# Family Conferences: Reasons, Levels of Involvement and Perceived Usefulness

Daniel L. Meyer, PhD, James A. Schneid, MD, and Frederic C. Craigie, Jr, PhD
*Augusta, Maine*

*In this study, family conferences conducted in a family practice model clinic were prospectively monitored. Study goals were (1) to identify the distribution of clinical situations for which family conferences were being conducted, (2) to test whether the levels of physician involvement typology developed by Doherty and Baird represented a hierarchy of skills, at least in their frequency of application in conferences, and (3) to generate clinicians' estimates of conference utility. During a 1-month period 57 conferences were held, primarily for medical management problems. Sixty-one percent took place in the model clinic (3% of office visits) and 23% in the hospital (20% of admissions). A hierarchy of levels of involvement was found: the clinicians indicated that medical information and advice was most often provided "a lot," emotional support was provided "some," systematic assessment and intervention were provided "a little," and family therapy skills were usually not used. Clinicians perceived the conferences to be usually useful to the patient, almost always useful to the family, and always useful to themselves. These results can provide information for future training, practice, and research.*

Family-oriented medical care is one of the basic tenets of family medicine. One method of implementing this family orientation is through family conferences in patient care. Models of physician involvement with families recently developed by Doherty and Baird[1] and Christie-Seely[2] are short-term, problem-focused, family-based interventions directed at issues commonly seen in primary care practice. Such meetings are intended to mobilize family resources for dealing with the stresses of both medical and psychosocial problems. By this definition the family conference is not family therapy, but one meeting between a physician and family members that may, but most likely will not, lead to further such meetings.

Little empirical work has appeared in the family medicine literature on family conferences. An exception is the series of studies by Kushner and colleagues[3–5] at the University of Wisconsin at Madison. In the first study,[3] 276 patients surveyed at a family practice model clinic indicated high levels of interest in family conferences, particularly for serious medical problems and for some psychosocial problems. A similar survey using the same 21 clinical situations was sent to 127 graduates of the University of Wisconsin–Madison Family Practice Residency.[4] Respondents indicated a high level of interest in such conferences and relatively good agreement with patients' priorities for convening family conferences. The study suggested, however, that these family physicians may underestimate patients' actual interest in such conferences.

A second patient survey,[5] collected at a staff model health maintenance organization and a family practice model clinic, was designed to address patients' goals and expectations of family conferences using Doherty and Baird's model of levels of physician involvement with families.[1] For six representative clinical situations, proportions of patients interested in conferences ranged from 89% for "hospitalization for serious illness" to 37% for "frequent patient visits with no improvement." One half or more of those patients who expressed interest in a family conference desired all four types of family physician involvement (providing medical information, sharing feelings and support, developing family coping skills, and providing brief family therapy). The authors concluded that patients overwhelmingly expressed interest in conferences for serious medical problems, that patients expressed interest in different levels of involvement (from no conference to family therapy) depending upon the type of problem or situation, and that further research was needed on the family confer-

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*From the Maine-Dartmouth Family Practice Residency Program, Augusta, Maine. Requests for reprints should be addressed to Dr Daniel Meyer, Maine-Dartmouth Family Practice Residency Program, 12 East Chestnut St, Augusta, ME 04330-5796.*

ence in actual clinical situations rather than through hypothetical scenarios.

The purpose of the present study was to monitor prospectively family conferences conducted in a family practice residency program that emphasizes the use of family conferences in clinical care, using the levels of involvement typology employed by Kushner and colleagues.[5] This approach allowed the investigators (1) to identify the distribution of clinical situations for which family conferences were being conducted, (2) to test whether Doherty and Baird's[1] levels of involvement represented a hierarchy of skills, at least in their frequency of application in conferences, and (3) to generate clinicians' estimates of the utility of the conferences. Thus, the present study was designed to go beyond descriptions of clinical management approaches (eg, Christie-Seely[2]), highly selected clinical case descriptions (eg, Doherty and Baird[6]), or results based on hypothetical situations posed to patients and physicians (eg, Kushner and colleagues[3–5]).

