Family Outcomes: Family-Practitioner Interface

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In their recent text on <u>Family Theory Development in Nursing,</u> Whall and Fawcett (1991) presented an historical overview of nursing literature related to family. They concluded that "interest in the family as a unit of nursing care originated with Nightingale's concern for family members. Continued interest in the family is documented in books and journal articles since Nightingale's time as well as in the American Nurses's Association standards of practice" (pp.24-25). For example, as early as 1917 Beard wrote about the implications for public health nursing of considering the family as the primary unit of intervention, and in 1937 Bean and Brockett reported the results of an investigation aimed at documenting the extent to which public health nurses had expanded their practice to include the entire family. Since 1950, Whall and Fawcett (1991) noted a dramatic increase in the quantity and scope of nursing literature related to families. Not only do clinical texts continue to include sections on family systems, theories, and roles, but textbooks dealing entirely with family content began to appear in the mid 1970's. Increasingly, such texts have reflected a combined focus on family theory, practice, and research (Gilliss, Highley, Roberts, & Martinson, 1989; Sherwen, 1987).

The amount of research of families has been sufficient to generate major reviews both in nursing and other disciplines which have categorized the substantive content of this research and identified areas which have received considerable attention as well as notable gaps in the literature (Feetham, 1984; Gilliss, 1989; Litman, 1974; Schwenk & Hughes, 1983). A large body of research exists which addresses how families and their individual members respond to a variety of illness and health care situations. Depending on the investigator's theoretical and methodological convictions, the research may be framed as a study of family impact, coping, adjustment, adaptation or management. Nurse researchers have focussed considerable attention on family roles and the transition to parenthood. Gilliss (1989), in a recent review of family research in nursing, found that over half of the studies reviewed dealt with perinatal events. According to Murphy (1986) other areas of substantive focus include family interface with societal institutions including the health care system, public policy and the family, and cross cultural family research. Complementing these substantive investigations has been a growing body of theoretical and methodological work which addresses issues pertinent to conceptualizing the family as a unit of study and intervention (Feetham, 1991; Gilliss, 1983; Leahey & Wright, 1987).

In spite of the tremendous body of family research, relatively few studies have been undertaken on the interface between the family and the health care system. Gilliss (1989) identified only 5 out of 76 articles which focussed on the family - practitioner interface. Whall and Fawcett (1991) concluded that there was in-

sufficient research in this area to include it in their recent anthology of nursing perspectives on the family. Similarly, a major review of the literature on help seeking and receiving behavior noted a relative scarcity of literature on the practitioner-patient relationship (Whitcher-Alagna, 1983).

Although, the family - practitioner interface has not been a primary focus for family researchers in nursing or other disciplines, there is modest body of research directed toward describing the relationships that develop between health care providers, families, and family members and identifying variables and themes associated with these relationships. In addition, there are several theoretical models which depict the level and nature of family - practitioner relationships. The intent of this discussion is to provide an overview of this literature as a basis for conceptualizing and designing nursing-focussed patient outcomes research.

PATIENT-PRACTITIONER RELATIONSHIPS

Varying conceptualizations of patient-practitioner relationships set the stage for subsequent investigations of the family-practitioner interactions and nursing practice and family outcomes. In an early theoretical work, Szasz and Hollender (1952) described three models of the doctor-patient relationship: activity-passivity, guidance-cooperation, and mutual participation. They maintained that these models have implications for how illness, treatment, and therapeutic outcome are defined and how decisions are made in each of the three arenas. For example, in the activity-passivity model, the physician alone defines the quality of the therapeutic outcome; while in the guidance-cooperation and mutual participation models both the physician and the patient contribute to the evaluation of outcome.

Over 30 years later, Whitcher-Alagna (1983) continued to identify the nature and quality of the patient-provider relationship as a key determinant of the patient's medical outcome. Based on an extensive literature review, Whitcher-Alagna developed what she termed an "integrative model of reactions to medical aid". As shown here, specific aspects of the relationship which either directly or indirectly influence outcome include: patient's desired role, patient's preferences for information, empathy, and control over decision making, practitioner's characteristics, extent to which the desired patient role is fulfilled, and the magnitude of preferences for the desired patient role.

As reflected in Whitcher-Alagna's review, numerous empirically based studies have addressed the types, dimensions, and importance of the patient-provider relationship. For example, Lorber (1975) distinguished between good, average, and problem patients. Good patients were characterized as passive, cooperative, and undemanding; problem patients resented being cast in a passive role and were viewed as complaining and disruptive. Similarly, Rosenthal, Marshall, MacPherson, and French (1980) described problem patients as unpleasant, controlling, non compliant, complaining, violent, manipulative, and demanding.

