Family Involvement in Routine Health Care: A Survey of Patients' Behaviors and Preferences

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Background. The purpose of this study was to assess the behavior and preferences of patients regarding family involvement in their routine health care visits.

Methods. A self-administered questionnaire was given to a convenience sample of patients visiting a family medicine center for an appointment.

Results. Thirty-nine percent of patients came to the physician's office with a family member or friend. Married patients and those with higher emotional involvement scores were significantly more likely to come to the office with someone. Two thirds of accompanied patients reported that this person came into the examination room with them. One third of the accompanied patients, however, thought that their physician was unaware that someone had accompanied them to the office. The majority (55%) of patients indicated that they would prefer to have a friend or family member in the examination room with them for some of their visits. No patient indicated that they never wanted a family member or friend to come into the examination room.

Conclusions. Patients prefer direct family involvement in their health care more often than what occurs in practice. Physicians can easily address this discrepancy by asking patients whether and in what way they would like others to be involved in their health care.

Key words. Physicians' practice patterns; physicians, family; patient satisfaction; professional-family relations.
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The specialty of family medicine emphasizes the importance of assessing the patient's health, illness, and disease within the context of family and community. Providing family-oriented primary care is one distinguishing feature of the specialty. Advocates for family-oriented primary care purport that health care is best accomplished through the concurrent care of the patient's family members and the appropriate use of family resources.[1-3] These advocates have influenced the clinical and educational aspects of family practice.[4-9]

A variety of family-oriented interventions are available for use in clinical and educational settings. These include family functioning assessment techniques,[10] family charting systems,[11] family genograms,[12] and family conferences.[6,8,13,14] Furthermore, curricula and other training materials have been developed to teach the application of family systems theory to medical care.[6-9,13,15-23] These clinical interventions and education programs can help physicians develop innovative ways of practicing family-oriented primary care.

Considerable research has shown the degree to which family factors can influence an individual's illness and disease.[24] Research studies[25-27] have assessed various aspects of family-oriented primary care: for example, assessing patient expectations about family physicians caring for the whole family, and patients' perceptions about families obtaining their usual care from a family medicine center or from a private family physician. There is, however, a paucity of primary care research to demonstrate how the patient, family, and physician can work together to improve health outcomes.[9]

With respect to patient expectations of their family physician, one half of all patients in one study felt that a family physician should care for the whole family, whereas

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62% of family physicians agreed with this statement.[25] A patient survey conducted in a family medicine training program found that 63% of respondents considered their family medicine center as their usual source of care, while only 35% of their other household members shared this perception.[26] These figures contrast with the findings of another survey, in which 95% of the respondents and 54% of their household members considered the center as their usual source of care.[27] In another study, only 28% of families in a private family practice received care for all household members from the same family physician.[28]

With regard to how family physicians work in primary care, less than 5% of the problem lists in one family medicine residency practice contained any family data.[29] During initial assessments of patients, physicians discussed family issues less than 6% of the time and they rarely explored family dynamics.[30] Family members were identified as additional sources of psychosocial information in only 8.7% of patients.[31]

These findings question the extent to which physicians and patients value a family-oriented approach to health care. It is difficult to estimate how much patients value family-oriented primary care, because many families may not recognize the value or may not have had the opportunity for one physician to care for the whole family.[32] The discrepancies between the idealism and practicality of family-oriented primary care certainly raise interesting philosophical and research questions.

Some researchers do not regard family-oriented care as a feasible option for practicing family physicians. Merkel[23] raised objections to such care because of practical reasons (time, space, and money), medicolegal reasons (eg, confidentiality), and the inherent difficulties of making an epistemological shift in thinking and practice. He suggested that the marriage of family therapy and family practice is not worth further investment. Ethical issues of implementing a family-oriented approach in the real world have been raised because of potential conflicts of interest between the individual's autonomy and the interests of other family members.[33,34] These concerns, however, are not supported by research findings. This controversy about family-oriented primary care represents different world views between professionals who support the value of family-oriented primary care and those who question it. Clearly, more research is needed to demonstrate the purported benefits of family-oriented primary care.

Three studies have assessed patients' and physicians' perceptions about the need for family conferences, the level of physician involvement, and various aspects of convening the family to deal with health issues.[35–37] No studies, however, have assessed the extent to which patients involve or want to involve family member(s) in routine health care, without formally convening a family conference. This omission in research studies may reflect the tendency of proponents of family-oriented primary care to assume, without asking, that patients want family involvement. Thus, there is a need to ask patients what they prefer. This study evaluated factors associated with (1) patients who bring family members with them to see their physicians for routine visits, and (2) the extent to which patients prefer family involvement in routine health care.