## METHODS

The study was conducted in an 18-resident university-affiliated, community hospital-based family practice residency program in a small town (population 20,000) in northern New England. The patient population is white and somewhat skewed toward lower socioeconomic groups (36.3% of patients are self-paying, 19.9% are covered by Medicare, 11.8% are covered by Medicaid, 20.8% are covered by Blue Cross/Blue Shield, and 11.2% are covered by other commercial insurance) and toward younger patients (20.9% aged 0 to 9 years, 12.4% aged 14 to 19 years, 38.3% aged 20 to 34 years, 16.6% aged 35 to 64 years, and 11.8% aged 65 years and over).

The concepts and methods of family conferences had been systematically addressed in the residency program over the previous 3 years, using faculty development sessions led by a nationally recognized expert (Dr Macaran Baird), monthly family-in-family-medicine seminars,[7] and family chart reviews.[8] A reporting sheet (described below) was introduced and discussed at a noon teaching conference for faculty, residents, and clinic staff. Data were collected for one 4-week "block" rotation (March 28 to April 24, 1988). Reporting sheets were attached to the chart of each patient seen by faculty, resident physicians, or mid-level practitioners for an outpatient visit at the model clinic. Sheets were also available to faculty and residents at daily morning hospital "signout" rounds and at nursing home sites. Clinicians were asked to complete the form following any meeting addressing a clinical issue that included a patient and one or more significant persons in that patient's life. While the presence of the sheets may have served to prompt more conferences, this method was designed to foster more complete reporting than would a passive system that relied on clinician recall.

A simple one-page family conference reporting sheet was designed. Items included date and site of conference, patient's age and sex, clinical situation or problem, a listing of all participants, and the name of the person who requested the conference. Using a 4-point scale (1 = not at all, 2 = a little, 3 = some, 4 = a lot), clinicians then rated the extent to which they provided the four levels of involvement corresponding to Doherty and Baird's levels 2 through 5.

Doherty and Baird[1] describe five levels of counseling intervention that physicians might offer in family conferences. The first level is minimal emphasis (not conducting a family conference), level 2 is providing ongoing medical information and advice in a conference, level 3 is sharing feelings and support, level 4 is systematic assessment and planned intervention on ways to cope with the clinical situation, and level 5 is conducting brief family therapy aimed at preexisting family dysfunction. Four single-sentence descriptors, identical to those used in the study by Kushner and colleagues,[5] were used. For example, level 2 read: "[Indicate the extent you] provided information about the patient's medical condition and advised the family on how to manage the medical aspects of the patient's condition."

Finally, the clinicians estimated the duration of the conference in minutes and rated on 3-point scales (1 = yes, 2 = maybe, 3 = no) whether they felt the conference had been useful to the patient, to the family, and to themselves.

## RESULTS

During the 4-week data-collection period, 57 family conferences were held. Each of the five faculty physicians conducted at least one conference for a total of 22 (39%), the family nurse practitioner and the physician assistant together conducted 13 (23%), and 7 of the 17 residents conducted at least one conference for a total of 20 (36%). One conference was reported by a physician assistant student, and for one the clinician was unidentified. Thirty-five (61%) of the conferences took place in the outpatient clinic from a total of 1176 outpatient visits, yielding a rate of about 3 per 100 visits. Thirteen conferences (23%) were held in the hospital and constituted 20% of the 66 admissions for the period. Eighteen of the 66 admissions were for obstetric care, and the majority of the remainder were for care of older patients with complications of chronic illnesses such as chronic destructive pulmonary disease or heart disease. (Between one third and one half of these 66 admissions were patients from the community without regular physicians who were assigned to the hospital service according to hospital protocol; the reporting sheet does not

