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Family Issues in Health Care

Thomas L. Campbell, Susan H. McDaniel, and Kathy Cole-Kelly

Caring for families is one of the defining characteristics of family practice. Families are the primary context within which most health problems and illnesses occur and have a powerful influence on health.[1] Most health beliefs and behaviors (e.g., smoking, diet, exercise) are developed and maintained within the family.[2] Marital and family relationships have as powerful an impact on health outcomes as biologic factors,[3] and family interventions have been shown to improve health outcomes for a variety of health problems.[4]

Family members, not health professionals, provide most of the health care for patients. Outside the hospital, health care professionals give advice and suggestions for the acute and chronic illness, but the actual care is usually provided by the patient (self-care) and family members. Chronic illness requires families to adapt and change roles to provide needed care. The aging of the population and increasing medical technology leads to a significant increase in the prevalence of chronic illness and disability and a rise in family caregiving.

Unfortunately, families are often neglected in health care. Our culture is individually oriented, valuing autonomy over connectedness. The impact of serious illness on other family members is often ignored. Family practice developed around the concept of caring for the entire family, yet many family physicians have received inade-

quate training in how to work with families. Some have even argued that it is not practical and takes too much time to work with families. The ability to work effectively and efficiently with families and to use them as a resource in patient care is an essential skill for all family physicians.

Despite rapid societal changes in the structure and function of families, the family remains the most important relational unit and provides individuals with their most basic needs for physical and emotional safety, health, and well-being. The family can be defined as "any group of people related either biologically, emotionally, or legally."[5] This includes all forms of traditional and nontraditional families, such as unmarried couples, blended families, and gay and lesbian couples. The relevant family context may include family members who live a distance from the patient or all the residents of a community home for the developmentally delayed persons. In daily practice, family physicians are most often involved with family members who live in the same household.

Premises of a Family Systems Approach

There are three basic premises upon which a family systems approach is based. These premises are derived from systems theory, are supported by research, and help guide the clinical application of family systems.

1. A family systems approach is based on a biopsychosocial model of health care in which there is an interrelationship between biologic, psychological, and social processes. This approach places the patient and the illness in a larger framework involving multiple systems. The family-oriented physician must recognize and address the psychosocial factors as well as the biomedical factors in understanding patients and their illness. A systems approach emphasizes the interaction among the different levels of the larger systems and the importance of continuous and reciprocal feedback.
2. The family has an influence on physical and psychological health and well-being. This principle is well supported by research and has important implications for clinical practice. Clinicians must understand how the family can positively and negatively influence health and utilize the information to improve health care. There are several corollaries to this basic premise.
   a. The family is a primary source of many health beliefs and behaviors.

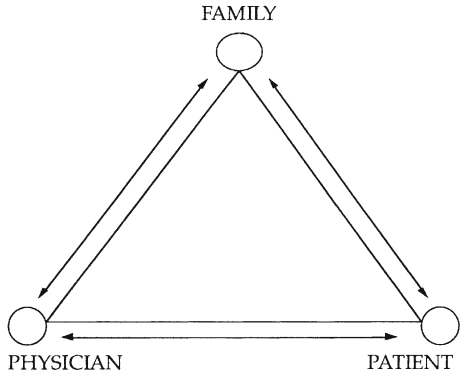


Fig. 2.1. Therapeutic triangle. (*Source:* Doherty and Baird.[6])

b. The family is an important source of stress and social support.
c. Physical symptoms may have an adaptive function within a family and be maintained by family patterns.

3. The family is the primary social context in which health care issues are addressed. Although the patient is the primary focus of medical care, the family is often the most important social context that must be understood and considered when delivering health care. It is not useful to think of the family as the "unit of care." Family physicians treat individuals within families, not families themselves. They must consider the family context and address family relationships when they influence health problems. This is important whether a physician cares for only one or every member of a family.

Doherty and Baird[6] have challenged the "illusion of the medical dyad" between the physician and patient and have described the relationship of the physician, patient, and family as a therapeutic triangle (Fig. 2.1). This triangle emphasizes that the family plays a role in all patient encounters regardless of whether family members are present and the need to be cognizant of both the patient–family relationship and the physician–family relationship.

