Patients' Attitudes Toward Physician Involvement in Family Conferences

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Patients' interest in family conferences was investigated using Doherty and Baird's concept of level of physician involvement with families. Patients entering two primary care clinics (N = 239) completed a questionnaire assessing their interest in physician level of involvement for each of six representative clinical situations: hospitalization for serious illness, new diagnosis of serious illness, depression, marital or relationship problems, stress-related symptoms, and frequent visits without improvement. Most patients indicated that they would want family conferences with their primary physician if a family member experienced hospitalization, new diagnosis of a serious illness, or depression. Slightly less than one half of the patients indicated that they would want family conferences for the remaining situations. Among those patients desiring family conferences, majorities responded that they would want their primary physician to provide all of Doherty and Baird's levels 2 through 5 (ongoing medical information and advice, feelings and support, systematic assessment and planned intervention, and family therapy), especially for hospitalization for serious illness and for depression. Most patients who indicated that they would want their physician to provide family therapy in the family conference also responded that they would want referral to a mental health professional for family therapy. The implications of these findings for clinical practice, residency training, and future research are discussed.

The extent to which family physicians should conduct family counseling and therapy has been a controversial issue since the inception of the specialty of family practice. There are those who hold that family physicians should learn advanced family counseling and therapy skills and that they should be prepared to offer therapeutic intervention on a par with that provided by mental health specialists.[1] Others decry the emphasis not only on family counseling skills but also on the general concept of family-oriented primary care. Notable here is Merkel,[2] who suggests that the "marriage" between the family and family medicine is ill conceived, and recommends a "divorce."

Between these two poles are found more moderate positions. Christie-Seely[3] and Doherty and Baird[4] have offered models of family-oriented primary care in which physicians are encouraged to conduct family conferences with their patients' families, particularly in cases of serious medical illness and selected psychosocial problems. Such family conferences may or may not result in further meetings conducted by the physician, depending on the specific clinical situation and the expertise of the physician. Referral to a mental health professional may be one outcome of a family conference. In fact, in some instances Doherty and Baird advocate a family conference with the physician prior to referral to a mental health professional.

Doherty and Baird[5] have recently articulated a model of levels of physician involvement with families that has bearing on the extent of counseling intervention physicians might offer in family conferences. The five levels in the model are as follows:

Level 1: Minimal emphasis on families
Level 2: Ongoing medical information and advice
Level 3: Feelings and support
Level 4: Systematic assessment and planned intervention
Level 5: Family therapy

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A family conference would, of necessity, be at least a level 2 intervention in that it would show more than minimal emphasis on the family. Once a family conference is convened, the remaining levels could be used to describe the types of instrumental counseling activities offered by the physician. A level 2 intervention could involve discussion with the family of medical information (such as prognosis) and giving advice (such as how a family could attend to an ill member). Attention to the emotional aspects of the family, such as discussing the family's emotional reactions to an ill family member or the physician giving emotional support in the midst of a medical crisis, would be classified as a level 3 intervention. Level 4, systematic assessment and planned intervention, would describe brief, circumscribed interventions aimed at problems arising secondarily to a specific clinical condition. An example of this would be a physician helping a family plan strategies on how to adjust their lives so as to be better able to cope with the difficulties caused by a seriously ill family member. Finally, a level 5 intervention would involve addressing in depth longstanding family problems that predated current medical problems but which came to light in the wake of an illness.

A study recently published by Kushner et al[6] addressed the degree to which patients of family physicians want family conferences. Family practice patients were given a questionnaire in which they were asked to rate on a five-point scale how much they would want a family conference should each of 21 clinical problems occur in their family. When the patients' responses were subjected to a varimax factor analysis, the following four factors were extracted: serious medical problems, behavioral problems, problems of living, and low-rated problems (those rated lowest in terms of interest in family conferences). The means of scales derived from these factors showed strong interest on the part of the patients in having family conferences for such serious medical problems as terminal illness and for behavioral problems such as depression. Attempts to find predictors of patients wanting family conferences were limited to demographic variables and were unsuccessful.

While the study described above showed that patients are interested in family conferences for certain circumstances, it did not address patients' perceptions of the goals of such conferences or the degree of counseling involvement desired from their physicians. The primary purpose of the present study was to assess patients' desires for family conferences, using Doherty and Baird's model of levels of physician involvement with families.

METHODS

To study patient desires regarding physician level of involvement in family conferences, it was necessary to identify a small number of representative clinical situations that would elicit a range of patient interest in having family conferences. Accordingly, the two highest loading items from each of the top three factors identified in the Kushner et al[6] study that best reflect the overall theme of the scale were selected. This selection resulted in six situations: hospitalization for serious illness and new diagnosis of serious illness (from the serious medical problem factor); depression and marital or relationship problems (from the behavioral problems factor); and stress-related problems and frequent visits to physician without improvement (from the problems of living scale). Items from the fourth factor, low-rated problems, were excluded from the present study because patients overwhelmingly indicated that they would not want family conferences for those situations.