**TABLE 1. CLINICAL SITUATIONS FOR WHICH FAMILY CONFERENCES WERE HELD**

| Clinical Situation | Number | (%) |
|---|---|---|
| Serious medical problem | 14 | (25) |
| Acute or minor illness | 9 | (16) |
| Chronic illness | 8 | (14) |
| Health maintenance | 6 | (11) |
| Dementia | 5 | (9) |
| Prenatal | 3 | (5) |
| Other medical problem | 3 | (5) |
| Child abuse | 2 | (3.5) |
| Anxiety or depression | 2 | (3.5) |
| Other behavior problem | 2 | (3.5) |
| Nursing home placement | 1 | (2) |
| Not reported | 2 | (3.5) |

**TABLE 2. EXTENT OF LEVELS OF INVOLVEMENT OF CLINICIANS IN FAMILY CONFERENCES**

| | Extent Provided in Conferences | | | |
|---|---|---|---|---|
| Level of Involvement | Not at All No. (%) | A Little No. (%) | Some No. (%) | A lot No. (%) |
| Medical information | — | — | 18 (33) | 37 (67) |
| Emotional support | 8 (15) | 10 (18) | 24 (44) | 13 (24) |
| Assessment or coping skills | 13 (24) | 22 (41) | 15 (28) | 4 (07) |
| Family therapy | 31 (58) | 14 (26) | 6 (11) | 2 (04) |

permit distinguishing regular model clinic patients from this group.) Four (7%) were conducted at an Alzheimer's evaluation unit, one in a nursing home, and one in the emergency department; for three the site was not reported.

The clinicians requested the meetings 25 times (44%), compared with 6 patient requests (11%), 11 family requests (19%), and 10 chance encounters (18%), that is, the participants happened to be in attendance. For 55% of the conferences, only one other family member was present in addition to the identified patient, compared with 2 members at 21% of the conferences, 3 members 12%, and 4 or more members 11%. The mean estimated duration of the conferences was 25 minutes (median = 15 minutes).

The ages of patients who were identified as the primary focus of the conferences ranged from 3 months to 98 years (19% were under 10 years and 44% were over 65 years). The patients were 58% female. Other demographic data were not collected, but as reported above, the model clinic provides care to a broad cross-section of the community, slightly skewed toward lower socioeconomic groups. The clinical situations of the 57 conferences are summarized in Table 1. Serious acute medical problems accounted for 25% of the problems, and other biomedical problems, such as minor or chronic illnesses and health maintenance, accounted for an additional 41%. A broad range of other situations was represented, including psychosocial or behavioral problems such as anxiety or depression, dementia, and child behavior problems. Of particular interest is that two conferences focusing on child abuse were reported during the period. Approximately one half of the conferences held by residents were for serious medical conditions compared with 22% of the faculty physician conferences and none of the nurse practitioner or physician assistant conferences. An additional 30% of residents' conferences were for chronic illness, health maintenance, or acute minor illnesses compared with 41% of faculty physician conferences and 58% of the nurse practitioner or physician assistant conferences. In 12 of the 57 reports (21%), a secondary clinical problem was also reported, for example, a co-morbid condition of the patient or an illness in another family member.

Table 2 shows the extent to which each of the four levels of involvement was addressed in the 57 conferences. As shown, medical information and advice (Doherty and Baird's level 2) was addressed to "some" extent (33%) or "a lot" (67%) in all conferences, with a mean response of 3.67 on the 4-point scale. Feelings and support (level 3) was next most commonly addressed, most frequently to "some" extent rather than "a lot" (mean score = 2.76). Systematic assessment or planned intervention (level 4) most frequently was performed "a little" (mean score = 2.18), and finally, family therapy (level 5) most frequently was performed "not at all" (mean score = 1.6). To test whether within conferences each level was provided more extensively than its adjacent higher level (level 2 > level 3 > level 4 > level 5), Wilcoxon matched pairs signed-ranks tests were used. The three $Z$ scores were all $\geq 3.18$ ($P < .002$). These results support a hierarchical construct of application of skills, with medical information sharing, the most basic skill, being used more extensively and processing finally to family therapy skills, which were used "a lot" in only two (4%) of the conferences.