Research on Families and Health

A large body of research has demonstrated the powerful influence that families have on health. There are many randomized controlled

trials demonstrating the effectiveness of family interventions for medical disorders.[4] A recent Institute of Medicine report on families, health, and behavior reviewed the research on the influence of family relationships on the management and outcomes of chronic diseases.[7] Several general conclusions can be made from a review of this research:

1. Families have a powerful influence on health and illness. Numerous large epidemiologic studies have demonstrated that social support, particularly from the family, is health promoting. In an 1988 article in the journal *Science*, sociologist James House et al[3] reviewed this research and concluded, "The evidence regarding social relationships and health increasingly approximates the evidence in the 1964 Surgeon General's report that established cigarette smoking as a cause or risk factor for mortality and morbidity from a range of disease. The age-adjusted relative risk ratios are stronger than the relative risks for all cause mortality reported for cigarette smoking."

   Family support affects the outcome of most chronic medical illnesses. After suffering a myocardial infarction (MI), women with few or no family supports have two to three times the mortality rate compared to other women who are recovering from an MI.[8] Many stresses within the family, such as loss of a spouse and divorce, significantly impact morbidity and mortality.
2. Emotional support is the most important and influential type of family support. Social and family support can be divided into different types: instrumental, informational, and emotional. Instrumental support is the actual provision of services (e.g., driving the patient to the hospital) or caregiving (e.g., giving insulin injections) provided by family members. Informational support usually involves giving health-related information, such as advice on whether to seek medical care. Emotional support provides a listening ear, empathy, and the sense that one is cared about and loved. Although there is overlap among these categories, studies suggests that family emotional support has the most important influence on health outcomes and therefore cannot be replaced with social agencies or services that provide instrumental and informational support.
3. Marriage is the most influential family relationship on health. Even after controlling for other factors, marital status affects overall mortality, mortality from specific illnesses, especially cancer and heart disease, and morbidity. Married individuals are healthier than widowed, who are in turn healthier than either divorced

or never-married individuals. Those who are married have healthier lifestyles and less disability, and they live longer. Bereavement or death of a spouse increases mortality, especially for men.[9] Separation and divorce is also associated with increased morbidity and mortality. Studies in psychoimmunology have shown that divorced and unhappily married men and women have poorer immune function than those in healthier marriages.[10]

4. Negative, critical, or hostile family relationships have a stronger influence on health than positive or supportive relationships. In terms of health, "being nasty" is worse than simply not being nice. Research in the mental health field with schizophrenia and depression first demonstrated that family criticism was strongly predictive of relapse and poor outcome.[11,12] Similar results have been found with smoking cessation,[13] weight management,[14] diabetes,[15] asthma, and migraine headaches. Physiologic studies have shown that conflict and criticism between family members can have negative influences on blood pressure,[16] diabetes control,[17] and immune function.
5. Family psychoeducation is an effective intervention for health problems. There is a wide range of types of family interventions that have been used for health problems, from simply providing family members with information about the disease to in-depth family therapy. The most consistently effective and studied family intervention seems to be family psychoeducation, in which family members are given training on how to manage and cope with the illness and provided with emotional and instrumental support.[18]

An excellent example of an effective, family psychoeducational intervention has been developed for family caregivers of Alzheimer disease (AD) patients.[19] In a randomized controlled trial, families attended individual and group instructional and problem-solving sessions where they learned how to manage many of the troublesome behaviors of patients with AD. They also participated in ongoing family support group and can access a crisis intervention service to help them with urgent problems. The caregivers who received this intervention were less depressed and physically healthier than those who did not, and AD patients were able to remain at home for almost a year longer than caregivers in the control group. The savings in nursing home costs were several times the cost of the interventions. This study should serve as a model for other family intervention programs.

This research establishes that families have a strong influence on overall health and on the outcome of specific illnesses. The impact

is the greatest for illnesses in which there is a high burden on family caregivers. Effective family interventions range from complex, multifaceted programs (e.g., for AD patients) to educating family members about the illness (e.g., hypertension). To implement any of the interventions, family physicians must know how to work with families and use them as a resource in patient care.

Working with Families

Much of what has been written about working with families has focused on the family conference, the most formal and uncommon form of a family interview. It is useful to distinguish three approaches to working with families: the family-oriented approach with an individual patient, involving family members during a routine office visit, and the family conference or meeting (Table 2.1). In all of these contexts, medical care is enhanced by obtaining information about the family, assessing family relationships, and encouraging appropriate family involvement.

