Guest Editorial

Ethics in Family Medicine: Patient Autonomy and the Family Unit

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A discipline shows its maturity when it can engage in a frank and spirited debate over some of its most fundamental philosophical and ethical presuppositions. For family medicine there can be no more fundamental discussion than what it means to treat the family as a unit of care, and how the family physician should manage conflict between the interests of the individual patient and the interests of other family members. The case presented in this issue by Williamson, McCormick, and Taylor[1] raises this discussion in a compelling way, and the authors have forthrightly stated and defended their views. By raising these issues and subjecting their conclusions to scrutiny and possible criticism in an academic journal, these authors submit, implicitly, that family medicine has matured beyond the stage where any internal dissent over basic philosophy must be suppressed, lest "we" open a chink in our armor that "they" (the better established, traditional specialties) might exploit to their advantage.

In keeping with the forthright tone of Williamson and colleagues, this editorial will attempt to develop an opposing point of view regarding their illustrative case, which, it will be argued, keeps faith with the basic principles of family-oriented care while counseling a very different course of action. It is through the comparison of different interpretations of the basic concepts of family

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care, as well as by means of empirical studies of how family physicians make ethical decisions,[2] that a full understanding of the ethical basis of our discipline may eventually emerge.

Williamson et al describe the problem of an elderly patient who wants to remain at home to help care for a retarded son, while the married son, on whose shoulders much of the burden for keeping the family afloat has fallen, wishes to have both of them institutionalized, especially in light of the mother's worsening cardiac status. Out of the many moral considerations that impinge upon the choice, Williamson et al eventually place highest priority upon a principle that calls for the promotion of family growth in the face of a challenge to the status quo. They appeal to the family systems concept as justification for this priority. But the systems concept, alone, cannot be used as a license to justify any particular form of family-oriented intervention. The concept demands that we respect the family unit as well as the individual person and that person's organ systems, tissues, cells, and molecules as all constituting "real entities" making up a hierarchy of systems linked by patterns of information flow.[3-5] The concept demands that we see the family unit as one causal factor that may impinge upon the health or disease state of the individual, and that we see the family unit as one entity that will change as a result of anything we might do to affect the health or disease of that individual. But that does not give us license to choose to intervene at the family level instead of at the level of the individual patient. One might as well claim that because a systems-minded physician has identified the workplace as a stress factor causally related to his patient's irritable bowel symptoms, the physician ought to intrude into the work site to change the nature of employer-employee relationships.

Furthermore, even if a family-level intervention can be justified on independent moral grounds (such as the informed consent of all competent family members to seek this means of resolving their conflicts), what "family growth" means in operational terms must still be specified. Allowing one family member (the married son) to get what he wants, while two family members (the mother and the retarded son) are summarily denied what they want, is a questionable interpretation of a "growth" response to a family crisis. Such an outcome might constitute growth if it were arrived at as a result of face-to-face discussion among all interested parties, but cannot be so viewed when it is unilaterally imposed by the physician, however benevolent the intentions.

These problems, first in justifying the priority of the "family growth" principle and then in applying it unambiguously to the case at hand, raise in turn questions about the ethnical problem-solving methodology Williamson and colleagues have employed. Their "Potter box" table has the virtue of listing all relevant considerations and making some important distinctions among them. But its disadvantage is its inability to offer guidance on making priority judgments among competing considerations—a disadvantage not shared by some other methods that have been proposed for clinical-ethical inquiry.[6,7] On the face of it, there is no good reason for taking family growth, or the spreading of burdens and benefits more equally among family members, as a higher priority value than the autonomy of the mother (and the limited but not absent autonomy of the retarded son). A value scale that diminishes the importance of autonomy and control over one's personal life in this way runs completely contrary to a widely held consensus in the contemporary medical-ethical literature.[8] And, indirectly, the family systems perspective supports this consensus; a family that maintains its equilibrium only by severely limiting the autonomy of its members is generally seen not as a "growth" system but as a pathological one.[5]

Summarily placing the mother and retarded son in custodial care (and, in the process, denying them the support of a physician who could possibly serve as an advocate for their own interests) might still be the best possible outcome if the only available alternative were a return to the earlier status quo. It then becomes crucial to ask whether all possible alternative solutions were considered at the start of this ethical analysis.[9] It appears on review that Williamson et al did not consider the possibility of an approach that would try to combine the following elements: (1) the physician's frank acceptance of the desire of patient (the mother) to remain at home and his promise to support this so long as it remained medically realistic, (2) the physician's approach to the married son, offering sympathy for the burden he is under, help in responding to it, and perhaps even marital

counseling, and (3) exploration of community resources to provide home health assistance, visiting nurse services, and so on, for the mother and retarded son, and perhaps even brief periods of custodial respite care if the married son finds this essential to his own ability to cope with the problem. There are perhaps other alternative approaches that avoid the either-or problem of totally accepting or totally denying the autonomous choice of the mother as the identified patient.

Still, it may indeed be the case that custodial care for the mother is the only workable solution. If in the end she must be persuaded to accept this, she would seem at least to deserve the consolation of knowing that her physician took her needs and desires seriously, not merely as something to be bargained away in pursuit of the best solution for other family members. To put it crudely, if the hypothetical Dr. S. in this case felt the need to be the "physician of the whole family unit," Mrs. F. needed a different physician to be *her* physician and to serve as an advocate for *her own* needs and interests. As the case ended, Mrs. F. had *no* physician.

This critique of the arguments of Williamson et al has, in conclusion, touched upon the following points:

1. The family systems concept requires the scientific family physician to be aware of causes and effects at the family as well as the individual level; it is not by itself a moral imperative requiring family-oriented intervention.[10]

2. The autonomy of the individual patient may conflict with needs of other family members and of the family as a whole, but at another level *some* respect for the autonomy of individuals is necessary for healthy family function.

3. Most reasoned arguments to be found in the contemporary ethics literature place great stress on respecting the autonomy of the individual patient; very weighty reasons are generally required to overrule an autonomous choice. Respect for autonomy, however, need not conflict with the role of the family physician in identifying what he or she thinks is the best course of action and trying without coercion or manipulation to persuade the family to follow this advice.[11,12]

4. The family physician who tries to serve the "family as a unit" in the face of specific conflicts of interest among family members may inadvertently deny the individual, identified patient the sort of physician-patient relationship that that individual wishes and deserves.

Williamson and colleagues, and those who would support their conclusions, might agree with all four points above while disagreeing over how they are to be applied to the case of Dr. S. and the F. family, or they may dispute one or more of the four points and offer other ethical considerations as more compelling. Eventually, though, it is through such give-and-take, touching upon both principled moral argument and individual case analysis, that a sound ethical basis for the practice of family medicine will be articulated.[13]

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