Family-Oriented Primary Care

Second Edition

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Foreword by David Satcher, MD, PhD

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To our families:

David, Hanna, and Marisa
Kathy and Megan
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Jenny, Kate, August, Emily, David, Amylark, Rebecca, and Annalise

Foreword

I was a Medical Student in 1966 when the Millis Report on the training of the generalist physician was published, defining the concept of primary care. According to the Report, the primary provider has four major responsibilities or roles. The first role is that of initial contact care of the undifferentiated patient. The second is to provide comprehensive care based on the belief that the primary provider should be able to manage the overwhelming majority of problems with which patients present. Equally important is the third role—continuity and coordination of care within the health care system. Finally, the primary provider is responsible for demonstrating leadership in the community. This Report's description of a primary provider seems as relevant today as it was when it was written. In 1994, the Institute of Medicine's assessment of primary care added the responsibility of family and community integration of care to the Millis Report description.

Without question there are many challenges to a contemporary implementation of this comprehensive description of primary care, beginning with the level of individual patients who so often suffer from complex problems, such as mental disorders and obesity. Treating these conditions in a brief primary care visit is difficult. At the level of the larger system, reimbursement is often inadequate and can represent policies that are unsupportive of primary care, such as those that compromise payment for preventive services that help patients to quit smoking or lose weight. Perhaps the major policy barrier for comprehensive primary care is the profoundly limited access to care for people who are either uninsured or underinsured. According to a recent Institute of Medicine report, lack of access has been shown to dramatically impact quality of care; at least 18,000 deaths a year are attributed to patients being uninsured. At the community and national levels, when America and many other countries are trying to draw strength from our diversity, major disparities continue to exist in health and health care for different populations. Much of the weakness in our healthcare system is on the frontline with primary care. If people do not get into the healthcare system, with problems clearly defined and strategies for care effectively implemented, then they suffer and the whole system suffers.

At the level of clinical practice, the family represents what may be the most important challenge *and* opportunity for today's primary care provider. As the concept of family continues to evolve, research makes it more and more evident that relationships have a powerful effect on health, for better and for worse. A major contribution of this text is its compelling case for family issues and family dynamics to be recognized in primary care, not only as potential influences on illness, but also as powerfully positive resources in providing quality primary health care. The extent to which families are appropriately valued, respected, educated and involved will increase the opportunity we have to enact the roles described by the Millis Report and to significantly enhance the achievement of early diagnosis, continuity of care, health promotion and disease prevention, and successful treatment, especially of chronic diseases. It is refreshing and useful to have a book that helps us to understand the role of the family in recognizing illness and influencing treatment adherence, and to show us how to establish and maintain a truly family-oriented primary care practice.

The principles described in this book can be applied to many of the clinical challenges facing providers today. For example, the United States has more than 35 million people, ages 65 and older, and this population is projected to double by 2030. The good news, of course, is that life expectancy has increased significantly—by 30 years in the last century. The fastest growing group of people in America today are people more than 85 years of age. The bad news is that quality of life for older adults has not kept pace; today more than half of the people over the age of 80 are incapacitated physically, mentally or both. Primary care has a major role in dealing with the challenges provided by the aging of our population; it is through a partnership between the family and the primary care provider that these issues can be most successfully addressed.

Family-Oriented Primary Care, Second Edition, gives us the insights and tools needed to address some of the many challenges listed above. If we are to achieve the goals of Healthy People 2010, or even Healthy People 2020, it will be not only because we rectify some of the healthcare disparities that threaten our system, but also because of our commitment to treat the whole person with the illness, understanding that the person lives in a family that affects his/her health beliefs, lifestyle, and healthcare. If we as health professionals can partner with families to support and educate them, listen closely to their concerns, and advocate for their health, together we can increase the physical, mental, and social well-being of all our citizens and communities.

David Satcher, MD, PhD
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Preface to the Second Edition

Much has happened since *Family-Oriented Primary Care* first was published in 1990. Many physicians and nurses wrote to us about their experiences with family-oriented care, in the United States as well as in England, Germany, Israel, South Africa, Finland, Spain, Japan, and South Korea, to name just a few countries with strong family-oriented health professionals. We have been influenced by many of these colleagues and by the changes in the healthcare climate and practice. Ours is a time that requires innovation and rethinking of clinical approaches. This second edition of *Family-Oriented Primary Care* represents our current thinking and practice in response to the current healthcare environment.

Primary care is delivered in so many different settings and contexts that we are acutely aware that one approach cannot fit all situations. An intervention can have a variety of meanings across cultures. The examples in this book come from our experiences. The particulars may not fit your context or culture; however, we understand from our contact with others regarding the first edition that the principles of family-oriented primary care hold true regardless. For example, the meaning given by a patient to the symptom of fatigue or fainting may be different in the Rio Grande area of Texas than it is in New York City or outside Capetown, South Africa, but the principle of asking about and understanding the meaning or belief of the patient remains the same.