A Family-Oriented Approach with an Individual Patient

A family orientation has more to do with how one thinks about the patient than how many people are in the exam room. Since family physicians meet with individual patients more often than with family members, having a family-oriented approach to all patients is an important skill. This approach complements a patient-centered approach in which the physician explores the patient's experience of illness, an experience that occurs in a family or relational context. The patient's presenting complaint can be thought of as an entrance or window into understanding the patient in the context of the family. By exploring the patient's symptoms and illness, the physician can learn more about the patient's family, its relationship to the presenting complaint, and how the family can be used as resource in treatment. A key to being family oriented is choosing appropriate questions to learn about the psychosocial and family-related issues without the patient feeling that the physician is intruding or suggesting that the problem is "all in your head."

In a qualitative study of exemplar family physicians, Cole-Kelly and colleagues[20] examined the core components of a family-oriented approach with individual patients. These family physicians used both global family questions, such as "How's everyone doing at home?" as well as focused family-oriented questions, such as "How is your

Table 2.1. **Working with Families**

	Family-oriented approach with individual patient	Involving family members in routine office visits	Family conference
Common medical situations	Acute medical problems Self-limiting problems	Well-child and prenatal care Diagnosis of a chronic illness Noncompliance Somatization	Hospitalization Terminal illness Institutionalization Serious family problem/conflict
Percent of time used by physician	60–75%	25–40%	2–5%
Length of visit	10–15 minutes	15–20 minutes	30–40 minutes
How scheduled	Routine care	May need to request family member attendance	Special scheduling and planning

Source: Adapted from McDaniel et al.[5]

wife doing with that new treatment?" The exemplars frequently inquired about other family members and were able to keep a storehouse of family details in their minds that they frequently interspersed in the visits. The physician would commonly punctuate the end of the visit with a greeting to another family member: "Be sure to tell John I said hello."

A risk of being family-oriented with an individual patient is getting triangulated between family members—the one speaking to the physician and a family member being talked about. In Cole-Kelly et al's[20] study, the exemplar physicians were sensitive to the dangers of inappropriately colluding in a triangulated relationship with the patient and were very facile at avoiding those traps. The exemplars seemed to have an appreciation for the importance of understanding the concept of triangulation and to use it for their and the patient/family's advantage. The exemplars often explored family-oriented material during physical exams or while doing procedures, thus not using extra time for these areas of inquiry. Visits with a high family-oriented content occurred 19% of the time and family-oriented talk was low or absent in 52% of the visits. The visits that had the highest degree of family-oriented character were chronic illness visits and well-baby and child visits.

Asking some family-oriented questions can metaphorically bring the family into the exam room and provide a family context to the presenting problem.[21] Here are examples of family questions:

"*Has anyone else in your family had this problem?*" This question is often part of obtaining a genogram. It reveals not only whether there is a family history of the problem, but also how the family has responded to the problem in the past. The treatment used with one member of the family or in a previous generation may be a guide for the patient's approach to his/her illness or may describe how a patient does not want to proceed.

"*What do your family members believe caused the problem or could treat the problem?*" Family members often have explanatory models that strongly influence the patient's beliefs and behaviors regarding the health problem.[22] If the physician's treatment plan conflicts with what important family members believe or have recommended, it is unlikely the patient will comply.

"*Who in your family is most concerned about the problem?*" Sometimes another family member may be the one most concerned about the health problem and may be the actual person who really wants the patient to receive care. When the patient does seem concerned about the health problem or motivated to follow treatment recom-

mendations, finding out who is most concerned may be helpful in creating an effective treatment plan.

"*Along with your illness (or symptoms), have there been any other recent changes in your family?*" This question is a useful way to screen for other additional stressors, health problems, and changes in the patient's family and how it is affecting the patient.

"*How can your family be helpful to you in dealing with this problem?*" Discovering how family members can be a resource to the patient should be a key element of all treatment planning.

