Family in Family Medicine

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In this issue of The Journal, Kenneth Kushner and colleagues report on patient attitudes and physician perceptions of having family conferences in a family practice setting.[1,2] These studies are an extension of this group's earlier research, which was also reported in The Journal.[3] These three articles together represent one of the first extended efforts to explore the family in family medicine. Although this type of questionnaire data does not qualify as "the family research" according to Ransom's criteria,[4] this research is an example of the type of important first step that must be taken before family physicians can proceed with any intervention that is vaguely related to family therapy.

The following is a brief historical outline of recent efforts to build bridges between family practice and family therapy:

1981. The Society of Teachers of Family Medicine established a task force on the family in family medicine, which began sponsoring annual conferences that continue today.

1981. "The Family as a Unit of Care: Looking Ahead" was the subject of a conference sponsored by the New York Medical College and New York State Psychological Association.

1982. "The Family in Medicine, Present State and Future Trends" was a conference sponsored by the Department of Family Practice, University of Michigan School of Medicine.

1983. The first issue of *Family Systems Medicine—A Journal at the Confluence of Family Therapy, Systems Theory and Moderate Medicine,* was published.

1985. A conference entitled "Research on the Family Systems in Family Medicine" was sponsored by the Department of Family Medicine, University of Oklahoma.

At the above-mentioned meetings, virtually all of the presentations that offered specific suggestions for the family physician's management of families were anecdotal or based on one individual's perspective or experience.[5,6] An attempt to identify specific medical problems around which it might be helpful to convene the family[7] has been justifiably criticized as being "enthusiastically uncritical and accepting of results of poorly designed and seriously flawed research."[8]

The only effort attempting to determine whether there is a benefit to be gained by convening the family was reported in 1973 from McMaster University.[9] Family meetings were conducted for families with an index patient suffering from emotional problems or masked psychosomatic complaints. This approach had a significant effect on the pattern of overall demands for health care by the families. Forty-two families engaged in family sessions were matched for problems and health care utilization during the previous year. A control group received traditional care. In the year following the first joint session, the study group showed a 49 percent decrease in utilization of health services in contrast with a 10 percent increase in the control group of families, even though 28 of these 42 families in the study group met for one or two sessions.

One of the most significant contributions to the family in the field of family medicine in the past decade or more has been Campbell's publication "Family's Impact on Health: A Critical Review."[8] This lengthy paper and annotated bibliography offers few firm conclusions. The only conclusion relevant to the present discussion is "simple family intervention, such as involving the spouse in the care of a hypertensive patient, can have a major impact, and has been demonstrated to lower overall mortality. In hypertension, the effect of family involvement is primarily due to increased compliance with anti-hypertensives and diet."[8] This research on hypertension did not come from the discipline of family medicine.

In the earlier study,[3] Kushner and colleagues asked 276 patients from three family practice residency program training sites to indicate their attitude toward participating in a physician-family conference for any of 21 given clinical situations. The patients believed that a family conference would be most helpful if a family member (1) was dying, (2) was hospitalized for a serious illness, or (3) was suffering from chronic illness with poor control. The patients did not perceive the usefulness of the family conference for

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(1) marital or relationship problems or (2) a life cycle change such as retiring. Eighty-three of the 276 subjects (30 percent) participating in the study indicated that they had been part of at least one physician-family conference in the past. The major reasons for these previous family conferences included (1) emotional and behavioral relationship problems, (2) obstetric care, (3) illness in children, (4) family crisis or disruption through death, divorce, hospitalization, loss of job, or a move.

That 30 percent of the subjects had experienced a physician-family conference in the past is astonishing. Even if this high rate can be accounted for by the fact that the practice sites are training programs, it is encouraging to learn that family practice residents are participating in family conferences during their formative years. It is probably reasonable to assume that the percentage of patients who have experienced family conferences in an average community-based private practice would be considerably smaller.

Also of interest is that although the patients do not believe they would turn to their family physician for marital or other relationship problems, these problems constituted the major reason given for that subgroup who actually experienced such a conference.

In the studies reported in this issue of The Journal,[1,2] the investigators have modified the original questionnaire to focus on the most common reasons for a family conference found in the previous study. These reasons include hospitalization for serious illness, new diagnosis of serious illness, depression, marital or relationship problems, stress-related symptoms, and frequent physician visits without improvement. In addition, the authors incorporated Doherty and Baird's[10] recently articulated model of levels of physician involvement with families, which range from minimal emphasis on families to family therapy. The percentage of patients wanting a family conference for the above situations ranged (in the rank order given above) from 89 to 47 percent. In all situations, those who wanted a family conference also wanted family physician involvement at all levels, including family therapy. The majority of these same patients also wanted referral to mental health professionals for family therapy. This finding suggests that patients want a high degree of attention paid to psychosocial problems, but that they do not discriminate between treatment modality and the type of provider.

The third study surveys 91 of 127 graduates from the Family Practice Residency Program in Wisconsin. These practicing physicians were trained in the family practice centers from which the above patient data were obtained. It was demonstrated that the physicians' estimates of patients' desire for family conferences were lower than the patients' stated preferences. The actual number of family conferences conducted by each physician during the month prior to the survey averaged 2.6. The physicians who reported that they had participated in a family conference gave the following reasons for such a conference in rank order: serious illness, death and dying, and nursing home placement.

The authors fully recognize the limitations of their current research: (1) questionable generalizability from the family practice training site to other practice settings, (2) questionnaire data that reflect the attitudes and perceptions but not necessarily the actual behavior of patients or physicians, and (3) the possibility that patients who indicate they would not consult their family physician for certain types of problems are not averse to such help but merely unaware of its availability from that source.

Despite these limitations, the group in Wisconsin has advanced our understanding of the family in family practice. These data suggest that patients accept, even want, family conferences in a number of specific medical situations. In addition, we know the patients expect the family physician to be involved thoroughly with certain family interventions. Finally, many physicians are interested in conducting family conferences and do convene the family on a regular basis.

The next challenge is to demonstrate in prospective studies that this type of intervention produces a more desirable outcome than traditional care, which does not include family conferences.

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