In addition to belief systems, family-oriented primary care is also very much affected by the economics of the particular healthcare delivery system in which the clinician works. In the United States, with the increasing corporatization of healthcare, clinicians have had to become even more aware of the bottom line. With decreased reimbursement in the face of increased paperwork, clinicians are even more pressured for time. The need to be efficient has never been greater. At the same time, there has been increased emphasis on "customer satisfaction." Primary care has new prominence as a key element of this new delivery system, with primary care clincians sometimes functioning as gatekeepers who decide when and how much to utlize other services.

All this change and turmoil in the delivery of healthcare has been both stressful and exciting. Whereas many professionals worry about patients receiving the appropriate quality of care when decisions are driven by financial considerations, one of the real benefits of attention to cost has been the overdue respect now given to the patient and family as consumers of healthcare. Healthcare systems are suddenly competing openly, and they want to know what their patients want.

Family-oriented approaches have become more, not less, relevant in this environment. With the decreased length of hospital stays and increased use of less-expensive paraprofessionals for a range of services, family members increasingly are care providers for patients with a broad range of problems. It has become essential for primary care clinicians to know how to work with family members, and to understand the family context even when only working with an individual patient as is typical.

Another development that influences this edition is the work of McDaniel and Hepworth, with their colleague Bill Doherty, in the development of an approach for mental health professionals termed "medical family therapy" (2). This biopsychosocial approach to psychotherapy has the same underlying principles as family-oriented primary care, and provides a complementary approach for family-oriented behavioral health clinicians on the primary care team.

New organizations and new journals have sprung up to support these innovations in healthcare. For example, the Collaborative Family HealthCare Association (CFHA)[1].org is a multidisciplinary organization for professionals interested in family-oriented, collaborative approaches to integrated healthcare. Its members include primary care physicians, nurses, a range of behavioral health specialists, and others committed to collaborative care. The journals *Families, Systems & Health* and the *Journal of Family Nursing* both devote themselves to research, literature reviews, and care reports about family-oriented healthcare. The research on the efficacy and effectiveness of family interventions has grown, will be seen in Chapter 2.

These many changes motivated our desire to update the first edition of *Family-Oriented Primary Care*. David Seaburn has turned his considerable talents to training in the area of research and health (thank you, Dave, for all of your important contributions to the first edition), and two new authors joined Susan McDaniel and Thomas Campbell in the revision of this volume: Jeri Hepworth, a family therapist who has taught and practiced in a Family Medicine residency program since 1981, and Alan Lorenz, a family physician who had a rural, family-oriented primary care practice for 10 years before coming to the University of Rochester Department of Family

[1] Information about CFHA is available by writing 40 West 12 St, NY, NY 10011, Fax: 212-727-1126, E-mail: staff@cfha.org, Web site: www.cfha.org

Medicine in 2001. Both authors bring a long history of experience and creativity to this project.

For those who know the first edition, you will notice that we have added new chapters on topics that students, residents, and practitioners continuously asked us about: how to conduct a routine, family-oriented visit with an individual; how to work with the difficult (angry, uncooperative, multiproblem) patient and family; and a family-oriented approach to genetic screening. In addition, much of the previous material has been updated and expanded. In the chapter on abuse, for example, we include approaches to partner violence and elder abuse, as well as on child abuse. This manual reflects our rapidly changing field, although we retain material and principles that seem to us to be timeless. We have given more attention in this volume to diversity: the diversity of patients treated in primary care, the diverse family forms that are part of our current cultural fabric, and the diversity of clinicians now working in primary care.

Health professionals today come in a variety of forms. In the first edition, we focused our efforts on family physicians. Part of the purpose of the second edition has been to broaden the focus to include internists, pediatricians, nurse practitioners, physician assistants, obstetrician/gynecologists, and any specialty physicians wishing to bring more of a family focus to their practice.

Many of these changes are the result of feedback that our readers have provided on the first edition. We hope you will do the same, as we continue to try to provide a practical, working guide to the practice of family-oriented primary care.

There are many people to thank in making a project this large and long-standing finally come to fruition, most especially Jeanne Klee, the assistant to Susan McDaniel and Tom Campbell, who supported the revision and development of this book, drew genograms and figures, and performed countless other tasks, always with a smile.

There are also the many professionals who read specific chapters and gave us invaluable feedback. Thank you to: Louise Acheson, Robert Cushman, Laurie Donohue, Steven Eisinger, Kevin Fiscella, Starlene Loader, Robert McCann, June Peters, Peter Rowley, Robert Ryder, Aric Schichor, David Siegel, Linda Sinapi, and the residents and fellows in the Departments of Family Medicine at the University of Connecticut and the University of Rochester.

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Our patients, of course, taught us the most about family-oriented primary care. Thank you to all of them.

