The Family Conference: What Do Patients Want?

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This study investigated patients' desire for family conferences in a variety of clinical situations encountered in family practice. Two hundred seventy-six family practice center patients were given a questionnaire in which they indicated the likelihood that they would want a family conference in 21 clinical situations. Patients' past experiences with family conferences as well as demographic information were obtained. For serious medical problems and some behavioral problems, patients indicated a high likelihood of wanting a family conference. They showed moderate to low interest in such conferences for guidance for family developmental stages, health promotion, and minor acute problems. Demographic factors and previous experiences with family conferences did not predict patients' interest in future conferences.

One of the central questions confronting the field of family medicine today is the degree to which the family should be the focus of health care. A frequently advocated position within family medicine circles maintains that the family is the appropriate unit of health care[1-3] and that this family focus separates family practice from general medicine and other medical specialties. Features of family-oriented health care include having one family physician provide medical care to all members of a family, using family charting systems, applying family systems theory as a unifying perspective from which to view health care, and convening conferences with multiple members of the famly when appropriate. Critics of the concept of family-oriented health care, such as Merkel,[4] argue that the "marriage" between the family and family medicine was misguided and advocate a "divorce." In spite of this controversy, there have been few studies investigating the efficacy, practicality, and desirability of family-oriented medical care that might help to resolve these opposing philosophical positions.

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This study is concerned with one feature of family-oriented medical care: patients' interest in family conferences. The family conference is not seen as being synonymous with family therapy. Rather, the family conference is one meeting between a physician and family members that may, but most likely will not, lead to further such meetings. As such, the family conference fits well into models of physician involvement with families recently developed by Christie-Seely[3] and by Doherty and Baird.[5] Christie-Seely refers to her model as working with families and Doherty and Baird refer to theirs as primary care counseling. There is considerable similarity between the underlying aims and principles of these models. Both Christie-Seely's concept of working with families and Doherty and Baird's concept of primary care counseling are very short-term, problem-focused, family-based interventions that are directed at issues commonly seen in primary care practice. The foci of the interventions are likely to be prevention and health maintenance, facilitation of normal development, adjustment to acute and chronic medical problems, and management of behavioral problems. Further differentiation of these models from family therapy can be found in the original works of Christie-Seely and Doherty and Baird.

Despite the potential importance of the family conference to the practice of family medicine, surprisingly little research has been conducted on this topic. The issue of when to convene the family, however, has been addressed by three authors.

Christie-Seely[2] identified the following eight clinical situations for which she would recommend a family interview.

1. Diseases that are causally related to lifestyles and environmental factors
2. Difficulty in the management of chronic illness; poor compliance
3. Frequent visits for symptoms with poor response to treatment (eg, fatigue, headache, abdominal pains, backache)
4. Frequent visits to the office by different family members
5. Emotional, behavioral, or relationship problems (eg, sexual counseling)
6. Family crisis and loss of family composition through death, divorce, hospitalization, loss of a job, or a move
7. Anticipatory guidance for family developmental stages (eg, parental couple counseling, pre-retirement counseling)
8. Health promotion (eg, change in lifestyle, nutrition, immunization, genetic counseling)

Schmidt[6] presented a number of medical conditions for which he maintains it would be beneficial to convene the family. These conditions were selected on the basis of research evidence that suggested either that family functioning contributed to the cause of the illness or that the family would probably have a major reaction to the illness.

1. Pregnancy
2. Failure to thrive
3. Recurrent childhood poisoning
4. Preschool behavior problems
5. School behavior problems
6. Adolescent maladjustment
7. Major depression
8. Chronic illness
9. Diabetes
10. Arteriosclerotic heart disease, coronary bypass surgery
11. Poor adherence to medical regimen
12. High inappropriate use of health services
13. Terminal illness
14. Bereavement

Doherty and Baird[5] present a continuum of the importance of convening the family for primary care counseling. The five points of this continuum, ranging in ascending order from situations in which patients are generally seen alone to those in which family conferences are essential, are as follows:

1. Minor acute problems (eg, common cold, contact dermatitis)
2. Routine self-limiting problems (eg, influenza)
3. Treatment failure or regular recurrence of symptoms
4. Routine preventive or educational care (eg, prenatal visits, routine well-child visits)
5. Chronic illness (eg, hypertension), serious acute illness (eg, myocardial infarction), psychosocial problems, lifestyle problems (eg, obesity), and death

To date there has not been empirical research on patients' attitudes toward family conferences. While Schmidt[1] makes a claim that research upholds that families desire family-oriented care, he does not present any data that substantiate the specific proposition that patients desire family conferences. The present study was undertaken to determine empirically those circumstances in which patients would want to have family conferences organized and conducted by their family physicians.

