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REVIEW ARTICLES

Palliative care: A need for a family systems approach

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ABSTRACT

Objective: When a family member is faced with a terminal illness, the impending death presents a crisis and a challenge to the entire family as a system. This article highlights the importance of caring for a family when one member has a life-threatening illness, and describes the applicability of Family Systems Theory and its major tenets to the palliative cancer population.

Methods: A MedLine and CINAHL search of Family Systems Theory related papers was conducted.

Results: Research studies that have been done fail to capture the view of the entire family system, often limiting the perspectives of the family to one single member. The concepts of holism, balance, boundaries, and hierarchal subsystems must be addressed in the care of any family, including those who have a family member who is dying.

Significance of results: A Family Systems Theory framework can be useful in helping health care providers, and particularly nurses, deliver optimal care to palliative cancer patients and their families and standardize the way research is done by providing an appropriate framework with which to study the family. In addition, the adoption of Family Systems Theory as the standard framework from which to study families in palliative care will provide consistency for future studies that is presently lacking. Finally, nursing interventions to care for the family are suggested based on Family Systems Theory.

KEYWORDS: Family Systems Theory, Palliative care, Cancer, End of life

INTRODUCTION

When a family member is faced with a terminal illness, the impending death presents a crisis and a challenge to the entire family. Family members almost inevitably take on caregiving roles as they deal with constant crises such as symptom management or frequent hospitalizations. Even when family members do not take on a caregiving role, there may still be a need for adjustment when a family member has a life-threatening illness. The upcoming loss of a family member presents an enormous challenge, as the family must try to find new balance during the illness and then in the absence of an integral member. Furthermore, caring for a palliative cancer patient in the home also forces the family to reorganize as they learn the intricacies of caring for the dying. The definition of *palliative care* recognizes this, as it includes the need to consider the family in the process of care. *Palliative care* is defined as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual" (World Health Organization, 2002). In addition, definitions of *family* often are interpreted broadly, such as the one from the Canadian Hospice and Palliative Care

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Association (2003), which states that "a 'family' is whoever the person says his or her family is. It may include relatives, partners and friends."

Considering the impact on the entire family, studies in palliative care should adopt a framework that utilizes a global perspective. Although there exists research addressing patients or family caregivers, there is little research that studies the family unit. Studies on the family unit are required to guide the most appropriate interventions and the most compassionate care. To secure this link between research and practice, a conceptual framework is critical when studying families in order to fully comprehend observations made, select interventions, and to evaluate their effectiveness. Description, explanation, and predictions are made easier with a coherent guideline or framework (Meleis, 1997).

This article highlights the importance of the family in the care of the palliative cancer patient, briefly explains Family Systems Theory (FST), and describes how it can benefit palliative care research and provision of heath care. We argue that such a framework is needed because such concepts can help nurses and other health care providers deliver optimal care to palliative cancer patients and standardize the way research is done by providing an appropriate framework with which to study the family.

PALLIATIVE CARE AND THE FAMILY

In Western societies today, care for the dying involves both their families and the health care system, whether the patient is dying at home or in the hospital. For example, in the hospital, families are an anticipated presence at the bedside, and in the home, they share the responsibility of care with health care professionals. Today, family members play an integral role in symptom assessment, monitoring, and delivery of complex therapeutic interventions (Wilson, 1999; Aranda & Hayman-White, 2001). To deliver the best care, we need to understand that the patient is immersed in a context called family, an interactive system. Death and dying should be perceived as a family event that likely throws the family out of balance and requires adjustment of all family members to the new family reality. Family Systems Theory can provide a framework to guide the research on families required to provide the best comprehensive palliative care.

FAMILY SYSTEMS THEORY

In defining and describing each of the major tenets of Family Systems Theory, we argue for its adoption as a consistent, clear framework for research with and the treatment of a palliative care population. There are a few theories using a family systems framework, some of which have been tailored to working with families with a family member facing a life-threatening illness (see, e.g., Rosen, 1990; Walsh & McGoldrick, 2004). Although there are some versions of systems theory used in nursing (King, 1981; Neuman, 2002) and in other palliative care studies (Knapp & Delcampo, 1995; Murtonen et al., 1998; King & Quill, 2006), the one described by Wright and Leahey (2005) is described here as it is perhaps the most relevant to palliative care nursing because (1) it was based on practice and thus is more easily applied in clinical work than more abstract models and (2) the model draws on diverse theoretical underpinnings, including sociological, general systems theory, communication theory, change theory, cybernetics, theory of the biology of knowing, and theory of the mind as well as constructivist and narrative approaches. Integrated approaches such as these versus theories based on one theoretical orientation are more open to different possibilities within families and less likely to be limiting in understanding the family (Kaakinen & Hanson, 2004) and thus are more suited to better understanding such a complex phenomenon as the impact an upcoming death may have on the family as a unit.