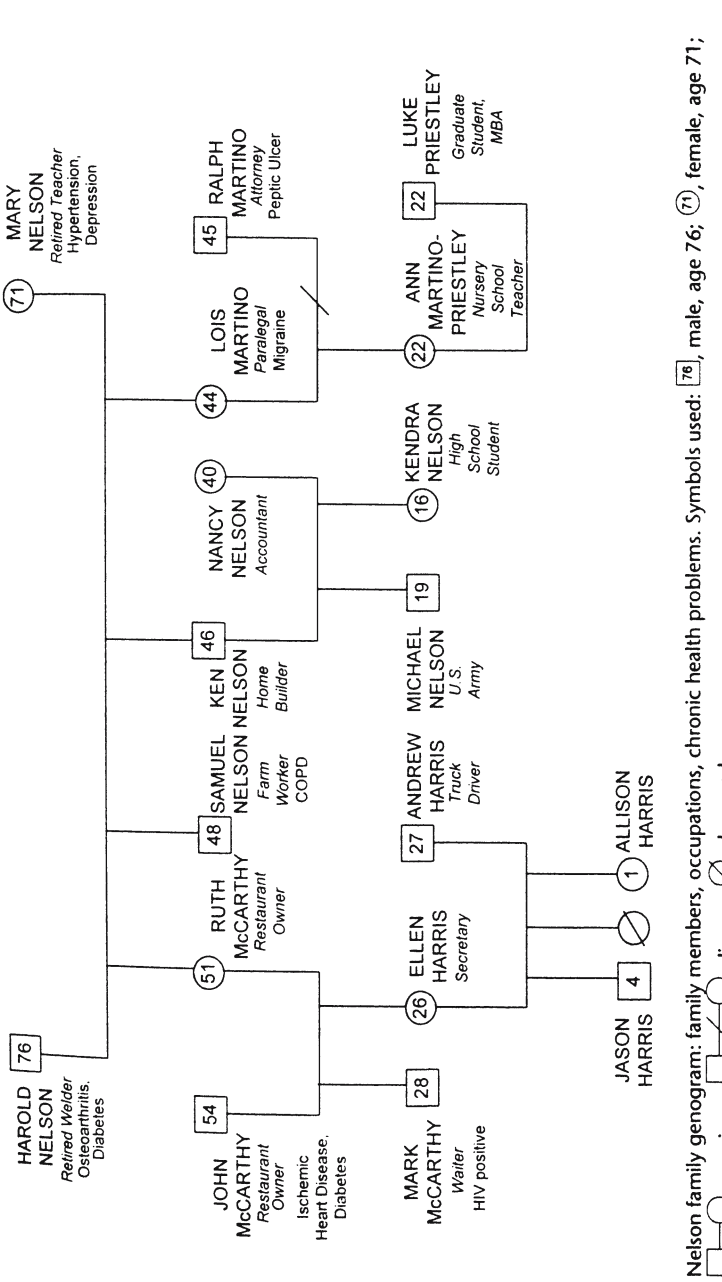
These questions can be integrated into a routine 15-minute office visit with an individual patient and provide valuable family information relevant to the problem.

Genograms

Genograms or family trees are one key to a family-oriented interview with an individual patient. They are the simplest and most efficient method for understanding the family context of a patient encounter[23] (Fig. 4.2) and provide a psychosocial "snapshot" of the patient. Genograms provides crucial information about genetic risks and any family history of serious illnesses. With advances in genetic research, a detailed genogram should be an essential component of every patient's medical evaluation and database. Ideally a genogram should integrate genetic and psychosocial information.

The genogram can be started at an initial visit and added to during subsequent encounters. It may be quite simple and only include the current household and family history of serious diseases or provide more detailed information about family events and relationships. When possible, the genogram should include family members' names, ages, marital status, significant illnesses, and dates of traumatic events, such as deaths. Computerized genogram programs are available so that the genogram can be integrated into an electronic medical record.

Obtaining a genogram can be a particularly effective way to understand the family context and obtain psychosocial information from a somatically focused or somatizing patient. These patients often present with multiple somatic complaints and try to keep the focus of the encounter on their physical symptoms and distress. They are challenging patients, and it is often difficult to obtain family or psychosocial information from them. Since obtaining a family history is considered a routine part of a medical evaluation, it can often provide access to more relevant psychosocial illness. It provides a way



Nelson family genogram: family members, occupations, chronic health problems. Symbols used: [76], male, age 76; (71), female, age 71; ○, marriage; ○/○, divorce; ∅, deceased.

