Partnering With Families
John Saultz, MD

Reading medical journals is an exercise in searching for those occasional papers that either teach us something new or remind us of something important. Once in a while, we find a paper that does both. The study by Hinojosa and colleagues in this issue of *Family Medicine* is such a paper.1 Examining data from the National Survey of Children’s Health, they studied the impact of family-provider partnership on 5,495 children with attention-deficit hyperactivity disorder (ADHD). They chose ADHD as an example of a common health problem in children that creates special health care needs. It is certainly no surprise to most family physicians that strong partnerships between the families and health care providers were associated with improved outcomes in these children. Our discipline was built on the principle of caring for families, and we have a rich tradition of studying the relationship between families and the health of family members. This paper reminds us of this heritage at a time when health care reform has focused our attention on population health outcomes and the “triple aim” of health care reform. Even before the first family medicine residency programs were established, Balint was studying the powerful therapeutic effects of general practitioners in the doctor-patient relationship.2 In 1983, Doherty and Baird described the triangular therapeutic relationship between doctors, patients, and families in what might be the single most important book in our discipline’s history.3 This was followed by books by Christie-Seeley,4 Henao,5 Ramsey,6 and McDaniel7 that collectively defined the field of family systems medicine at the interface of family therapy and family medicine. Such books and hundreds of journal articles in this field have influenced a generation of clinicians and scholars in family medicine. With the rise and fall of managed care in the 1990s, much of our attention seems to have turned elsewhere. Thus, Hinojosa’s paper reminds us of something fundamental to our work as family physicians, something that should never be lost or forgotten. We care for families, not just patients, and the care of families is often fundamental to achieving good outcomes for individual family members.

This paper also teaches us something new; family-provider partnerships were stronger in Latino families, poor families, and families with increased levels of strain. Family strain was determined from the answers of family caregivers to questions about how well parents can talk with one another, share ideas, and cope with the demands of raising a child with special needs. The more severe the ADHD and the higher the level of family strain, the more likely it was for a strong partnership to exist between the family and the health care provider. Strong partnerships were also more common with low-income families and when mothers had less than a high school education. In essence, the partnerships were strongest with those families that need them most.

A strong family-provider partnership score was associated with fewer missed days of school, more preventive visits, and even more frequent dental visits. Paradoxically, socioeconomically vulnerable families and those with higher family stress were also less likely to report having unmet health care needs. It is important to note that families with strong partnerships were also less likely to be uninsured, a factor that probably confounds these results. Nevertheless, these findings are
consistent with earlier research that interpersonal continuity of care is more valued by people with chronic health conditions, those with Medicare or Medicaid, less educated people, the elderly, and parents of young children. This work provides solid evidence that vulnerable patients and their families in particular depend on close working relationships with their health care providers.

Hinojosa and colleagues defined a family-provider partnership as including “communication, information gathering, mutual respect, and trust.” They measured partnership by examining five elements: (1) how often the physician spent enough time with the child, (2) how often the doctor listened carefully to them, (3) how often the doctor gave them specific information, (4) whether the doctor was sensitive to their customs and values, and (5) whether the doctor was a partner with the parents in the care of their child. This defines a wonderful blueprint for excellence in family medicine. We have always believed that we should teach these principles to our residents and students. Isn’t it great to know that this same prescription improves measurable outcomes for some of the most vulnerable families in our communities?

References