Definitions and Tenets

The Family as a System

Family Systems Theory focuses primarily on the interaction between members of the family and between the family and other systems. A system can be defined as a set of interacting elements. The family is seen as a small group of interrelated and interdependent individual elements, making the family a system. The theory further postulates that a change in one family member will influence the entire system (Wright & Leahey, 2005). Its main concepts are discussed below.

Hierarchies, Subsystems and Boundaries

In a hierarchy, each higher level unit contains lower level systems. A family system is part of a larger suprasystem and it is itself further composed of many subsystems (Wright & Leahey, 2005). Communities, the health care system, and the educational systems are all examples of suprasystems within which the family is nested. The palliative care unit or the home care agency may be a suprasystem the family belongs to. Within a family system there are often many subsystems. Two or more family members interrelating can form a subsystem. For example, sibling, parental, and spousal subsystems may exist

within a family system. Furthermore, each family member may be part of a variety of different subsystems. A mother is part of the parent–child subsystem as well as part of the mother–father (husband–wife) subsystem. It is also important to note that families today are increasingly complex, with divorce and remarriage redefining the family system and creating new subsystems.

Each system can be defined and understood by its boundaries. The boundary essentially defines the system and highlights the extent and type of contact between the system and other systems, including subsystems (Boss et al., 1993). It is the understanding of the family's boundaries and the degree to which they are permeable that allows health care professionals to gauge their ability to make an impact on the family unit. For example, if a family has extremely rigid boundaries that prevent exchange with other systems, the family members remain enclosed in the comfort or discomfort of their personal system. They may not be open to palliative care consultants when issues such as pain need better management. In contrast, a family system that has more permeable boundaries will allow in more resources and accept contact with other systems more readily. Perhaps the most crucial means that families have of facilitating adaptation to both increased outside demands and internal needs is through their effective use of their semipermeable family boundaries (Boss et al., 1993).

Holism

Another central concept in Family Systems Theory is that the family as a whole is greater than the sum of its parts (Wright & Leahey, 2005). In other words, the family system must be understood as a whole and cannot be fully understood by the examination of individual members or subsystems in isolation from each other and from the suprasystems of which the family forms a part (Artinian, 1994; McClement & Woodgate, 1998). This means a patient cannot be understood without a careful examination of the "parts" of his family. How these parts relate, communicate, and behave is critical to the overall understanding of the family as a whole.

A Change in One Family Member Affects All Family Members

If the family is seen as an interactive unit as Family Systems Theory suggests, then no individual member exists in isolation from another. A further critical concept is that any significant change or event in one family member affects all the family members (Wright & Leahey, 2005). In fact, even those family members absent at the time may be affected and can affect others. Therefore, when a family member is diagnosed with a terminal illness, the family has to reorganize itself. The individual members and the unit as a whole may not function as they previously had.

Homeostasis

Another important concept in Family Systems Theory is that the family is able to create a balance between change and stability (Wright & Leahey, 2005). This means that changes in one part of the system are followed by compensatory changes in another part (Sholevar & Perkel, 1990). This idea of the family continually striving to maintain some degree of homeostasis is presently being challenged. Families are now thought to be constantly changing and are therefore unable to maintain a state of equilibrium (Wright & Leahey, 2005). This is evident with the family of a palliative care patient, as the uncertainties related to symptom management and the patient's life expectancy may place them in a constant state of flux. Such families often struggle with finding a balance between stability and change, and a reorganization of the family may occur to attempt to regain a balance between change and stability.

