Treat or Refer: Patients' Interest in Family Physician Involvement in Their Psychosocial Problems

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Seven hundred fifteen patients entering three family practice clinics (rural private practice, urban private practice, urban residency) completed a questionnaire assessing their interest in their family physicians' involvement in four representative psychosocial problems: spouse abuse or neglect, lack of exercise, a dying family member, and a sexual problem. A majority of the patients (57 to 78 percent) wanted help for the four problems from their family physicians either independently or in conjunction with a specialist, whereas only 4 to 21 percent wanted referral to specialists exclusively.

Desired level of family physician involvement was predicted (R^2 = .291) by a series of reason for involvement variables representing the following conceptual areas: perception of value in talking about personal problems; perception of family physician background, time, and interest; and the Health Belief Model. This study supports the conclusion that family physicians need skills in managing psychosocial problems so they can provide the type of care that most patients want.

The extent to which patients expect their family physicians to be involved in the management of their psychosocial problems is an issue that has received limited attention in family medicine research.[1-8] Papers by Schwenk et al[1,2] and Frowick et al[3] are the most extensive works to date. Both studies investigated the level at which patients expected or desired their family physicians to be involved with 45 psychosocial problems that had been identified by Schwenk et al through a literature review as the ones most commonly seen in family practice.

In the Schwenk et al study, patients responded to a questionnaire requesting them to give an expected level of family physician involvement for each of the 45 problems by selecting one of the following completions to the sentence "My family doctor would . . ."

Level 1: Not be involved; if I sought help, it would be elsewhere.

Level 2: Be somewhat involved by learning enough about the problem to arrange for an appropriate specialist.

Level 3: Be more involved in demonstrating concern for my family's problem by asking questions, being sympathetic, and providing some help.

Level 4: Be very involved and give expert help for solving my family's problems by giving advice, doing specialized therapy, and prescribing appropriate medicine.

In the Frowick et al study, 256 patients responded to the original questionnaire of Schwenk et al, while 281 patients responded to a similar questionnaire modified by rewording the trigger phrase "My family doctor would . . ." to " I would want my family doctor to. . . ." Their findings resembled those of Schwenk et al, except that patients responding to the "want" questionnaire indicated desire for a higher level of family physician involvement than did patients with the "would" questionnaire.

The purpose of this study was to go beyond those earlier works by investigating perceptions and motivations that might explain the differences in patients' preferences for various levels of physician involvement. The research questions were (1) Do patients want family physicians and/or specialists involved in the management of psychosocial problems? (2) Do patient perceptions, values,

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TABLE 1. CORRELATIONS BETWEEN THE COMPOSITE LEVEL OF INVOLVEMENT VARIABLE AND THE TEN REASON-FOR-INVOLVEMENT VARIABLES

Reason for Involvement	Pearson r	P
Perception of value in talking about personal problems		
I would want to discuss this with my family physician, since it is helpful for me to talk with someone about such things.	.512	.001
I would want my family physician to know about this so that he or she would know me better as a person.	.480	.001
My family physician would be able to provide me with better medical care if he or she were aware of this.	.443	.001
Perception of family physician background, time, and interest		
My family physician would be interested in knowing about this.	.411	.001
My family physician would have time to help me with this.	.389	.001
My family physician has been trained to help with such things.	.367	.001
Health belief model		
It would be worth my time, cost, and inconvenience to seek help for this.	.397	.001
This would likely be serious for me.	.342	.001
This would likely affect my health.	.313	.001
In reality, it is likely for this to happen to me in the future.	.146	.005

and beliefs explain the differences among patients in desired level of physician involvement?

METHODS

To study in depth patients' reasons for wanting different levels of family physician involvement, it was necessary to identify a small number of representative psychosocial problems that had been found in previous studies to elicit the widest range of patient preferences for physician involvement. Schwenk et al's results were examined to identify the four psychosocial problems for which there was maximum variation in the distribution of patients' choices across the four levels of physician involvement.[1] The four problems that fit this criterion were spouse abuse or neglect, lack of exercise, a dying family member, and a sexual problem.