Methods

During a 2-week period, the receptionists at the central check-in station distributed questionnaires to all registered patients aged 18 and over as they entered the family medicine center, an urban training practice for 30 family medicine residents. Patients were asked to complete the questionnaire in the waiting room before seeing their health care provider to maximize the response rate. Data were collected on the following: basic demographics; whether the patient came alone or accompanied by a family member or friend; whether a family member or friend went in with the patient to see the doctor; whether unaccompanied patients would have liked a family member or friend to accompany them into the examination room; and patient preferences about who they would like to go with them when they see the doctor. The survey instrument also contained four items from the Family Emotional Involvement and Criticism Scale,[38] which has the highest predictive value for its two subscales: perceived family criticism and emotional involvement. These subscales were included to assess their association with patients' behavior and preferences about family involvement in health care.

A dichotomous variable for patient preference for family or friend involvement in health care was created using responses to a series of questions regarding the involvement of specific family members or friends in care. Patients were considered to prefer involvement if they expressed a desire for at least one family member or friend to accompany them to their visit at least some of the time. Patients who responded "rarely" or "never" for any family members or friends were considered to prefer no family involvement. This dichotomous variable was used in the regression analysis. Statistical analyses including univariate and logistic regressions were performed using SAS.

Results

More than two thirds of the 457 survey respondents were women and nearly two thirds were white. Based on the

Table. Univariate Analysis of Patients Who Came to Office With and Without a Family Member

Patient Characteristics	Without Family Member, % (n=281)	With Family Member, % (n=176)	*P* Value
Age, y	41.7	40	NS
Sex			
Female	63.3	76.1	
Male	36.7	23.9	.04
Level of education			
Grades 1–8	4.7	9.8	
Grades 9–11	11.9	23.0	
Grade 12	37.8	29.9	
Above grade 12	45.7	37.4	.001
Ethnicity/race			
African-American	26.3	33.7	
Asian	2.1	1.1	
Hispanic	4.3	4.6	
White	64.4	58.9	
Other	2.8	1.7	NS
Marital status			
Married/partnered	36.7	40.1	
Separated/divorced	23.4	24.5	
Widowed	6.5	11.6	
Single/never married	33.5	23.8	.004
Type of visit			
Prenatal	4.7	11.5	
Routine	29.9	33.3	
Problem duration of <4 weeks	32	33.3	
Problem duration of >4 weeks	33.5	21.8	.007

NOTE: Not all patients answered all questions.
NS denotes not significant.

number of adults attending over this 2-week period, the estimated response rate from this convenience sample was at least 55%. The mean age was 41 years, more than 40% were married, and more than 40% had more than a high school education.

Behavior

The characteristics of the patients who came to the office with a family member or friend and those who came alone are shown in the Table. Thirty-nine percent of all respondents reported that a friend or family member had accompanied them to the office. Excluding children under the age of 18, who accounted for 14% of visits, 25% of all respondents reported that an adult family member or friend had accompanied them to the office. Among those who came with someone, 40% were accompanied by their spouse, 27% by a friend, 16% by a daughter, 9% by their mother, and 15% by their father, son, or sibling. Only 48% of patients were sure that their doctor knew that they had come with someone that day. Of those who brought someone with them to the office, 67% reported that their family member or friend also accompanied them into the examination room. The most frequently cited reason for having the person in the examination room was because the patient, not the physician, invited them to do so. Only 2.4% of respondents cited a physician's invitation as the reason for having a companion accompany them to the examination room.

Among those who came to the office alone, 30% indicated that they wished a family member or friend had accompanied them to their visit today. Of those who wished that someone had come with them, 44% expressed a preference for their spouse and 20% cited a friend, while the remainder listed other family members.

Logistic regression analyses were conducted to predict which factors (age, sex, race, marital status, educational level, perceived criticism, and emotional involvement) were associated with accompaniment. The following characteristics were significant positive predictors of coming to the office with an adult or child: lower educational level ($P<.001$), higher emotional involvement scores ($P=.004$), and being married ($P=.008$). Significant positive predictors of coming to the office with an adult included: lower educational level ($P=<.001$) and higher emotional involvement scores ($P=.012$). The magnitude of the effects of these predictive variables was low.