Fig. 2.2. Genogram.

to step back from the presenting complaints to obtain a broader view of patients and their symptoms in a manner that is acceptable to the patients. The genogram can also be used to screen for substance abuse and family violence.[23]

Involving Family Members in Routine Office Visits

Routine visits, in which one or more family members are present, are common and may be initiated by the patient, family members, or the clinician. These visits allow clinicians to obtain the family members' perspective on the problem or the treatment plan and answer the family members' questions. Family members accompany the patient to office visits in approximately one third of all visits, and these visits last just a few minutes longer than other visits. In some situations, they may be more efficient and cost-effective than a visit with an individual patient because a family member can provide important information about the health problem, or the visit may answer questions that might later arise. Family members may serve various roles for the patients, including helping to communicate patient concerns to the doctor, helping patients to remember clinician recommendations, expressing concerns regarding the patient, and assisting patients in making decisions. Physicians report that the accompanying family members improve their understanding of the patient's problem and the patient's understanding of the diagnosis and treatment.

There are many situations when a family physician may want to invite another family member to the next office visit. Partners and spouses are routinely invited to prenatal visits. Fathers and coparents should be invited to well-child visits, especially when the child has a health or behavior problem. Whenever there is a diagnosis of a serious medical illness or concern about adherence to medical treatments, it is helpful to invite the patient's spouse or other important family members to come for the next visit. Elderly couples are usually highly dependent on each other. It can be particularly effective and efficient to see them together for their routine visits. Each can provide information on how the other one is doing and help with implementation of treatment recommendations. Consulting with family members during a routine visit is advised whenever the health problem is likely to have a significant impact on other family members or when family members can be a resource in the treatment plan.

Principles of Family Interviewing

The principles of interviewing an individual patient also apply to interviewing families, but there are additional complexities. One must

engage and talk with at least one additional person, and there is opportunity for interaction between the patient and family members. In general, the physician must be more active and establish clear leadership in a family interview. This may be as simple as being certain that each participant's voice is heard ("Mrs. Jones, we haven't heard from you about your concerns about your husband's illness. Can you share those?") or may entail acting as a traffic cop with a large and vocal family ("Jim, I know that you have some ideas about your mother's care, but I'd like to let your sister finish talking before we hear from you.").

When interviewing families, establishing rapport and an initial relationship with each family member is particularly important. In a family systems approach, this is known as joining. An essential component of joining is making some positive contact with each person present so that each feels valued and connected enough to the physician to participate in the interview. Family members have often been excluded from health care discussions and decisions, even when they are present. They may not expect to be included in the interview or to be asked to participate in decision making. By making contact and shaking hands with each person, the physician is making clear that everyone is encouraged to participate in the interview.

There are several other important reasons for joining with family members at the beginning of the interview. The physician often has an established relationship with the patient, but may not have one with other family members, who may feel either left out or that their role is merely that of an observer. One common example of this occurs commonly during hospital rounds when there is a family member by the bedside. The usual approach is to either ask family members to leave during the interview or to ignore them. This is disrespectful of families and fails to use family members as a resource. It is recommended that the physician greet and shake hands with each family member and find out something about each person. At a minimum, this may be the family member's relationship with the patient and involvement in the patient's health problems. It may also involve thanking them for their presence and help.

All the principles of good medical interviewing can be extended to family interviewing. It is helpful to encourage each family member to participate and to be as specific as possible when discussing problems. Individual and family strengths should be emphasized. Emotions that are present in any family member during the interview should be recognized and acknowledged: "Mr. Canapary, you look upset. Is there anything about your wife's health or her medical care that you are concerned about?" In addition, the physician must take

an active role in blocking persistent interruptions and preventing one person from monopolizing the conversation.

Establishing a positive relationship with family members is particularly important and more challenging when there is conflict in the family. In these cases, a family member may assume that the physician has taken the side of the patient in the conflict. The physician must take extra steps to join with family members in conflict and establish one's neutrality. The goal in these situations is to develop an alliance with each family member and the patient without taking sides in the conflict. An exception to this goal is when family violence threatens and then safety must be the first priority.

In addition to establishing rapport and building a relationship through verbal communication, the physician can also make use of nonverbal strategies to enhance the relationship with the patient and family members. Just as it is important to be sure that the physician and an individual patient are in a comfortable sitting position and at eye level with one another, it is important also that other family members are sitting near enough that they can hear what's being said and be easily seen by the physician. This proximity will help the physician make eye contact with each person in the room.