A questionnaire was developed in which, in the first section, subjects were presented with a series of questions asking what they would want if each of the six situations happened to them or another member of their family. Each question required a yes or no dichotomous response. In the first question, subjects were asked whether they would want the patient to continue to be seen individually by the family physician. The second question asked whether they would want to have the patient referred to a specialist for that disease or problem. In the third question they were asked whether they would want to have a family conference with the family physician and at least one other family member. Those who indicated that they would want a family conference were then directed to a series of four questions in which they were asked whether they would want the physician to intervene on each of Doherty and Baird's levels 2 through 5. For example, the question for level 2 involvement was: "Would you want this conference in order to receive medical information from the family physician and to get advice about how to manage the medical aspects of this problem?" All subjects were then asked two more questions: whether they would want the patient referred to a mental health professional for individual counseling or therapy, and whether they would want the family referred to a mental health professional for family therapy.

In the second section of the questionnaire, subjects were asked whether each of the six situations had ever occurred to them or another family member and whether they had a family conference at that time. Finally, patients were asked a series of demographic questions.

The questionnaire was administered to consecutive patients aged 18 years or older at two clinics. One clinic is a teaching facility of the family practice residency of the University of Wisconsin, Madison, and is staffed by family practice residents and attending family physicians. The other clinic is a health maintenance organization with two primary care teams, each consisting of two family

physicians and one internist. One hundred ninety-two patients of the family practice residency clinic and 47 patients of the health maintenance organization clinic agreed to participate. Approximately 12 percent of patients approached by the research assistant declined participation, most commonly citing lack of time.

RESULTS

Subjects were predominantly young, female, white, and middle to upper middle class (Table 1). There were no significant differences between the two clinics on any of the demographic variables.

Table 2 displays the proportion of patient responses for each of the six situations in which they would want the patient to continue to be seen by the primary physician and whether they would want the patient to be referred to a specialist. For all six situations a majority of patients indicated that would want both continuity with their primary physician and referral to a specialist. For the two situations describing serious medical illness, over three fourths of the patients wanted both continuity with the primary physician and referral to a specialist. For marital problems, hospitalization for serious illness, frequent visits without improvement, and depression, patients were somewhat more likely to want referral without continued contact with their family physician than to want only continuity with their primary physician.

There was considerable variability in the proportions of patients wanting family conferences (Table 3). Patients were clearly more interested in having conferences for the situations describing serious medical illness—hospitalization for serious illness (89 percent) and new diagnosis of serious illness (83 percent)—than they were for the other situations. Pairwise chi-square tests of proportions indicated that these two situations were not significantly different from each other, but were significantly greater than the four others in terms of the proportions of patients wanting family conferences. In addition, a significantly higher proportion of patients wanted a conference for depression (71 percent) than for marital or relationship problems (48 percent), stress-related symptoms (49 percent), and frequent visits without improvement (37 percent).

Figure 1 displays the distributions of the most common combinations of levels of involvement desired in family conferences for those patients who indicated that they would want family conferences. Patients were more likely to want all of Doherty and Baird's levels 2 through 5 than any single level or combinations of levels. The patients wanting all levels ranged from 75 percent for hospitalization for serious illness to 50 percent for frequent visits without improvement. Pairwise chi-square tests of proportions were again performed. A significantly higher proportion of patients indicated that they would want all four levels of intervention for hospitalization for serious illness than they did for the remaining situations. A significantly higher proportion of patients wanted all four levels for depression than they did for new diagnosis of serious illness and for stress-related symptoms. Finally, the proportion of patients wanting all four levels for frequent visits without improvement was significantly greater than that for new diagnosis of serious illness.

TABLE 1. PATIENT DEMOGRAPHIC CHARACTERISTICS

Patient Characteristics	Number	Percent
Age (years)		
Mean	30.6	
Range	18–71	
Sex		
Male	50	21
Female	189	79
Race		
White	232	97
Other	7	3
Income		
<$10,000	24	10
$10,000–$19,999	62	26
$20,000–$30,000	69	29
>$30,000	84	35
Marital status		
Single/never married/widow	53	22
Separated	2	1
Divorced	19	8
Married	134	56
Partnered	31	13
Children		
Yes	123	51
No	116	49