Preferences

Among all respondents, more than one half (55%) expressed an interest in having a family member or friend come with them to some of their doctor visits. Only one of four (26%) indicated that no one was ever available to come with them, and only one of five (19%) indicated that they would rarely want someone to come with them. None of the respondents indicated that they would never want any family member or friend to come with them to the doctor. A logistic regression model was used to evaluate independent predictors of preference for having a family member or friend present for at least some visits. The only two statistically significant predictors were being accompanied to the office by a family member or friend ($P<.05$) and greater family emotional involvement score ($P<.01$).

Discussion

Most patients who responded to the survey indicated that they preferred having a family member or friend accompany them into the examination room for routine office visits. None of the patients surveyed indicated that they

would *never* want any family member or friend to come with them. More than one third of patients who responded to the survey indicated that either a family member or a friend had accompanied them to the office, and in two thirds of the cases, this person or persons also accompanied the patient into the examination room. Although greater family emotional involvement and being married predicted greater preference for family involvement, neither factor accounted for sufficient variance in preference to be clinically useful.

These findings suggest that most patients prefer that a family member or friend accompany them into the examination room for regular visits. A significant number of patients come to the family practice center accompanied by a family member or friend. Patients who prefer greater family involvement cannot be readily distinguished from those who do not on the basis of demographic or family function characteristics.

The findings of this study are similar to those of studies by Kushner et al,[35,36] who reported that most patients expressed an interest in family conferences and that patient preferences could not be successfully predicted. The Kushner studies found that family physicians tended to underestimate the extent to which patients want to have family conferences. An important distinction exists, however, between the findings of the Kushner studies,[35,36] which focused on family conferences for selected scenarios, and the current study, which focused on family member involvement in routine patient visits without formally convening a family conference.

This study was conducted using a convenience sample in a residency training program that emphasizes family-oriented care.[8] The conclusions of this study are limited to this selected population and to this training environment. The sample method used may have introduced response bias affecting the results. Furthermore, the survey instrument was given to patients before their appointment because an exit survey is less likely to be completed. The questionnaire itself could have acted as an intervention in its own right and affected patients' behavior with respect to inviting family members into the examination room.

Despite these limitations, the survey raises important questions about whether the health care team supports direct family involvement in the patient's health care and about whether patients are given the opportunity to decide when and how to involve their family members in health care. Physicians have been trained to work with individual patients and seldom receive training on how to deal simultaneously with patients and their family members. The issue of confidentiality may be another barrier to family involvement in patient care.

The discrepancy between how much direct family involvement patients want in their health care and what occurs in practice raises a question about whether the discipline of family medicine has turned its back on the family.[39] This proposition is refuted by the counterclaim that physicians deal with families on the run, over time, and to varying degrees of involvement.[40,41] The dilemma created by these issues and opinions can be easily resolved if physicians, nurses, and receptionists simply ask patients whether they would like family members to be involved in their routine health care, and if so, the kind of family involvement that they prefer at different times and with different problems. In this way, physicians can honor the confidentiality of the doctor-patient relationship while expanding the family involvement in health care. In many instances, family members or friends may be no farther than the waiting room, and the physician, nurse, or receptionist need only ask patients what they prefer.

