Family Awareness Demonstrated by Family Practice Residents: Physician Behavior and Patient Opinions

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Audiotapes of the visits of 50 new patients with 20 family practice residents were analyzed to determine how aware the residents were of their patients' families. The same patients' opinions about family awareness were elicited by interviews. Residents exhibited only limited family awareness. Despite this, patients thought that the residents showed more interest in family matters than they usually expected from a family physician.

Patients thought the physicians were most interested in their family situations when they asked more questions about family matters. Physicians were seen as least interested when they asked few family questions and when they were absent from the examination room for a relatively high proportion of the visit. Physicians were much less likely to discuss family matters with a patient during a short visit for an acute problem than during a longer visit for a chronic problem or for health maintenance.

Most patients identified physician attitudes and behaviors as more important obstacles to the discussion of family matters than patient attitudes. Patients generally wanted substantially more help from their family physician for family problems than they expected to receive.

Since the beginning of family practice residencies in 1969, family practice leaders have urged attention to the family in health care.[1-7] Although recent opinions vary about the desirability of making the family the main focus of care, most discussions acknowledge important relationships between the family and health and illness.[8-15] Many family practice residencies therefore attempt to teach residents to care for individual patients within the context of the family. However, there is no documentation of the clinical behavior of family practice residents that shows they actually are aware of their patients' families.

This study was carried out to (1) examine how family practice residents demonstrate awareness of their patients' families, (2) survey the opinions of their patients regarding the discussion of family

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matters, and (3) correlate selected physician behaviors with patient opinions about family awareness.

Methods

Study participants were 50 new adult patients making their first visit to the University of Missouri–Columbia Family Medical Care Center. New patients were chosen for the study because of the beliefs that family information would be more likely sought in first visits for new patients than in any particular subsequent visit, and that it was important to document what kind of precedents residents set during the initial visit for discussing family matters with patients.

Prior to the study, this family practice residency program did not strongly emphasize the systematic teaching of family awareness to its residents. For both inpatients and ambulatory patients, most faculty physicians paid substantial attention to family matters only when they seemed to be directly relevant clinically. During the study, the faculty neither taught family awareness in any special or additional way, nor did they avoid the topic.

Twenty of 22 first- and second-year family practice residents participated in the study. In each visit the resident was identified as the primary physician for the patient. All patients were seen between October 1981 and April 1982.

One of the investigators obtained written informed consent from each patient and resident prior to entry into the study. Patients and residents were told that the study would focus on certain unspecified aspects of physician-patient communication. Thus, none of the participants knew the specific nature of the study during the visit. Patients were informed of the express purpose during a post-visit interview. Residents were informed of the study's purpose and its results after the study was concluded.

All conversation between residents and patients was recorded with a tape recorder placed in the examination room. The investigators were not present in the room during the visits. The times of the physician's entry into and final departure from the room were recorded, as well as the duration of any physician absences from the examination room during the visit (to consult with the attending physician, respond to a page, etc).

Immediately following each visit, one of the investigators interviewed the patient, asking about physician-patient communication regarding family and home life. The interview questionnaire contained both open-ended and closed items. Response choices for the closed items were presented verbally and visually on a 5-point scale, with both adjectival and numerical labels for each point.

Both investigators reviewed each visit tape independently. A transcript was typed of all conversation containing any direct or indirect reference to the patient's family or to family-related concepts (family content material). The transcripts were coded independently by both investigators for numerous variables. Codings were compared and discussed, and the senior investigator made a final coding judgment. Interrater reliability values ranged from 0.68 to 0.94 for the reported parameters, and averaged 0.78 for all codings.

The patient's progress note, dictated by the physician, was later examined to determine how the family content material was documented by the resident in the patient's medical record.

The data were processed using the Statistical Analysis System (SAS). For a number of variables distributed in a skewed pattern (nonnormal), median values rather than means are reported.

Results

Patient Characteristics

Fifty patients participated—36 women and 14 men. Forty-seven were white, 3 were black. A majority (76 percent) were young adults aged 20 to 34 years; the median patient age was 32 years (range, 20 to 70 years). Twenty-seven patients were married, 6 were divorced, 1 widowed, and 16 had never been married. Most patients were middle-class with respect to economic and job characteristics.

Visit Characteristics

The median visit duration was 39 minutes. The median interruption time was 7 minutes, leaving a median interaction time of 32 minutes. The median proportion of time the physician was out of the room during the visit (interruption index) was 18 percent.

A median of four family content episodes (FCEs) occurred per visit. The median duration

for an FCE was 20 seconds. The resident physicians initiated 75 percent of the 280 FCEs observed. FCEs occupied a median total time of 1.8 minutes per visit (5.7 percent of the interaction time).

Family content episodes were not restricted to specific sections of the history, but occurred during all the phases of the visit. FCEs occurred during the social history phase of 62 percent of all visits. Other visit phases having frequent FCEs were presenting problem (48 percent of visits), family medical history (46 percent), past medical history (42 percent), and physical examination (32 percent).