A comparison of the levels of involvement across types of clinical situations is difficult because the number of cases were relatively few in some categories and because the need for and provision of specific levels of involvement may depend on the specific family situations and clinician skills. Nevertheless, medical information was almost always provided "a lot" in dementia and with serious medical, chronic, and acute illnesses compared with the remaining problems. Emotional support (level 3) tended to be covered to a larger extent ("some" or "a lot") when dealing with serious medical conditions, abuse cases, and anxiety

and depression. Level 4 skills (assessment and coping) were somewhat more likely to be used when dealing with abuse cases, anxiety or depression, nursing home placement, and prenatal visits. Because very few cases involved use of level 5 (family therapy) skills above the "a little" category, and perhaps because application of such skills is more dependent on family characteristics than on clinical situation, no trends were apparent in applying these skills across the situations.

The data on usefulness of the conferences indicate strongly that clinicians perceived value in such conferences. In 92% of the conferences, the conference was felt to be definitely useful to the clinician, and in 8% maybe useful. In addition, clinicians felt that the conference was definitely useful to the identified patient in 67% of the conferences, maybe useful in 26%, and not useful in only 6%, and even more often useful to the family (81% definitely useful, 17% maybe useful, 2% not useful.) While these perceptions regarding patients and families do not directly assess actual usefulness, they do indicate that clinicians impute usefulness to them, providing an increased rationale for convening conferences. In general, within each level of involvement, providing that level to a greater extent was associated with greater perceived usefulness for patient, family, and clinician. For example, conferences that provided emotional support "not at all" were rated useful to the family 62% (5 of 8) of the time compared with 67% (4 of 6) for "a little," 83% (20 of 24) for "some," and 100% (13 of 13) for "a lot" of emotional support.

## DISCUSSION

The large number of conferences found in this study supports the notion that patients and families are interested and willing to participate in family conferences. Rates of family conferences in practice have not been previously reported; future studies will be needed to determine the range in rates per clinic visits and hospital admissions compared with the rates of 3% and 20%, respectively, found in this study. Doherty and Baird,[6] citing their informal survey of the 50 family physician contributors to their casebook, indicated that the typical physician held three to five conferences per week (they acknowledge that their sample is probably not typical of all family physicians). By contrast, two thirds of the physicians in the Kushner and Meyer study[5] reported at least one conference in the previous month and averaged 2.6 conferences in that month (these physicians had graduated from a residency that had little formal emphasis on use of family conferences). While all faculty physicians in this study conducted at least one conference, only 7 of 17 residents conducted conferences, a finding that could not be accounted for by numbers of patients seen or practice panel differences. Whether this rate is due to attitudes, inadequate training, or other factors requires further study; future studies may also help identify reasons for variations in rates across physicians and practice sites.

The clinical situations of the family conferences reported here are in agreement with both the retrospective reports of physicians[5] and Doherty and Baird's informal survey: "The physicians in this book are most apt to convene family conferences around serious or chronic illness and the dying process. The majority deal with psychosocial issues insofar as these issues interact with medical illness. . . ."[6]

The data on levels of involvement during the conferences suggest a hierarchy of skills used by family physicians. The clinicians in this study universally supplied medical information and advice, they usually provided time for sharing feelings and support, they sometimes provided systematic assessment and intervention directed at helping the family cope with the situation, and they rarely provided short-term family therapy. To determine whether these proportions are optimal requires outcome studies that match physician and family perceptions of the conferences. The average length of the conferences appears to be somewhat shorter than previously reported. Study data suggest that even brief conferences are perceived as useful to physicians; future studies will need to explore optimal time spent in conferences from physician and family perspectives.