References

1. Curry HB. The family as our patient. J Fam Pract 1977; 4:757–8.
2. Bauman MH, Grace NT. Family process and family practice. J Fam Pract 1977; 4:1135–7.
3. Geyman JP. The family as the object of care in family practice. J Fam Pract 1977; 5:571–5.
4. Rakel R. Principles of family medicine. Philadelphia, Pa: WB Saunders, 1977.
5. Schmidt DD. The family as the unit of medical care. J Fam Pract 1978; 7:303–13.
6. Christie-Seely J. Working with families in primary care: a systems approach to health and illness. New York, NY: Praeger Press, 1984.
7. Doherty WJ, Baird MA. Family-centered medical care: a clinical casebook. New York, NY: Guilford Press, 1987.
8. McDaniel SH, Campbell TL, Seaburn DB. Family-oriented primary care: a manual for medical providers. New York, NY: Springer-Verlag, 1990.
9. Sawa RJ. Family health care. Beverly Hills, Calif: Sage Publications, 1992.
10. Smilkstein G. The family APGAR: a proposal for a family function test and its use by physicians. J Fam Pract 1978; 6:1231–5.
11. Arbogast RC, Scralton JM, Krick JP. The family as patient: preliminary experience with a recorded assessment scheme. J Fam Pract 1978; 7:1151–7.
12. McGoldrick M, Gerson S. Genograms in family assessment. New York, NY: Norton Press, 1986.
13. Doherty WJ, Baird MA. Family therapy and family medicine: toward the primary care of families. New York, NY: Guilford Press, 1983.
14. Schmidt DD. When is it helpful to convene the family? J Fam Pract 1983; 16:967–73.
15. Crouch M, Roberts L. The family in medical practice: a family systems primer. New York, NY: Springer, 1987.
16. Glenn ML. On diagnosis: a systemic approach. New York, NY: Brunner/Mazel, 1984.
17. Christie-Seely J. Teaching the family system concept in family medicine. J Fam Pract 1981; 13:391–401.
18. Doherty WJ, Baird MA. Developmental levels in family-centered medical care. Fam Med 1986; 18:153–6.
19. Clark CH, Schwenk TL, Plackis CX. Patients' perspectives of behavioral science care by family practice physicians. J Med Educ 1983; 58:954–61.
20. Frowick B, Shank C, Doherty WJ, Powell TA. What do patients really want? Redefining a behavioral science curriculum for family physicians. J Fam Pract 1986; 23:141–6.

21. Schwenk T. Caring about and caring for the psychosocial needs of patients. J Fam Pract 1987; 24:461–3.
22. Hansen J, Bobula J, Meyer D, Kushner K, Pridham K. Treat or refer: patients' interest in family physician involvement in their psychosocial problems. J Fam Pract 1987; 24:499–503.
23. Merkel WT. The family and family medicine: should this marriage be saved? J Fam Pract 1983; 17:857–62.
24. Campbell TL. The family's impact on health: a critical review and annotated bibliography. Fam Systems Med 1986; 4:135–328.
25. Hyatt JD. Perceptions of the family physician by patients and family physicians. J Fam Pract 1980; 10:295–300.
26. Chatterton HT, Clapp NE, Gehlbach SH. Patterns of health care utilization in an academic university family practice. J Fam Pract 1982; 893–7.
27. Wall EM, Shear CL. Characteristics of patients seeking family-oriented care. J Fam Pract 1983; 17:665–8.
28. Fujikawa LS, Bass RA, Schneiderman LJ. Family care in a family practice group. J Fam Pract 1979; 8:1189–94.
29. Crouch MA, Theidke CC. Documentation of family health history in the outpatient medical record. J Fam Pract 1986; 22:169–71.
30. Crouch MA, McCauley J. Family awareness demonstrated by family practice residents: physician behavior and patient opinions. J Fam Pract 1985; 20:281–4.
31. Yaffe MJ, Stewart MA. Patients' attitudes to the relevance of non-medical problems in family medicine care. J Fam Pract 1986; 23: 241–4.
32. Bartholomew L, Schneiderman LJ. Attitudes of patients toward family care in a family practice group. J Fam Pract 1982; 15:477–81.
33. Brody H. Ethics in family medicine: patient autonomy and the family unit. J Fam Pract 1983; 17:973–5.
34. Williamson P, McCormick T, Taylor T. Who is the patient? A family case study of a recurrent dilemma in family practice. J Fam Pract 1983; 17:1039–43.
35. Kushner K, Meyer D, Hansen M, Bobula J, Hansen J, Pridham K. The family conference: what do patients want? J Fam Pract 1986; 23:463–7.
36. Kushner K, Meyer D. Family physicians' perceptions of the family conference. J Fam Pract 1989; 28:65–8.
37. Kushner K, Meyer D, Hansen JP. Patients' attitudes toward physician involvement in family conferences. J Fam Pract 1989; 28: 73–8.
38. Shields SG, Franks P, Harp J, McDaniel S, Campbell T. Development of the Family Emotional Involvement and Criticism Scale (FEICS): a self-report scale to measure expressed emotion. J Marital Fam Ther 1992; 18:395–407.
39. Smilkstein G. The family in family medicine revisited, again [editorial]. J Fam Pract 1994; 39:527–31.
40. Fischer PM. . . . and Again [editorial]. J Fam Pract 1994; 39:533–4.
41. Marvel MK, Schilling R, Doherty WJ, Baird MA. Levels of physician involvement with patients and their families: a model for teaching and research. J Fam Pract 1994; 39:535–44.