Upon entering the room and seeing that one family member is sitting very far from the physician or isolated from other family members, the physician can gently motion the person to come closer to enhance the sense of everyone being included in the patient visit and being an important part of the encounter. Similarly, one family member might dominate both the verbal and nonverbal space in the encounter, making it difficult for the other family members to have as much involvement with the patient or physician. For these cases, the physician must "direct traffic," so all voices can be heard.

A physician who meets with multiple family members needs to learn how to avoid taking sides with one family member at the exclusion of another. It is very easy for the physician to unwittingly be pulled into unresolved conflicts between family members. In the case of an ill child, one parent may try to form a relationship with the physician that excludes the other parent. Or a wife can try to get the physician to side with her, hoping that the physician's alliance will bolster her position against her husband. To avoid getting caught in the middle of a triangle, the physician must listen to each member of the family but still remain neutral. Furthermore, the physician can assert that it won't be helpful to the family if the physician takes sides with one member against another. The physician can emphasize the importance of everyone working together as the most beneficial way to enhance the health care of the patient (Table 2.2).

Table 2.2. **Dos and Don'ts of Family Interviewing**

Dos
Greet and shake hands with each family member.
Affirm the importance of each person's contribution.
Recognize and acknowledge any emotions expressed.
Encourage family members to be specific.
Maintain an empathic and noncritical stance with each person.
Emphasize individual and family strengths.
Block persistent interruptions.
Don'ts
Don't let any one person monopolize the conversation.
Don't allow family members to speak for each other.
Don't offer advice or interpretations early in a family interview.
Don't breach patient confidentiality.
Don't take sides in a family conflict, unless some one's safety is involved.

Source: Adapted from McDaniel et al.[5]

Family Conferences

A family conference is usually a specially arranged meeting requested by the physician, patient, or family to discuss the patient's health problem or a family problem in more depth than can be addressed during a routine office visit (see Table 2.1). All the principles of family interviewing discussed previously are used in a family conference. However, a family conference is usually longer than most office visits and involves more planning and structure.

Every family physician should have the skills to convene and conduct a family conference or meeting. In a randomized controlled trial, Karofsky and colleagues[24] examined the impact of an initial family conference for new pediatric patients and their families through a randomized controlled trial. The families that received the family conference had fewer subsequent visits for health problems or to the emergency room and more visits for health supervision (well-child visits). This study suggests that family conferences may be cost-effective by reducing health care utilization.

Meeting with entire families is most important when diagnosing and treating life-threatening illnesses. Family members are usually eager to obtain information from the physician and want to know how they can be helpful. Most physicians meet with a patient's family at the time of a hospitalization to explain a diagnosis and treatment plan. A family meeting at the time of hospital discharge should be routine. Usually family members must assume the responsibility for the care of the patient and need detailed information about the

patient's condition and follow-up treatment. One study of couples coping with a myocardial infarction found that the best predictor of the wife's emotional well-being 6 months after her husband's heart attack was whether she had an opportunity to meet and talk with his physician prior to discharge.[25] Under managed care, hospital stays have shortened dramatically, and patients are going home with significant health care needs that must be provided by family members or assisted by visiting nurses.

Family conferences should also be a routine part of palliative or end-of-life care, whether at home or in a hospice. Clarifying the patient's diagnosis and prognosis with the family can be very helpful for treatment planning. Family conferences are often essential to resolve conflicts about whether to move from curative to comfort care. Some family members may resist a patient's decision to stop chemotherapy or other medical treatments, often because they are not emotionally ready for the patient's death. If the decision can be discussed and emotional reactions shared in a family meeting, these problems or conflicts can be avoided. Finally, it is helpful to routinely meet with family members after a patient's death to answer questions, allow the sharing of grief, and assess how family members are coping. With large families or difficult problems, the physician may wish to ask a family therapist to help conduct the meeting.

Conducting a family conference requires skills in addition to those used when meeting with family members during a routine office visit. There are usually, but not always, more family members involved. A family assessment and some type of planned family intervention may be required. The reason for convening the family may involve difficult or conflictual issues, which require special skills to handle.

A detailed outline or blueprint for conducting a family conference has been described elsewhere.[5] Prior to meeting with the family, the physician should have a clear rational and initial plan for the conference. Here are the basic steps or phases of a family conference that can guide the physician.

