Should family physicians treat members of the same family?

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YES

We owe to our families both the ideas that we live by and the diseases that will one day claim our lives.
Marcel Proust, *Within a Budding Grove*

In Canada, it has long been a given that physicians treat entire families. This notion is so deeply rooted in the culture of family medicine that it is part of the name of our discipline. The world in which we live has changed, however, and so have our patients and our discipline. It is high time that we asked ourselves whether a "family" practice is still a desirable practice. I will attempt to demonstrate that it is indeed a desirable practice, but with one condition: our patients must want and ask for this. In general, I think that they do want this.

There are a few notable exceptions. The first that comes to mind is the physician's area of expertise. Personally, I do not deliver babies nor do I provide follow-up care to patients who have just given birth. I have neither the expertise nor the interest. Another exception that comes to mind is confidentiality and conflict of interest. One example would be a patient who has consulted for screening for sexually transmitted infections because he has been unfaithful to his wife and he now wonders whether I would take his wife on as a patient. These are rare exceptions and they are not the point of this debate. This debate is about the principle of treating entire families and whether, in most cases, this practice is advisable.

Practical considerations: added value

The practice of treating entire families is beneficial on a practical level. Being aware of the patient's family context helps me, in very tangible ways, to more fully understand his experiences with his symptoms, as well as everything that is undifferentiated—his ideals and his beliefs. I am not attempting to reduce the patient to his family. Far from it. But what a man is, what he becomes, what he holds dear as values and ideas, his vulnerabilities, and his genes are clearly rooted in his family.

What are we afraid of? That we will find ourselves in a delicate situation that requires us to keep a secret? That we will misjudge a situation because we have been unduly influenced by what we know about a patient's family? These situations are complex, but isn't this exactly what our work as family physicians requires of us? Isn't this what we are about?

Our mission is to care for our patients, regardless of their socioeconomic standing or their family and social circumstances. We care for them by recognizing and integrating all of these aspects, not by denying they exist in order to make our job easier. It is precisely when a patient falls ill or when interpersonal conflicts cause stress that our comprehensive knowledge of our patients becomes useful and relevant. Tolstoy said it so eloquently in the opening passages of *Anna Karenina*: "Happy families are all alike; every unhappy family is unhappy in its own way."

Meeting the expectations and needs of our patients

If my patient and his wife want to have the same family physician—which is what we are talking about—I do not see how this can be undesirable. If they have chosen a physician whom they both want to see, saying that this is not good for them smacks of paternalism. Generally speaking, our patients are aware of the benefits and limitations of this family practice. If they choose it, it is because they feel that this family practice is what is best for them. The only reason to refuse to treat an entire family would be because the family itself did not want this. It happens, but only rarely.

The individual, the family, the community: postmodern excess

There are also situations in which this practice is unavoidable. Take the case of a small rural community with only 1 family physician. In this scenario, this issue simply goes away, unless those who oppose the idea are going to argue that it is better not to have a family physician than to have the same family physician as one's spouse or one's neighbour!

The example of the small rural community offers us an opportunity to reframe the question and to ask it in a broader context. In small communities, everyone knows everybody else; the anonymity of the big city does not exist. Relationships are more intimate and often have the intensity of family relationships. Confidentiality and conflict of interest are issues that apply to all patients. Isn't this debate about the individual in relation to the community as a whole, ie, his family, his neighbours, and his co-workers?

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I am well aware of the value placed on the individual in postmodern Western societies. However, because I am aware of the tangible benefits of "family practice" and because I know that patients and their families often ask for it, I feel that it is important to question the tyranny—the absolute dominance—of the *me* over the *we*. In medicine, the importance of the patient's family and social circumstances is too important to be ignored.

In light of these thoughts, I wonder what opposition to this notion says about us, about our profession, and about our commitment to serve the public. What do we think about human relationships and relationships within families? Is a fear that family relations will poison the patient-doctor relationship to be our starting point? Is our confidence in our ability to make judgments and to understand and integrate our patients' families that tenuous? Or do we want to offer our patients our presence, our expertise, our condition as fellow human beings, our judgment, and *above all,* our ability to weave all of these pieces together in our practice?

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CLOSING ARGUMENTS

- There is a practical benefit to treating members of the same family: it makes our job easier and it makes us more effective as physicians.
- This is a matter of social responsibility: it is what our patients need and want from us.
- A cautionary note: we must not allow the pressures of individualism to govern our practice.

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do not fit neatly into any clear definition of family. Who decides? Or to put it more provocatively, who cares? For all the close-knit happy families, there are many unhappy ones. But I am a doctor, not a family therapist. I need to know about sources of stress and conflict for my patients. This might well be their families. But this does not mean I have to take them on as patients, any more than I need to meet my patient's boss (let alone take her on as a patient).

Of course, I do follow families, and I enjoy doing so for many reasons. But I do not believe that I offer them superior care compared to my "orphan" patients. I try not to neglect the role of family or any other important issue in the life of any patient, simply because other family members are not on my patient list.

Doctors treat patients—individuals—not families. To do our job well, we must try to understand the context of the patient's illness and wellness from many perspectives: biological, psychological, spiritual, and social, including family. But I can do this by listening to my patient. Treating all members of a family does not necessarily add much to the fundamental relationship in medicine, which is the relationship between doctor and patient.

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CLOSING ARGUMENTS

- Caring for patients from the same family represents a conflict of interest and confidentiality. It can provide a more complex picture of family dynamics, but such complexity often distracts from the account the patient chooses to share. Primacy should be given to the patient's version.
- Even close families require private space, and the doctor-patient relationship should be such a space to ensure patients are comfortable disclosing problems.
- The obligation to treat whole families is an unrealistic expectation that can be a disincentive to new doctors pursuing family medicine. It can also lead to unfair prioritization of new patients.

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