And finally, to our own families, who have loved and supported us throughout this project: David, Hanna, and Marisa Siegel; Kathy Cole-Kelly

and Megan Campbell; Robert, Jon, and Katie Ryder; Jenny and Annalise Lorenz, August and Amylark Lorwood, and Kate, Emily, David, and Rebecca Sharp. We love you all.

Susan H. McDaniel, PhD
Thomas L. Campbell, MD
Jeri Hepworth, PhD
Alan Lorenz, MD

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Preface to the First Edition

This book is a manual for physicians who want to enhance their skills in working with patients in the context of their families. It has evolved out of our work with physicians, patients, and families in a primary care medical setting, as well as our teaching within the Department of Family Medicine at the University of Rochester School of Medicine and Dentistry. Respected colleagues, such as Medalie, Doherty and Baird, and Christie-Seely, have made contributions to the theory of family systems medicine, but little has yet been written about the practicalities and skills involved in day-to-day family-oriented primary care. Building on this theoretical work, we are taking the step of integrating theory into the daily practice of primary care physicians.

Family-oriented primary care offers the practitioners a useful perspective that will help in caring for both the individual patient and the family. The skills that operationalize this approach enable the physician to utilize the support inherent in most families to the benefit of the patient. The National Heart, Lung, and Blood Institute has recognized the importance of the family in increasing compliance and promoting continuity of care. Based upon research studies and clinical experience with hypertension, they recommend that the physician:

> Enhance support from family members—identifying and involving one influential person, preferably someone living with the patient, who can provide encouragement, help support the behavior change, and, if necessary, remind the patient about specifics of the regimen (1).

In this book, we have extended this basic strategy to apply to all of primary care.

Whereas family-oriented primary care can result in more effective care of a patient, we also feel it is important to note that this perspective can be useful to the physician. Primary care can be a stressful and taxing, albeit rewarding, career. Recognizing the important of the family and utilizing its resources allows the physician to share the responsibility of care and

decision making with those who care most about the patient. This approach can help to prevent physician burn-out so that energy can be conserved for the physician's own personal and family life.

We begin the manual with a section that spells out our theory of family systems medicine, reviews the relevant research, and provides a guide for assessing and interviewing families in primary care. This section is called, "The Biopsychosocial Assessment of the Family." We then turn to a section entitled, "Health Care of the Family in Transition," and discuss how to treat specific health-care issues that arise when the patient and his or her family are facing normal developmental challenges. These issues range from the concerns of new couples, pregnancy, and adolescent difficulties, to sexual issues, aging, and death. In the next section, "A Family-Oriented Approach to Specific Medical Problems," we provide guidelines for a family-oriented approach to substance abuse, anxiety and depression, chronic illness, somatic fixation, and sexual and physical abuse. The final section, "Implementing Family-Oriented Primary Care," addresses general issues: the implementation of a family-oriented practice; hospitalization; collaborating and making referrals with family therapist; and managing personal and professional boundaries.

Throughout the book we will use case material to illustrate how to approach specific treatment problems in a family-oriented way. The case examples are actual primary care cases or composites of cases; however, identifying data have been changed and pseudonyms added to protect the confidentiality of our patients. Protocols appear at the end of the each chapter to be used as a quick guide in daily practice.

Many people have helped us in the completion of this project. Our patients have provided us with invaluable opportunities to learn about family-oriented primary care. The residents who we teach and the faculty with whom we work at the University of Rochester Department of Family Medicine have provided important feedback on our ideas and our clinical practice. Our colleagues in the Division of Family Programs in the Department of Psychiatry have also stimulated and informed our work. Particularly, the thinking and teaching of M. Duncan Stanton, The director of the division, and Judith Landau-Stanton have influenced and broadened our perspectives. The administration of the Department of Family Medicine, and Highland Hospital, has provided us with the financial support to work on this project. We would especially like to thank Jay Dickinson, The chairman of the Department of Family Medicine, for his guidance and support.

We would also like to acknowledge the many people who read and reviewed these chapters before publication. Their responses helped us to clarify our theories and sharpen our techniques. We are most grateful to three people who read the entire book in process and provided us with constructive feedback: Kathy Cole-Kelly, Eugene Farley, and Thomas Schwenk. Numerous colleagues read specific chapters along the way and responded

from their areas of expertise. Thank you to: Marvin Amstey, Macaran Baird, Richard Botelho, T. Berry Brazelton, Barbara Elliott, Annmarie Groth-Junker, Jeff Harp, Allison Beth Maher, Carl Maskiell, Cathy Morrow, Steve Munson, Elizabeth Naumburg, Paul Rapoza, Deborah Richter, Eric Schaff, Joseph Scherger, Cleveland Shields, Bernard Shore, David Siegel, Earl Siegel, Lucy Siegel, David Stoller, Sarah Grafton, Donald Treat, Michael Weidner, and Lyman Wynne.

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Susan H. McDaniel, PhD
Thomas L. Campbell, MD
David B. Seaburn

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Contents