Patients were also asked whether they would want individual or family therapy with a psychotherapist or other mental health professional. A majority of patients said that they would like both individual and family therapy for depression (74 percent; 7 percent wanted neither), marital problems (64 percent; 13 percent wanted neither), and hospitalization (60 percent; 27 percent wanted neither). For stress-related symptoms, 43 percent wanted both (26 percent wanted neither), new diagnosis of serious illness, 37 percent (51 percent wanted neither), and frequent visits without improvement, 32 percent (45 percent wanted neither). Thus, only 10 to 25 percent of patients selected only one type of psychotherapy. Most patients who expressed interest in having a family conference with their primary physician also wanted it combined with therapy with a mental health professional (individual or family). Exceptions to this include new diagnosis of serious illness (46 percent wanted physician family conference

TABLE 2. DISTRIBUTION AND PERCENTAGES OF PATIENTS' RESPONSES REGARDING CONTINUITY WITH FAMILY PHYSICIANS AND REFERRAL TO SPECIALIST

Clinical Situation	Want Primary Physician and Referral	Want Primary Physician and No Referral	Do Not Want Primary Physician and Want Referral	Do Not Want Primary Physician and Do Not Want Referral
Hospitalization for serious illness	84	12	15	0
New diagnosis of serious illness	77	11	12	0
Depression	64	6	30	0
Marital or relationship problems	52	11	30	7
Stress-related symptoms	57	19	22	2
Frequent visits without improvement	57	2	40	1

TABLE 3. PERCENTAGES OF PATIENTS WANTING FAMILY CONFERENCES WITH FAMILY PHYSICIAN

Clinical Situation	Percent of Patients Wanting Family Conference
Hospitalization for serious illness	89
New diagnosis of serious illness	83
Depression	71
Marital or relationship problems	48
Stress-related symptoms	49
Frequent visits without improvement	37

only), frequent visits without improvement (47 percent wanted neither family conference with physician nor specialist therapy), and marital problems (35 percent wanted specialist therapy without the family conference with the physician). Most of the patients who responded that they would like a family conference with their physician in which family therapy was offered (level 5) also responded that they would like a referral to a mental health professional for family therapy. The proportions ranged from 91 percent for marital problems to 60 percent for new diagnosis of serious illness.

Table 4 shows the distribution of patients indicating whether they had ever had that situation happen to themselves or another member of their family. Proportions ranged from 44 percent of the patients responding that they had experienced new diagnosis of serious illness of a family member to 31 percent indicating that a member of their family had experienced frequent visits to the primary physician without improvement. Table 4 also shows for each situation the percentage of patients who responded that they had had a family conference with their physician when the event occurred. The patients were much more likely to have had a family conference for serious illness (32 percent for hospitalization and 20 percent for new diagnosis) than they were for the other situations.

To determine whether having had a family conference in the past made patients more likely to want higher levels of physician intervention in the future, a composite score of patient interest in physician involvement was calculated for each situation. Patients who responded that they would want a family conference in that situation were given one point. They were given another point for each additional level of involvement that they indicated they would want in the conference. Thus, scores could range from 1, for a patient who did not want a family conference, to 5, for a patient who wanted a family conference in which Doherty and Baird's levels 2 through 5 were provided. One-way analyses of variance were then conducted for each situation using as independent variables the patient reports of whether a conference had occurred and as dependent variables the composite score of interest in physician level of involvement for the specific situation. None of the six analyses was significant, although there was a trend for those who had experience with the situations when a conference occurred to want higher levels of physician involvement with their families.

Clinic site and physician characteristics were also considered as potential contributors to patient interest in family conferences. One-way analyses of variance were performed using clinic site as an independent variable and the composite score of patient interest in physician involvement as the dependent variable. None of the six analyses approached significance. Similar analyses using physician type (family physician vs general internist) and physician sex were also nonsignificant.

DISCUSSION

The results of the present study indicate that patients are very interested in having family conferences when family members are hospitalized for serious medical illness and when new diagnoses of serious medical illness are made. They are also interested, but less strongly so, in having

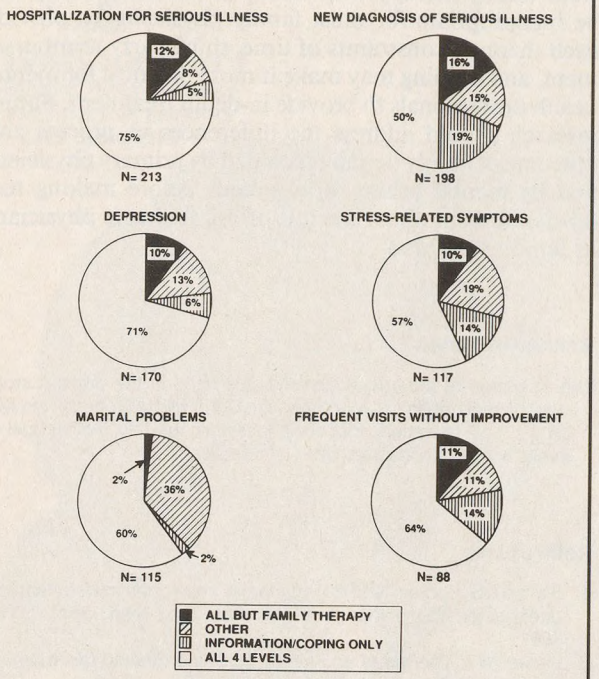

Figure 1. Distribution of combinations of levels of involvement by situation for subjects desiring family conferences (from a total sample of 239 subjects)