The residents asked a median of five family-focused questions per visit, but during one fourth of the visits the resident asked no family questions at all or only one family question.

Visits by patients who presented for different purposes contained different amounts of family content. Residents asked over twice as many family questions in the comprehensive visits as they did in the visits with a problem focus.

The physicians identified a health problem of some kind during every visit. There were differences in the amount of family discussion for visits with different types of main problems defined by the physicians. When the main problem was nonacute (23/50), the median interaction time was 36 percent greater than when the main problem was acute (27/50). The total time spent in FCEs during a nonacute visit was almost three times that of an acute visit. When seeing patients for a nonacute problem, residents asked 2.5 times as many family questions as they did when seeing patients with an acute problem.

Family Content

Most of the family information elicited by the residents pertained to health and illness. The most frequently discussed family content areas concerned family health beliefs, attitudes, and past illness experiences; family health behaviors and current illness experience; and family medical history. With respect to approaches that have been recommended for acquiring family information, residents obtained partial genogram (family tree)[16] data during only three visits. The five items from Smilkstein's Family APGAR[17] were seldom discussed. Family dynamics were rarely explored.

Two thirds of all of the family content episodes were not documented in any way in the patient's medical record. Information from only 2 percent of all FCEs was dictated under problem headings with a family focus. Dictation of family content was included in the record under a medical problem heading for 18 percent of FCEs, health maintenance for 6.5 percent, and psychosocial (without a family focus) for 5 percent of FCEs.

Patient Opinions

Most patients thought that it was important for their family physician to be aware of their family problems and expected him or her to show at least some interest in their family and home life. Most patients also thought that their physician showed more interest in family matters during the observed visit than they usually expected from a family physician.

In contrast, most patients (70 percent) expected relatively limited help from the family physician for family problems, with only 28 percent expecting much or very much help. However, the patients wanted more help from their family physician for family problems than they expected to get, with almost one half (47 percent) wanting much or very much help.

The amount of interest that the patients thought the physician showed in learning about their family correlated with several characteristics of the visit. Physician initiative was a common denominator in the two strongest correlations—number of physician-initiated FCEs (.37) and number of family questions asked (.29). A significant negative correlation (−.17) was observed between the proportion of time the physician was absent from the room (interruption index) and the amount of family interest the patients thought the physicians showed. The interruption index also correlated negatively (−.14) with the number of family questions that the patient thought that the physician asked during the visit.

When asked about potential obstacles to the discussion of family matters, most patients (2/3) believed that their own level of reluctance to talk about this area did not interfere seriously with discussing it with a family physician. The majority (2/3) also thought it was quite appropriate to talk about family matters with a family physician. However, a sizable minority (1/3) thought their feelings of reluctance inhibited family discussion considerably, and the same proportion felt that

such discussion was not very appropriate.

A majority of the patients said that several factors strongly affected how much they talked about family matters with their family physician. The patients identified the following as the most important obstacles: "doctor seeming too busy," "doctor seeming uncomfortable," and "not having enough trust or confidence in the doctor."

Discussion

If the findings of this study accurately represent the general level of family awareness among family practice residents, there is considerable room for improvement. If family awareness is to be an educational goal with a high priority, it will be necessary to identify desirable clinical behaviors, assess resident-patient interactions regularly, and develop effective teaching strategies to foster the desired changes. Schaffer's[18] outline of the content for a family curriculum should stimulate debate among those who are trying to teach family concepts to residents and, it is hoped, will promote the evolution of well-defined curricula.

To encourage residents to recognize and deal with family factors that may influence the health of their patients, more effort must be invested in the development of methods that are time efficient, clinically relevant, and effective for working with family matters. Practicing family physicians frequently need the skills to help their patients with family problems. Over one half of the graduates of one family practice residency program expressed a great need for additional training in family counseling once they were actually in practice.[19] For family-oriented treatment and counseling in primary care, Doherty and Baird[20] and Christie-Seely[21] have recently published detailed practical approaches.

Several features of this study limit interpretation and generalization of the results. The study was done in a single university-based family practice residency program, with a predominantly young, white, middle-class population of patients and family practice residents. Only first visits by new patients were observed; thus, there is no information as to how residents continued to learn about their patients' families on subsequent visits. Most of the valuable familiarity with families develops gradually over the course of a long-term relationship. The initial gathering of more extensive factual information than was usual among physicians in this study, however, may facilitate the familiarization process considerably.

The value of family physicians' approaching patient care with a family orientation has yet to be demonstrated convincingly. The results of this study suggest that family practice residents could enhance the quality and comprehensiveness of their care by better using the family information they do obtain, and by getting more family information than they tend to get. Further research on the acquisition of family information should attempt to define a basic data base that not only is practical for the busy physician to obtain but also facilitates excellence in both the process and the outcomes of patient care.

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