FAMILY SYSTEMS THEORY AND ITS USE IN RESEARCH

Many patient populations have been studied using the Family Systems Framework. Psychiatric, pediatric, geriatric, community, and critical care are but a few examples (Hamilton, 1989; McClowry, 1992; Williams-Burgess & Kimball, 1992; Boss et al., 1993; Brumfield, 1997; Goodell & Hanson, 1999; Drayton-Hargrove, 2000; Cummings, 2002). Although different versions of the framework are used, such studies demonstrate the utility of adopting the framework when trying to understand families in order to help them. The research projects that are successful in using Family Systems Theory are those that include a clear definition of the theory and use the concepts to guide their questions, observations, and interventions. Another feature these studies have in common is that they are aimed at understanding the entire family as a system. Although the studies differed in the populations studied and the methodologies used, Family Systems Theory has been successfully used in these studies to show that the family can be studied and understood as a system. Studies that use a family focused framework should be able to describe the families, explain their behavior, and allow for prediction if the concepts of the theory are well explained and understood.

Despite this, a Family Systems framework is surprisingly lacking in palliative care.

Research in Palliative Care

Family Systems Theory offers a way to work with families and understand families in palliative care, an area where there is little in-depth research. There are a couple of concerns with the way in which the idea of family is presently used in palliative care studies from a Family Systems theoretical perspective.

Some studies with the palliative population involve the primary caregiver, yet they claim a family perspective (Wright & Dyck, 1984; Given, Given, & Kozachik, 2001). Wright and Dyck in their descriptive exploratory study looked at 45 patients and their families to gain an understanding of the family's needs in the hospital. Fifteen of those patients were in the terminal phase of their illness. However, despite the fact their study question was "What are the needs of families of adult cancer patients?" they go on to define the family as only the next of kin. In a more recent study, Given et al. begin by discussing the increased role of families in caring for cancer patients at home and underline the fact that both the patient and their families are vulnerable to changes in the health care system. Despite the fact that they proceed to argue that all family members may need to devote time to caring for patients, they then limit their discussion to the primary family caregiver and do not discuss the impact of home care on the family as a whole. Although these studies acknowledge the importance of using a family perspective in research on a terminal cancer population, they are limited by the fact that they do not focus on the complete family. This is problematic because one family member's perspective is being generalized to reflect the consensus of the family. The researchers make the assumption that examining one part of a system comprised of many different yet related parts leads to an accurate depiction of the entire system.

Another problem is that a Family Systems Theory approach is mentioned as the framework but then is not described or applied appropriately (Davies, 1994; McBride & Simms, 2001; Syren, Saveman, & Benzein, 2006). A conceptual framework needs to be clearly defined and described in order to provide the context for a study. If this is not done, the reader is unable to comprehend the usefulness of the theory or its applicability to the data at hand. This lack of clarity leads to ambiguity in interpretation, and one cannot then determine whether the selected framework was used to adequately make sense of the phenomena being studied. For example, McBride and Simms, in their descriptive paper, claim to adapt a Family Systems framework to the grief process. Through the use of clinical examples, the authors found that when death and grief are understood within a Family Systems Model a family can be supported in successfully defining new roles and responsibilities as well as managing a shift in boundaries that help promote adaptation. However, none of the concepts are outlined or applied in the clinical examples provided. They mention that grief can disrupt the hierarchy of a family, yet never explicitly describe subsystems and their importance to Family Systems Theory. They also mention that a family's flexibility to adapt to changes will be affected, yet the concept of homeostasis is not mentioned. Overall, it is unclear how the authors are using this framework and how it can be used by others.

In contrast, Knapp and DelCampo's (1995) study is one of the few that highlights the fact that a Family Systems Theory approach would benefit the terminally ill and their families by allowing for more holistic care. They adapt Rosen's (1990) Family System Response to Stress Model to provide a framework for understanding and helping hospice families. They clearly define the family as a system and discuss and highlight how an impending death disrupts the balance in a family. They use case studies to illustrate the applications of this approach. Through their use of this methodology, they demonstrate that an upcoming death causes great distress within the family system. They argue that terminal care is generally based on the traditional medical model, which focuses only on the patient. This presents support for the argument that a conceptual framework is needed for this population that must place an emphasis on family dynamics, the impact of death on relationships, and the family as a whole. They use the concepts of homeostasis, hierarchies, and boundaries to help describe and explain the responses of the family. For example, in their case study where a newly married couple face the imminent death of their infant they show the distress experienced in the parent–child subsystem as well as the tension in the marital subsystem as they try to make sense of their situation. The husband's parents have become an overwhelming presence and have begun to make decisions regarding the child's care and funeral arrangements. The young couple argues over this often. They therefore have to redefine their boundaries to indicate to the extended family when they are permitted to participate in both the care and the decision making regarding their child. This gives the marital system more control over decisions about their own child and helps decrease marital tension as they regain a sense of balance. This

example provided a clear, concise picture of the family and how death can threaten it.