TABLE 4. PATIENT PAST EXPERIENCE WITH SIX CLINICAL SITUATIONS INVOLVING SELF OR FAMILY MEMBER

Clinical Situation	Percent of Patients in Study Who Had Experience With Clinical Situation	Percent of Those With Experience With Clinical Situation Who Had Family Conference
Hospitalization for serious illness	42	32
New diagnosis of serious illness	44	20
Depression	38	13
Marital or relationship problems	44	13
Stress-related symptoms	32	10
Frequent visits without improvement	31	8

family conferences when a family member is depressed. These results are consistent with those reported by Kushner et al[6] in that the rank orderings and relative magnitudes of interest in family conferences for these six situations were replicated here. The only exception was for frequent visits without improvement, which had the lowest rank ordering in the present study, compared with a rank order of four in the previous study. This finding could be attributed to the patients' view that lack of improvement was due to a failure on the physician's part and that referral to a specialist would be preferred over contact with the primary physician.

For all six clinical situations, majorities of patients wanting family conferences indicated that they would want their physicians to provide all of Doherty and Baird's levels of involvement, including family therapy, for long-standing problems. This finding was especially true for the events of hospitalization for serious illness and for depression. The high endorsement of high levels of physician involvement with families may indicate that patients see physician involvement in family conferences—including offering in-depth family therapy—as being appropriate, and welcome, behavior for a primary physician. That most of those patients expressing a desire for family therapy with their family physician also responded that they would want referral to a mental health professional for family therapy, however, indicates that patients may see such intervention offered by their primary physician as an adjunct to, but not a substitute for, family therapy provided by a mental health professional. This explanation would be consistent with data reported by Hansen et al,[7] which showed that patients are interested in having both treatment by their family physicians and referral to mental health specialists for psychosocial problems.

There is an alternative explanation for the subjects' expressions of desire for high levels of physician involvement in family conferences and for the tendency to indicate that they would want family treatment with their primary care physician as well as referral to a mental health specialist. Such results may indicate that many patients want a high degree of attention to the psychosocial problems, but that they do not discriminate between treatment modality and type of provider. It may be that these data reflect a tendency for such patients to want a lot of care regardless of who provides it and in what context it is delivered. This explanation also finds support in the findings that patients who wanted family therapy with their primary physician also tended to want individual or family therapy with a mental health professional, and that patients who wanted family therapy with a mental health specialist typically also wanted individual therapy with a mental health specialist.

While patients overwhelmingly indicated that they would want a family conference if a family member is newly diagnosed with or is hospitalized for having a serious

medical illness, less than one third of those patients who reported that such events had occurred in their families responded that they had had a family conference with their primary care physician at these times. For the other situations studied, the proportions of patients reporting having had family conferences were substantially less. These findings suggest that family conferences may be underutilized in the practices studied.

There are three major limitations to the generalizability of the results of the present study. First, only six representative clinical situations were studied. The degree to which these results could be extrapolated to other clinical situations is unclear and could be the basis for further empirical research. Second, only two demographically homogeneous clinics were studied; again, replication in other settings would be informative. Finally, the questionnaire measured patient self-reports of hypothetical situations, and may not accurately predict patients' acceptance of family conferences in real life.

In spite of the cautions to generalizability described above, the results of the present study have implications for the practice of primary care medicine, the training of primary care residents, and future research. Practicing physicians as well as trainees should be aware that patients appear to be keenly interested in having family conferences, especially in the face of serious medical illness and psychological problems such as depression. Physicians should consider arranging conferences at such times, and family physicians should receive supervised experience in conducting family conferences, at least for the lower levels of involvement. The high degree of desire expressed on the part of patients for in-depth family therapy conducted by family physicians is likely to be controversial in light of the frequent questioning of the role of family physicians as psychotherapists (Merkel,[2] Schwenk[8]). Even if future research corroborates the present finding that patients want family therapy with family physicians, it may still be inappropriate for most family physicians to provide such therapy; constraints of time, third-party reimbursement, and training may make it more practical for mental health professionals to provide in-depth treatment. Future research should address the differences in process and outcome of family therapy provided by primary physicians and by mental health professionals before making recommendations about the role of primary care physicians as family therapists.

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