The data also indicate that the clinicians see value in conducting the conferences. Here again the findings suggest a hierarchy: the conference is seen as usually helpful to the patient, almost always useful to the family, and always useful to the clinician. While attributions of usefulness to others is an imprecise measure, these data, as well as the overwhelming perceived utility to the clinician, suggest reasons for regular use of conferences in the model family practice setting. Continued work in training, modeling, and encouraging the use of conferences appears to be necessary, since less than one half of the residents conducted a conference. It was noted, however, that family conferences were often suggested (by both residents and faculty) for difficult or complicated cases presented at daily model clinic ambulatory rounds.

Several of the limitations of this study should be acknowledged. First, to promote cooperation by office staff, data were collected for only one month, and the method of data collection may have prompted clinicians to conduct more conferences than they might in a usual month. Studies of the use of prompts for prevention and screening activities suggest that performance is enhanced by such prompts, but only performance of activities that the clinician endorses.[9] If these data reflect this phenomenon, other programs might benefit from replication of this relatively simple method of encouraging family conferences. Except

for the chance encounters (18% of conferences) a prompting explanation seems unlikely, since family members other than the identified patient attend. In addition, no increase in numbers of meetings was found during weeks of data collection, which would not be true if the sheets induced use of conferences for subsequent visits. The validity of the levels of involvement data reported here may also be questioned, as the levels typology is explicitly taught in the residency curriculum and may have created bias in reporting. A sample of family conferences is currently being videotaped to develop an objective measure of levels of involvement that could be compared with participants' perceptions of levels of involvement.

Second, the method and type of data collected leave some gaps in the full picture of family conferences during the month. It is unclear whether family conferences were always conducted in clinical situations for which they might have been indicated. Thus, there is no way of estimating an appropriate rate of conferences. In addition, information was not systematically collected on conferences that were offered to patients but were refused. One reporting sheet was returned on a "failed" conference in which the patient attended but the spouse did not as the result of an apparent scheduling miscommunication. Future studies should more systematically address the issues of identification of appropriate situations for conferences and patient and family acceptance of the family conference.

Third, some of the meetings reported by clinicians in this study may not be considered family conferences as defined by Doherty and Baird.[6] Many of the conferences reported here were shorter than the 30-minute average reported by their physicians (median length for this study was 15 minutes). It seemed appropriate to allow the practitioners leeway in defining the limits of family conferences; the guideline used was any meeting held to address a clinical issue that included a patient and one or more significant persons in that patient's life. Eight of the 13 conferences for children aged under 10 years involved only one other family member (a parent) and thus may be construed as an individual consultation with the parent. Excluding these from the analyses has little effect on the overall distribution of reasons for conferences, on the hierarchical application of the levels of involvement, or on perceived usefulness of conferences. A less formal definition may have advantages, however. One of the program's part-time family physician faculty members who participated in the faculty development workshops contends that a formally labeled "family conference" may inhibit family participation; by encouraging family members to attend as often as possible, two or more adult family members are present in 40% of his private practice office visits, based on a review of 1 week of office visits.

Finally, the study was conducted in a single family practice residency. Thus, these results may not be representative of other programs or practices, and it would be helpful for others to document the use of family conferences in other settings. The high number of conferences is probably due in large part to the preceding 3 years of educational activities and the unanimity of the faculty's support of the concept of family conferences. Whether other training programs would find similar results with or without the family conference training emphasis of this program is a question for future investigation.

Despite these limitations, this study makes several important contributions: It demonstrates that family conferences can be conducted (and are accepted by families) for a variety of clinical problems in a busy residency clinic, that the levels of involvement physicians provide in them correspond to those identified in the training model of Doherty and Baird,[1] and that clinicians find them useful. A number of areas that require future study have been identified in the discussion above. High priorities for research should be (1) more careful study of the rates, clinical situations, and content of family conferences in private family practice offices, (2) prospective studies to test conference effectiveness as well as patient, family, and the clinician's perceptions of the conferences, and (3) studies of methods of training residents and practicing physicians to conduct effective family conferences.

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