Research in palliative care is now beginning to incorporate more members of the family into studies. Davies et al. (2003) looked at the impact of a children's hospice program on families and interviewed, as much as possible, entire families. This included the parents, the sick child, and any other siblings. They found that a major reason for parent satisfaction with the hospice was the individual focus on the family subsystems looking at each individual member. Similarly, Blatt (1999) was interested in the decision-making process a family goes through when faced with end-of-life decisions. She found that decisions in the study were made by family consensus and not limited to one individual. She noted that it was not enough to speak with only the spouses of the patients to gain insight into their decisions.

Another study showed that the family system is greater than, and different from, the sum of its parts. In a study done in England, 62 members of a nursing community team were interviewed and asked to identify the most important factor in their work with palliative patients. The essential antecedent to being able to provide quality palliative care was identified as "getting to know the family" (Luker et al., 2000). The nurses' understanding of the patient's family added a new dimension to the care they provided, as their understanding of the patient was more complete. This was because family members contributed valuable information. Furthermore, observations of their interactions with the patient and with each other helped the nurses become aware of which family members wished to be informed and involved. They could therefore design interventions based on this knowledge. This supports the argument that the emphasis should be on the whole family system, rather than the reduction into parts.

In light of this research, in the case of families facing the certain death of one of its members, it is clear that the previously established balance of the family is threatened. It begins to destabilize in light of a reorganization that will occur as each individual and each subsystem attempt to process the upcoming loss and deal with the ongoing changes as the patient approaches death. The experience of death and dying cannot be addressed in isolation, restricted to the patient alone. Palliative patients often face crises in symptom management, recurrent visits to the emergency room, and changes of roles within the family. These events are among many that push the family into a state of disequilibrium. Some examples of this will be discussed below as we examine the concepts of Family Systems Theory in palliative care research. Overall, the concepts of Family Systems Theory have demonstrated relevance to the palliative care population.

USING THE MODEL IN PALLIATIVE CARE

Seeing the successful use of a Family Systems approach in other populations suggests promise for palliative care research. Within the family, different subsystems may be affected by the impending death and death of a family member. In palliative care, describing a family using its key subsystems can provide a researcher or clinician with insight into family members' interaction patterns and reactions to certain events. This is because each subsystem within a family has its own interdependence and "mutual influence among members, with their own relationship boundaries" (Artinian, 1994). For example, a spousal subsystem or a parent–child subsystem will be greatly altered if a wife must care for her dying husband and then finds herself without a partner as she struggles to raise her children, or a child may find himself neglected as his parents focus on other issues related to the care of his/her dying sibling. For this reason, the care of the family of a dying patient cannot be limited to a single subsystem in isolation of the others. In fact, family members of palliative patients often say that they value the support given to them as their loved one is dying, which reinforces the fact that the entire system be included in the care (Ferrell et al., 1991; Wilson, 1999).

The Family Systems Theory concept of boundaries is also one that is important in palliative care, with the health care system and families in constant interaction. Information about a family's boundaries permits nurses to predict how it will respond to intervention, either welcoming their intervention or resisting it. Boundaries may often be difficult to penetrate as the family forms a protective circle around the patient (Aranda & Kelso, 1997; Young et al., 1998). This is often the case in the pediatric population. Nadeau (2001) also recognizes the importance of boundaries in relation to death and dying, as she found that the meaning of loss may differ depending on how "tight" the boundaries are within a family. For example, a family that does not permit much outside information or influence into their system will tend to gaze inward in their search for an explanation of the death. On the other hand, a family with more permeable boundaries may have had constant interactions with the health care team and may attribute the meaning of the death to a physiological explanation given to them. In the same way, rigid boundaries may mean a harder time in organizing

resources to help in the home, whereas other families may be more welcoming to external support.

BARRIERS TO THE ADOPTION OF A FAMILY SYSTEMS THEORY PERSPECTIVE TO RESEARCH

It can be speculated that there are several reasons there is such a scant discussion of Family Systems Theory in palliative care research. First, there exist competing frameworks from which to study the family. This presents a challenge when attempting to select an appropriate framework because they differ in paradigms, in focus, and in applicability (Boss et al., 1993; Artinian, 1994).