METHODS

A questionnaire was developed in which patients were asked to rate, on a five-point scale, the likelihood that they would want to have a family conference if they or other members of their family had any of the 21 listed medical and psychosocial problems. This methodology resembles those used in recent studies of physician involvement in patients' psychosocial problems by Schwenk and his colleagues.[7,8] In the present study, patients were instructed that "family" referred not only to immediate family members but also to people who are so close that they might be considered "family."

In constructing the questionnaire, Christie-Seely's model of when to convene the family was used as the main reference point. To that end, specific situations were selected to represent each of the categories for which Christie-Seely recommends family conferences. Some of these clinical situations were treated generically, and only one item was selected to represent them. For example, one situation was chosen to represent Christie-Seely's category "frequent visits to the office by different famly members." Other categories such as "anticipatory guidance for family developmental stages" were thought to be too general, and several situations were selected (eg, expecting a baby, retirement, and placement in a nursing home). In addition to the situations used to describe Christie-Seely's indications for family conferences, additional situations were included that illustrated other clinical issues the investigators thought warranted family conferences: new diagnosis of serious medical illness, hospitalization for serious illness, and stress-related physical symptoms. To control for response bias, two additional questions were included that represented relatively minor acute problems for which it seemed unlikely that patients would want family conferences: influenza and a broken ankle. Subjects were also asked several questions pertaining to their past experience with family conferences and the likelihood that they would suggest one to their physician if they wanted one in the future.

Subjects were recruited from three family practice clinics that are training sites for the Family Practice Residency Program at the University of Wisconsin–

TABLE 1. REASONS FOR PREVIOUS FAMILY CONFERENCES

	No. (%)
Emotional, behavioral, or relationship problems	31 (24)
Obstetric care	28 (22)
Illness in children	14 (11)
Family crisis and loss of composition through death, divorce, hospitalization, loss of job, or a move	9 (7)
Diseases causally related to lifestyles or environment	8 (6)
Hospitalization for serious illness	8 (6)
Serious, life-threatening illness without hospitalization being mentioned	6 (5)
Birth control and family planning	5 (4)
Missing data	5 (4)
Chronic, recurring problems	4 (3)
Other	4 (3)
Headaches	3 (2)
Health maintenance	2 (2)
Infertility	2 (2)
Lack of physical findings for somatic illness	2 (2)
Poor compliance	1 (1)
Total	133 (100)

TABLE 2. ANTICIPATED DESIRE FOR FAMILY CONFERENCES

	Mean	95 Percent Confidence Interval
Dying family member	4.51*	(4.39, 4.64)
Hospitalized for serious illness	4.43	(4.30, 4.56)
Chronic illness/poor control	4.27	(4.14, 4.40)
Suspected child abuse	4.22	(4.08, 4.36)
Alcohol abuse or smoking	4.22	(4.10, 4.35)
Nursing home placement	4.17	(4.03, 4.30)
Child behavioral problems	4.08	(3.93, 4.23)
Not taking medications	4.01	(3.87, 4.15)
New diagnosis of serious illness	3.97	(3.83, 4.11)
Depression	3.79	(3.64, 3.93)
Expecting baby	3.64	(3.48, 3.81)
Frequent visits and no improvement	3.66	(3.51, 3.81)
Stress-related symptoms	3.43	(3.29, 3.56)
Anxiety	3.42	(3.28, 3.55)
Family member died	3.39	(3.23, 3.56)
Marital/relationship problems	3.36	(3.20, 3.52)
Health habits	3.32	(3.17, 3.46)
Frequent visits by multiple family members	3.10	(2.95, 3.25)
Retiring	2.37	(2.23, 2.52)
Broken ankle	2.12	(1.98, 2.26)
Influenza	1.82	(1.68, 1.95)

**Higher score indicates greater likelihood of wanting family conference*

Madison. All patients aged 18 years or older who came into the clinic over the course of the data-collection period were asked to participate.