A recent nursing study by Waterworth and Luker (1990) described "toeing the line" as the role assumed and preferred by the 12 hospitalized medical patients in their study. "Toeing the line" included strict adherence to rules and was grounded in the patients' trust in the expertise and competence of the staff. The authors concluded that the promotion of individualized nursing care may not be synonomous with active patient involvement as much of the literature suggests.

Hayes-Bautista (1976) studied 200 urban, Hispanic patients' perceptions of doctor-patient interactions and identified convincing, countering, and bargaining tactics used by patients who were attempting to alter a prescribed treatment as well as counter-management tactics used by physicians to ensure compliance with the regimen. The outcomes of patients' attempts to influ-

ence decision making were classified in terms of both the patient's and practitioner's satisfaction with the negotiated treatment regimen.

Using a simulated clinical situation involving 84 undergraduate nursing students as subjects, Krouse and Roberts (1989) compared three different patient-provider interactive styles which varied with regard to the patient's role in decision making. They found that "subjects who participate in an actively negotiated process of decision making with the nurse practitioner expressed significantly stronger feelings of control over their treatment decisions" (p. 723).

Although focussing on individual patient-practitioner relationships, this literature highlights salient components of those relationships which also are likely to be relevant to understanding the family-practitioner interface. In particular, the patient's and the practitioner's preference for an active or passive role influences both the nature of the relationship and the participants' satisfaction with it. Specific aspects of patient-practitioner relationships and interactions which often vary on an activity-passivity dimension include information seeking and exchange, decision making role, the extent to which trust is an important aspect of the relationship, and the subjective quality of the human interaction. In general, authors of empirically based studies have discussed outcomes of varying types of relationships and roles in terms of either satisfaction with the interaction or compliance with the medical regimen.

FAMILY MEMBERS AND HEALTH CARE PROVIDERS

Most research on the family-practitioner interface has focussed on the roles that individual family members assume in health care settings. Like patients, family members' roles have been described, categorized and evaluated. For example, based a participant observation study of a community hospital in Canada, Rosenthal, et

al (1980) described three such roles, visitor, worker, and patient, into which nurses cast family members when a relative is hospitalized. They noted that by casting family members into these roles, the nurse "transforms the relative into someone who becomes part of the work context and therefore more controllable by nurses" (p. 101). This is especially true for the worker role where the family member becomes part of the health care team and the patient role where the family member becomes a legitimate focus of intervention.

The so called "worker" role has been the focus of attention for several authors who investigated family members' preferred participation in the care of a relative during hospitalization (Algren, 1986; Deatrick, Stull, Dixon, Puczynski, & Jackson, 1986; Knafl & Dixon, 1984; Knafl, Cavallari, & Dixon, 1988). These studies revealed a wide range of preferences, with some relatives wanting extensive involvement in care activities and others favoring a much more limited role.

Taking a somewhat different focus, Barbarin and Chesler (1984) explored seven general dimensions of parent-practitioner relationships: information transmission, communication, parental efficacy, conflict resolution, empathy with child, personal contact with staff, and assessment of staff competence. Based on interviews with 74 parents of children with cancer they found that "the quality of parents' personal contact with doctors, that is, the sympathy, warmth, concern, and attention shown to parents as individuals, was most highly related to their general satisfaction with the medical staff" (p. 310). Conversely, anger with the staff was most highly related to staff's lack of empathy with the patient.

In a community based study, Darling (1979; 1988) investigated the development of what she termed an entrepreneurial role in parents of children with handicaps. Based on a sample of 25 families, she described how parents became advocates "promoting their child's

cause as a result of repeated negative interactions with medical, educational, and social agencies" (1979, p. 225). Behaviors encompassed by the entrepreneurial role included seeking information, seeking control, and challenging authority in order to obtain necessary services.

Other authors described how family member-practitioner relationships evolved over time. Combining data from two qualitative studies of family response to chronic illness, Thorne and Robinson (1988a; 1988b; 1989), described three stages in the evolution of the relationship between chronically ill patients, family members and health care providers. They described these stages, which they named naive trust, disenchantment, and guarded alliance in the following way:

The stage theory proposes that the naive trust with which the chronically ill and their families enter health care relationships is inevitably shattered in the face of unmet expectations and conflicting perspectives between themselves and their professional health care providers. This shattering of trust precipitates a stage of extreme anxiety, frustration, confusion, and profound distrust. Eventually, in the resolution stage, an alternative form of trust is reconstructed on a more guarded basis. (1989, p. 154)

The authors suggested that sharing their proposed model with clients may facilitate the development of satisfying relationships.