Second, a barrier in implementing the Family Systems Theory as a framework is that there exist no validated instruments or tools to describe the family based on the concepts of the theory. As Kristjanson (1992) points out, there is no standardized tool that quantitatively captures the entire family. A MedLine and CINAHL search reveals that this remains the case today. The existing tools do not capture the family as a system or they are not validated tools that instill confidence when used. For example, General Systems Theory provides the underlying framework for the Family Adaptability and Cohesion Evaluation Scales III (FACES III) and the Family-Nurse Boundary Ambiguity Scale (FNBAS-PICU; Olson, 1986; Tomlinson & Harbaugh, 2004). FACES III captures the idea of homeostasis in Family Systems Theory. The FNBAS-PICU looks at the concept of boundaries, but both tools do not explore other concepts such as hierarchies or boundaries. Furthermore, the FACES III scale focuses on how individuals perceive their family and how they would describe their ideal family. This is an overall measure of family satisfaction, not of the functioning of the family as a system.

Other family assessment scales do exist, but again they do not measure the family as a system. The Family APGAR and the Family Assessment Device (FAD; Epstein et al., 1983; Flannery, 1991) focus on family functions and are based on the Structural-Functional Family Theory. Although both are considered valid and reliable tools and use the whole family as the unit of analysis, they do not cover the major concepts of Family Systems Theory. Only the Family Environment Scale (FES) developed by Moos and Moos (1976) offers Family Systems Theory as a theoretical framework. This self-report questionnaire measures three dimensions: relationship, personal growth, and system maintenance. This instrument is used to measure perceived family interactions by assessing the family and its social environment. Again, aside from homeostasis, other important concepts from the theory are not assessed. Furthermore, the internal consistency and the validity of this tool are seldom reported. Due to the lack of valid and reliable assessment devices that are based on a Family Systems Theory Framework, it remains difficult to use it as research is conducted. This barrier will remain until psychometrically sound tools are developed based on this framework.

Finally, practicality is always an issue in research. Time, budgetary constraints, and family availability are practical barriers (McClement & Woodgate, 1998). For example, FACES III requires that each family member fill it out twice at different time intervals. This poses a problem in the palliative care population where time is seen as best spent with the dying patient and length of time between referral to the service conducting the research and the patient's death is often a few days to weeks.

Furthermore, it is challenging to recruit palliative patients into research studies given the fluctuation in symptom management and the limited time frame (Bottomly, 1997). In addition, key family members are not always available, as they are involved in caring for the patient. Families are already faced with dealing with the impending death of a loved one as well as, for many members, caregiving, and questionnaires or interviews may be perceived as additional stressors. It is not always feasible to incorporate all members identified as important by the patient into the study being conducted. Multiple interviews may be needed, incurring extra costs. It is for this reason that studies with this population are often limited to one or two members, usually those who are the most present. Although these studies provide useful information, they do not inform us about the patient's family system. The reliance of singular informants is incongruent with the underlying assumptions of systems theory (McClement & Woodgate, 1998). It has been suggested that perhaps the best way to capture data from the total family in order to identify family processes is to employ a combination of observational as well as interview data (Woods & Lewis, 1992). However, both instrumentation and feasibility barriers are concerns with this approach.

There are also theoretical challenges with trying to determine what the family view is. This means that questions arise that require consideration. For example, if reliance on one family member does not provide a family perspective, how many family members does it take to capture the family view? Furthermore, does such a view theoretically exist given that each member of a family is unique and has a unique perspective on the situation. What if certain members of the family participate (a subsystem); is this *the* family view, or perhaps *a* family view, one of many? Finally, does synthesizing the views of many

family members into one family perspective truly capture any sort of meaningful perspective of the family or any of its individual members? It is these questions that emphasize the importance of examining the family in palliative care. Thus, when developing a tool, a Family Systems Theory may be a useful framework to address some of these concerns.

The whole family must constitute the unit of analysis for researchers guided by Family Systems Theory. This point will be elaborated as we examine how the adoption of this framework will help standardize research in palliative care.

IMPLICATIONS FOR HEALTH CARE PROFESSIONALS

Appropriate Interventions

An understanding of Family Systems Theory and its central concepts will help guide interventions that are aimed at stabilizing and supporting subsystems and addressing all parts of the family system. We propose some interventions to accomplish this. For example, one suggested intervention is a thorough family assessment at the initiation of every relationship with a patient and his or her family. This will provide valuable information on the family functioning as a system and its boundaries. The assessment should include a description of the family when family members feel they are balanced and what they do to restore balance in their family. The roles of each of the family members, past, present, and potentially in the future, and their contributions to the subsystems they belong to and to the entire family system is also important information.