RESULTS

A total of 276 patients filled out the questionnaire. Of these, 223 were women, 52 were men, and 1 failed to mark his or her gender. Ninety-seven percent of the subjects were white. The distribution of the subjects' yearly household incomes was as follows: 19.2 percent less than $10,000; 30.8 percent between $10,000 and $19,999; 27.5 percent between $20,000 and $30,000; and 19.2 percent greater than $30,000.

Eighty-three of the 276 subjects (30 percent) participating in the study indicated that they had had at least one family conference in the past. Thirty-seven subjects (13 percent) indicated that they had only one family conference in the past, 30 (11 percent) indicated that they had two such conferences, 10 (4 percent) indicated that they had three conferences, and 6 (2 percent) indicated that they had four previous family conferences. Such a high rate of patient reports of previous family conferences was not anticipated. It should be noted in this regard that there are no published reports of the frequency of family conference in family practice clinics. The patients indicated a high degree of satisfaction with their previous conferences, with a mean of 4.29 on a five-point scale of satisfaction.

The 133 previous family conferences reported by the subjects were categorized in terms of the situation for which they were conducted. The results of this categorization are displayed in Table 1. Obstetrics and behavioral problems accounted for 46 percent of the total number of conferences. Surprisingly, few of these previous conferences were conducted as a result of serious medical illness.

The means and 95 percent confidence intervals of the patients' ratings of anticipated likelihood that they would want a family conference for the clinical situations are displayed in Table 2. These means are presented in rank order, the higher the score indicating the higher anticipated likelihood.

When these results are compared with the models proposed by Christie-Seely, Schmidt, and Doherty and Baird, similarities are noted. The patients agreed with the previous authors that terminal and serious medical illness and at least some behavioral problems (suspected child abuse, child behavioral problems) are situations in which a family conference is indicated. They also agreed that for illness caused by lifestyle (alcohol abuse or smoking) and for some family developmental stages (nursing home placement), family conferences are indicated. However, major dissimilarities between the patients' reports and the other authors are also apparent. For some emotional, behavioral, or relationship problems, patients indicated mod-

TABLE 3. SCALES DERIVED FROM FACTORS

Scale	Loading
Scale 1. Serious medical problems	
Hospitalized for serious illness	.81
Chronic illness/poor control	.76
New diagnosis of serious illness	.76
Dying family member	.73
Not taking medications	.65
Nursing home placement	.58
Alcohol abuse or smoking	.53
Expecting baby	.43
$\bar{x}$ = 4.16; alpha = .87	
Scale 2. Behavioral problems	
Marital/relationship problems	.76
Family member died	.70
Depression	.66
Child behavioral problems	.57
Anxiety*	.53
Suspected child abuse	.43
$\bar{x}$ = 3.77; alpha = .75	
Scale 3. Low-rated problems	
Influenza	.88
Broken ankle	.76
Retiring	.65
Frequent visits by multiple family members	.55
$\bar{x}$ = 2.34; alpha = .76	
Scale 4. Problems of living	
Stress-related symptoms	.80
Frequent visits and no improvement	.61
Health habits	.58
$\bar{x}$ = 3.47; alpha = .72	

**Anxiety was included in this scale even though it had a slightly higher loading in factor 4 because it significantly decreased the reliability of scale 4*

erate to low interest in family conferences (depression, stress-related physical symptoms, anxiety, and marital problems). Similarly, they indicated little interest in a family conference during bereavement (family member died). Finally, patients showed little interest in a family conference for issues regarding retirement, a significant family developmental stage, and for health promotion such as smoking reduction, weight reduction, or exercise.

