought a problem to the doctor gives the doctor the authority to deal with it. Moreover, knowing that patients often conceal, for whatever reason, their real problems accords the doctor considerable leeway in delving into their personal lives. But this leeway is not unconstrained. The zeal to diagnose and manage a problem must be tempered by the understanding that it is, ultimately, the patient's problem. Because it is the patient's problem, the patient should be allowed to participate in both the definition of the problem and the adoption of a strategy for managing the problem. On the other hand, a too deferential attitude toward individual autonomy could prevent a physician from recognizing cues or interpreting them properly. Patients such as Hilda are asking for help with their personal problems in perhaps the only way possible for them. That help should not be refused in the name of absolute respect for an abstract ideal. From a moral point of view, the virtue of the patient-centered clinical method is that it tries to remain faithful to both the value of respecting patient autonomy and the value of promoting patient welfare.

#### 4. CONCLUSION

The biopsychosocial model describes a hierarchy of systems to consider in trying to make sense of a patient's problem. The patient-centered approach outlines a revised clinical method for zeroing in on the appropriate system or systems at both the stage of problem-solving and the stage of management. Together they provide the theoretical and practical tools that clinicians need to confront a wide range of problems in a manner that maximizes the potential to find common ground on which both the physician and patient can address a problem. As well, the search for common ground is a way of defusing the moral conflict between the value of patient autonomy and the value of patient welfare. The family is one system among many in the biopsychosocial model that may have to be considered in order to understand and deal with a patient's problem.

Following the patient-centered approach makes it possible to select the family as the system that deserves attention in a responsible manner. Thus, making the family a focus of care can be justified on theoretical, practical, and moral grounds.

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#### NOTES

<sup>1</sup> Henao, Sergio and Grose, Nellie P., eds. *Principles of family systems in family medicine*. New York: Brunner/Mazel, 1985, xiii (Emphasis in original).

<sup>2</sup> Engel, George L. The clinical application of the biopsychosocial model. *Journal of Medicine and Philosophy*, 1981, 6, 101–123.

<sup>3</sup> McWhinney, Ian R. Are we on the brink of a major transformation of clinical method? *CMAJ*, 1986, 135, 873–878; McCracken, Eric, *et al.* Patient-centred care: The family practice model. *Canadian Family Physician*, 1983, 29, 2313–2316; Levenstein, Joseph, *et al.* The patient-centred clinical method. 1. A model for the doctor-patient interaction in family medicine. *Family Practice*, 1986, 3, 24–30; Brown, Judy, *et al.* The patient-centred clinical method. 2. Definition and application. *Family Practice*, 1986, 3, 75–79; and Stewart, Moira, *et al.* The patient-centred clinical method. 3. Changes in residents' performance over two months of training. *Family Practice*, 1986, 3, 164–167.

<sup>4</sup> This quotation from Herbert B. Richardson is in Ransom, D. C. and Vandervoort, H. E. The development of family medicine. *JAMA*, 1973, 225, 1100.

<sup>5</sup> Bloch, Donald A. Editorial. *Family Systems Medicine*, 1986, 4, 132.

<sup>6</sup> Engel, *op. cit.*, 122.

<sup>7</sup> Laing, R. D. *The politics of the family and other essays*. London: Tavistock Publications, 1969, 4, 6, 18.

<sup>8</sup> Weston, W. Wayne. Family therapy and the family physician: Reflections after 15 years. *Family Systems Medicine* (in press).

<sup>9</sup> McWhinney, Ian R. Family medicine in perspective. *New England Journal of Medicine*, 1975, 293, 176.

<sup>10</sup> For a longer discussion see Chapter 5 in Christie, Ronald J. and Hoffmaster, C. Barry. *Ethical issues in family medicine*. New York: Oxford University Press, 1986.