Following this, another important nursing intervention would be the development of an appropriate nursing care plan. Although based on a different framework, Knapp and DelCampo (1995) stress the importance of using a family systems perspective in developing family care plans to provide a framework that will help health care professionals understand the complexity and diversity of family response in the palliative population. Used as a communication tool, this plan should outline who the members of the family system are, what roles they play, and what they have identified as beneficial to them in restoring balance. For example, if a family has an identified spokesperson, this information about this role would be included in the care plan. The nurse would then know who the family prefers having information given to. Similarly, if the family has identified that receiving information about procedures decreases their anxiety level and helps restore their family's equilibrium, then nurses will know to provide clear explanations prior to any procedure. Furthermore, this intervention will also identify those family members who wish to participate in the care of their dying loved one and the type of care they are most comfortable providing. This will establish a partnership between nursing and the families, where the family system can maintain control as much as possible.

This control is what sometimes allows the family to maintain a state of homeostasis. For example, a Systems Theory perspective was used as a guiding framework for McClowry (1992), who studied families of chronically ill patients who were intimately involved in the care of patients in the home. Family members were encouraged to participate in the care of their loved one. This created of a sense of control for the family members and was a critical intervention. Because family members of palliative care patients often feel helpless (Cohen, 2001; Mehta & Ezer, 2003), supporting family involvement in the care of the patients by encouraging their participation in such activities as pain control or hygiene can help a family system in reorganizing their roles and perhaps regaining a certain balance.

Another critical intervention is to organize and conduct a family meeting, allowing for the family system to participate, be heard, and be understood. A family meeting can be a valuable tool for palliative care health professionals (Boyle, 2005; King & Quill, 2006). This intervention provides an opportunity for the family to voice concerns, where all the "parts" are included, and, although it is a somewhat artificial setting, some observations of relationships between the different parts may be observed. A family meeting provides a forum to acknowledge feelings and reactions other family members may be having. It also helps the nurse identify the family's strengths and plan for further interventions. The concept of holism states that the whole can only be understood by examining the interrelatedness among these parts, and the intervention of a family meeting allows for the observation of this interrelatedness. It also permits each family member a feeling of being a valued member of the system, contributing to the successful functioning of their family.

The careful assessment of boundaries should also include an attempt to understand the reasons behind the boundaries. Culture at times may dictate the permeability of a family's boundaries. For example, members of a traditional Indian or Middle Eastern family may not be receptive to having a female nurse wash their dying male family member. On the other hand, boundaries may have been put up after a previous negative experience with health professionals. The knowledge of these reasons gives the nurse a necessary sensitivity in preparing interventions. Whenever possible, boundaries must be respected.

A male nurse may take on the responsibility of hygiene for the male patient. The building of a trusting relationship with a skeptical family by ensuring good communication may help decrease the barriers put up and allow for more permeability of the boundaries. If the family has been assessed to have flexible boundaries, then the nurse knows that the provision of information or the examination of outside resources will likely be a welcome intervention.

These are just a few examples highlighting how use of a Family Systems Theory perspective can guide creative and useful interventions for families in palliative care as well as avoid unnecessary iatrogenic distress. Nurses who view the patient as immersed in the context of their family will direct their care toward the entire family system.

CONCLUSION

Although Family Systems Theory has begun to be recognized as a valuable framework to assess families in nursing, it has not yet made an impact in palliative care literature or practice. Research studies that have been done fail to capture the view of the entire family system when they limit the perspective of the family to one single member. The concepts of holism, balance, boundaries, and hierarchal subsystems must be addressed in the care of any family, including those who have a family member who is dying. It is for this reason that we argue that the Family Systems framework be embraced as one that is appropriate for both clinical and research practice for the families of palliative patients. If this is done, then perspective of the family will truly be understood and its needs addressed. Palliative care researchers will no longer limit themselves to one view when doing family research. Studies should explain why certain tenets were chosen and how they were defined for the purposes of the study. This will also aid in the replicability of these studies in the same or in another population. Family Systems Theory gives nurses a richer insight into the interventions they select and implement. Interventions will be designed for and tested for impact on the family, not restricted to the patient or patient and family caregiver, once it is acknowledged that it is impossible to remove the patient from the context of the family. Such interventions help keep the entire family in balance and help the family feel in control and stay connected to each other.

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