To determine which items grouped together as factors, a varimax factor analysis was performed on the subjects' ratings of the likelihood that they would want a family conference for the 21 situations. Four factors were extracted, representing 60 percent of the total variance. The items that loaded highest in factor 1 were the most potentially serious medical problems among the situations in the questionnaire. The items loading highly in factor 2 were mainly behavioral problems. Loading most highly in factor 3 were the situations that were rated the lowest in the questionnaire and were mainly the least potentially serious medical problems. The items that loaded highest on factor 4, the final factor, can best be described as situations relating to problems of living.

For easier interpretation of subsequent attempts to identify predictors of interest in family conferences, the factor analysis was used to generate scales composed of the most highly loaded items in each factor. For example, all seven items that had their highest loading in factor 1 were included in a scale that was labeled "serious medical problems." Using this procedure, each of the 21 items was contained in one of the four scales. The names of the scales, together with their items, means, and reliabilities, are displayed in Table 3. The means of these scales indicate the following continuum of patients' attitudes regarding when they would want to have family conferences (in descending order): serious medical illness ($\bar{x}$ = 4.16), behavioral problems ($\bar{x}$ = 3.77), problems of living ($\bar{x}$ = 3.47), and minor medical problems ($\bar{x}$ = 2.34).

To identify predictors of subjects' scores on the scales, four stepwise regression analyses were performed using each of the four scales as the dependent variable. The independent and dummy variables included the following demographic items: age, sex, physician's sex, number of times seen by the physician, employment, education, income, marital status, and number of children. Also included were the following items pertaining to the subjects' previous experience with family conferences: the number of previous conferences, the clinical situation for which they were held, and patient satisfaction with the conferences. None of the regression analyses identified significant predictors. The failure to identify predictors of patients' likelihood of wanting family conferences was surprising, especially in that positive previous experience with a family conference did not appear to make a patient more likely to want one in the future. The failure of the demographic variables to predict subjects' attitudes toward family conferences may be attributable to the cultural homogeneity of the present sample. It is conceivable that replicating this study in a more heterogeneous population would result in the identification of predictor variables.

DISCUSSION

That 30 percent of the subjects in this study have had a family conference in the past indicates that family conferences are being conducted with some regularity in the clinics that were studied. Moreover, the patients appear to be very satisfied with the family conferences that they have had.

The results of this study clearly show that there are some circumstances in which patients would like to have family conferences with their physician. For serious medical illnesses and some behavioral problems, patients indicated a high degree of likelihood that they would want a family conference. At the same time, the patients showed moderate to low interest in

family conferences for some behavioral or relationship problems, anticipatory guidance for family developmental stages, and health promotion.

This study may be the first to investigate empirically patients' interest in family conferences. As such, these results should be seen as preliminary and should be interpreted with caution. For example, these data were collected in one geographic location, and generalizability to other geographic and ethnic areas is unclear. In addition, the present data are attitudinal in nature and may not reflect patients' actual behaviors (ie, in terms of asking for or accepting family conference) when confronted with the situations described in the questionnaire.

In spite of these caveats, the results of this study have implications for the practice of family medicine, for the education of family practice residents, and for future research. That patients indicate an interest in family conferences for certain common situations implies that patients perceive them as having clinical value. These results also indicate that clinicians are erroneous in assuming that patients do not want family conferences or that patients are likely to see a physician's suggesting one as being an intrusion. On the contrary, it would appear that many patients would welcome the suggestion of a family conference on the part of their physician, at least for serious medical illness.

If one accepts that family conferences are valuable and that patients want them, then it follows that family practice residencies should teach how to conduct them. Until recently, this has been difficult because of the lack of attention that the family conference has received in the literature. That there have not been models of how to conduct family conferences has led to confusion between the family conference and family therapy. Recent writings, notably those of Doherty and Baird and Christie-Seely, have helped establish models for the family conference and have delineated the boundaries between family therapy and the family conference. Patients' preferences expressed in this study indicate that skills requisite for conducting family conferences should be taught, at least for serious medical illnesses and serious behavioral problems, but they do not imply that family physicians should be expected to become competent family therapists.

Finally, the family conference should become the focus of more empirical research in the future. Accordingly, the present authors are currently conducting research that will better address what patients hope to accomplish in family conferences. Such issues as the impact of family conferences on medical and psychological well-being as well as research on the process of the family conference are important areas for further research.

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