Wuest and Stern (1991) conducted unstructured interviews with members of 10 families and described a four stage process through which families learned to manage a child's persistent middle ear problems. Their stages of acquiescing, helpless floundering, becoming and expert, and managing effectively were related to the child's response to the disease process, the amount of disruption to family life, and the family's relationship with health care professionals. These authors described how families moved from trust to disillusionment to

knowlegeable empowerment in their interactions with health care providers. Family members were particularly frustrated by providers' insensitivity to the disruptiveness of the illness on family life. In contrast to Thorne and Robinson (1988a; 1988b; 1989), who focussed on the eventual development of a satisfying working relationship between family members and providers, Wuerst and Stern (1991) emphasized the desirability of empowering families vis a vis the health care system and the role of nurses in promoting such empowerment.

All the research discussed in this section addressed the relationship between practitioners and individual family members. Similar to the previously discussed work on patient-practitioner interaction, these studies focused on the importance of the activity-passivity aspect of the relationship and variations in trust, decision making agency, and information exchange. Although focussing on family roles, these studies did not address the link between practitioners and the family as a unit of either interaction or intervention. To date, work on the family-practitioner interface has entailed primarily theoretical discussions of the range of possible involvements.

CONCEPTUALIZING THE FAMILY-PRACTITIONER INTERFACE

Leahey and Wright (1987) have made important contributions to the development of family nursing, which they conceptualized as occurring on three levels. First level family nursing considers the patient in the context of the family. At this level, the nurse's interventions are determined primarily by the patient's needs; the family's needs are viewed as secondary. In contrast, the nurse engaged in level two family nursing deliberately spends time directly with one or more family members and plans and implements nursing care with the family in mind. This often is what we think of when we hear the terms family centered or family focussed nursing care. The

third level of family nursing practice is family care in which the nurse's assessments and interventions are directed toward the family as a unit and include direct face to face interaction with every family member.

Another explicit attempt to conceptualize ways in which providers interact with families is provided by Doherty and Campbell (1988). They distinguished five distinct levels of interaction with families: (a) minimal emphasis on family, (b) ongoing medical information and advice, (c) feelings and support, (d) systematic assessment and planned intervention, and (e) family therapy. Doherty and Campbell (1988) discussed how these levels differed in terms of the knowledge base, degree of personal development, and skills needed for effective interaction. For example, at level two, ongoing medical information and advice, the knowledge base is primarily medical and personal development involves an openness to engage patients and families in a collaborative way; at level four, systematic assessment and planned intervention, the knowledge base is family systems and personal development involves awareness of one's own participation in a variety of systems.

Both Leahy and Wright's and Doherty and Campbell's frameworks distinguished interventions directed to individual family members from those directed to the family unit as a whole. Their developers pointed out that each framework was meant to provide a range of possibilities and was not a prescription for action. These authors assumed that the appropriate level of interaction varied across situations and families.

Taking a somewhat different approach, Craft and Willadsen (in press) surveyed nurses with expertise in family to identify and validate interventions nurses use with families. Using the Delphi method, they identified numerous intervention activities which they grouped under the following headings: (a) family support, (b) family process maintenance, (c) family integrity promotion, (d) family involvement, (e) family mo-bilization, (f) caregiver support, (g) family therapy, (h) sibling support, and (i) parent education. As indicated by the preceding categories, the interventions they identified included those directed to the family unit as well as those directed to individual family members. Their work is ongoing and predicated on the assumption that family interventions are an independent nursing function and "nursing cannot wait for the much needed family theory development . . . but must begin specifying and testing interventions related to family" (p. 3).

CONCLUSION

Examining the effectiveness of nursing practice with regard to family outcomes presents researchers in this area with a plethora of substantive, methodological, and conceptual challenges. Fundamental questions of who, what, and how to research the family/practitioner interface have yet to be articulated let alone be translated into "tight" experimental designs. Basic issues regarding what constitutes a family intervention or a family outcome have yet to be resolved. To say the least, there are no "classical" intervention studies to provide a model for future research. It is a field for those with a pioneering spirit, a tenacious mindset, and a high tolerance for ambiguity! As noted in this brief overview, the relevant literature includes two parallel and largely unconnected bodies of work, empirical studies of interactions between family members and providers and theoretical models of levels of practitioner involvement with the family unit. Although not providing a definitive map for guiding further research, this literature has been useful in identifying promising lines of inquiry. In order to stimulate further development of research in this area, Dr. Feetham and I have drawn on the existing literature to develop a working model of the family-practitioner interface. As shown here, the model includes characteristics of the family, family members, the health/illness states of family members, the practitioners involved in providing care,

and the health care system. These multiple, interacting characteristics shape health care interventions, which vary in terms of their level and timing. For example, family member's and provider's role preferences in terms of decision making will influence the eventual intervention. Interventions result in both affective and behavioral reactions which are likely to be interdependent and which give rise to different practitioner, family member, and family unit outcomes.

This model is meant as a heuristic device to foster our identification and discussion of the conceptual and methodological issues associated with studying nursing interventions and family outcomes.

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