Joining Phase

As discussed previously, it is particularly important to spend time to develop rapport with the family and get to know something about each family member at the beginning of the conference. This step is often neglected or given inadequate time by the inexperienced clinician. The family may want to discuss the problem or issue at the very outset, and the physician may lose the opportunity to join early and learn more about the family. The physician can stop the discussion of the problem and say, "I find it helpful to step back and learn

a little bit more about each of you, before we discuss the problem." This joining phase, which may seem like social chat to the inexperienced, helps to create a sense of trust between the physician and family and an environment in which family members feel safe and supported. If the physician already knows the family well, this phase may be abbreviated but should not be eliminated.

Goal Setting

It is helpful to jointly establish goals for the conference with the family. This often begins with the physician's statement about why the family has been convened, for example, "to discuss your mother's illness and plans for further treatment." It is then useful to ask what the family wants to accomplish during the session. The family's goals may be quite different from the physician's, and they need to be respected and addressed. This is analogous to asking individual patients what they were hoping to achieve during a routine office visit.

Information Exchange

The physician may ask what the family knows about the patient's illness or problem. This is often more effective and informative than launching into a detailed description of the patient's problem without knowing the family's level of knowledge. It also allows the physician to directly address misunderstandings or misinformation and to identify whether family members have varying views of the problem. It is important to get the views of all the family members present, even if it's as simple as having a family member say he or she agrees with the others.

Obtaining further information about the family is usually very helpful in understanding the issues or problems that the family is dealing with. Gathering a more detailed genogram is an easy way to obtain this information, and families usually feel comfortable and often enjoy this process. It is crucial to identify family strengths and supports during the interview. These are the resources that the family members will use to cope with the problem or illness they are facing.

When conducting an interview with a large, conflictual, or enmeshed family, the physician usually needs to be more active than during interviews with individuals, directing the conversations between family members and managing arguments. Each family member should be encouraged to speak, and no one should be allowed to speak for someone else who is present. It is important not to let any one person monopolize the conversation, and to interrupt and solicit other family members' opinion on the topic.

Establishing a Plan

During this final phase, the physician should work with the family to develop a mutually agreed upon treatment plan and to clarify each person's role in carrying it out. The patient, physician, and family members should have input into the plan. For some families, this may require writing up a formal care plan that everyone can agree on.

Confidentiality

When working with family members, the family physician must maintain confidentiality with the patient. Prior to speaking with a family member, it is important that the physician is clear about what the patient feels can be shared and what, if anything, cannot be. A family member may bring up difficult or awkward concerns, but the physician may only disclose information the patient has approved (unless the patient is incompetent). In most cases, patients will agree that their care plan can be fully discussed with the family members. However, in family meetings involving adolescents or divorced parents, the rules for the meeting need to be clearly spelled out. The physician may remind families at the beginning: "John has agreed that I can talk with you about the options for his diabetes treatment. He, of course, will be the one who will make the final decisions, but we both think it will be helpful to have all of your thoughts about what may be best." Such discussions value both the doctor–patient relationship as well as the patient–family relationships. The positive support of these relationships is only one of the positive outcomes of well-crafted family meetings.

Conclusion

The aging of the population, advances in medical research, and changes in our health care delivery system will continue to have dramatic impact on family issues in health care. There are increasing demands on families to provide care for aged and chronically ill patients, often without adequate services and insurance reimbursements. Family caregiving has led to an increasing burden on family members and poor physical and mental health for many caregivers. The role of the family in end-of-life decision making is only beginning to be addressed. Health care proxy laws allow patients to identify an individual, usually a close family member, to make medical deci-

sions if the patient is unable to, but little research has been done on how patients make these choices, what they discuss with their designated health care agent, and whether family members follow the wishes of the patient. Because of the genetic revolution, we will soon have the ability to screen or test for hundreds of genetic disorders, but the impact of this technology on families is just beginning to be examined. Genetic counseling needs to address not only the genetic risks of the individual but also the implications for other family members. More family research is need in each of these areas.

One of the unique and distinguishing characteristics of family medicine is its emphasis on the family. No other medical specialty has a family focus or uses a family-oriented approach. Under our changing health care system, there is increasing recognition of the importance and cost-effectiveness of involving the family in all aspects of medical care. New models of care are being developed that emphasize teamwork, prevention, and collaboration with patients and their families. A family-oriented approach will become increasingly valued and effective model in the 21st century.

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