A four-part questionnaire was developed. Part 1 was for the collection of demographic data. Part 2 resembled the Schwenk et al questionnaire, except that it included only the four selected problems and used Frowick et al's trigger phrase "I would want my family doctor to. . . ." Parts 3 and 4 dealt with four conceptual areas that the investigators hypothesized would explain patients' reasons for selecting given levels of physician involvement. These conceptual areas were (1) perception of value in talking about personal problems; (2) perception of family physician background, time and interest; (3) the Health Belief Model[9]; and (4) attitude toward self-disclosure of information to clinicians.

In part 3, the first three conceptual areas were operationalized in ten statements (Table 1). Patients were instructed to assume that they actually had each of the four psychosocial problems in turn. They were asked to respond on a five-point agree or disagree scale to each of the ten statements listed on a separate page for each problem. They were also asked to respond on the same scale to the following two statements: (1) I would want my family physician to give me advice or treatment for this. (2) I would want my family physician to refer me to a specialist or other source for help with this.

Part 4 consisted of the "Short Form of Patient Self-Disclosure Questionnaire," developed by Dawson et al.[10] This 28-item instrument uses a seven-point scale to measure the degree of difficulty a patient has in disclosing information to clinicians.

Three distinctly different family practice clinics were selected as sites for the study. The three clinics included a rural private practice with 7 family physicians, an urban private practice with 6 family physicians, and an urban family practice residency clinic with 4 family physician faculty and 18 residents. As adult patients entered each of the three clinics, a research assistant enlisted as many as possible for participation in the study over a two-week period at each site.

RESULTS

Seven hundred fifteen respondents were surveyed during the study period (Table 2). The patient populations were similar in the three samples except that there were more women ($\chi^2 = 8.7$, $df = 2$, $P < .05$) and less employment ($\chi^2 = 45.9$, $df = 2$, $P < .001$) in the rural site. No statis-

TABLE 2. DEMOGRAPHIC CHARACTERISTICS BY PRACTICE SITE

Site	Number	Mean Age (years)	Percent Female	Percent Employed	Average Education Level (years)
Urban residency	219	33.1	73	71	14.0
Urban	240	37.6	71	69	14.1
Rural	256	37.3	82	44	12.5

tically significant relationships were found between these demographic characteristics and the dependent variables of interest in this study.

The patients' level of involvement ratings for each of the four psychosocial problems were compared with the Schwenk et al and Frowick et al findings. Patients in this study indicated greater desire for physician involvement than was found by Schwenk et al (for spouse neglect $\chi^2 = 27.6$, $df = 3$, $P < .001$; for lack of exercise $\chi^2 = 33.5$, $df = 3$, $P < .001$; for dying family member $\chi^2 = 14.1$, $df = 3$, $P < .001$; and for sexual problem $\chi^2 = 54.8$, $df = 3$, $P < .01$). Compared with the Frowick et al study, these patients indicated greater desire for physician involvement only with the "lack of exercise" problem ($\chi^2 = 16.4$, $df = 3$, $P < .001$). The trend in differences between patients in the three studies with respect to level of involvement ratings for the sexual problem ($\chi^2 = 58.0$, $df = 6$, $P < .001$) is illustrated in Figure 1.

Two summary variables were created from parts 2 and 3. First, a composite level of involvement criterion variable was developed by averaging the level of involvement ratings given by a patient to the four psychosocial problems in part 2 (Figure 2). A high level of physician involvement in the four representative psychosocial problems was desired by most patients in this study, with only 8 percent typically wanting no involvement (composite level < 2).

The ten composite reason-for-involvement variables were also created by averaging the agreement ratings that a patient selected for a given statement appearing under each of the four problems in part 2. The composite level-of-involvement criterion variable and the ten composite reason-for-involvement predictor variables were moderately correlated (Table 1).

Stepwise linear regression analysis was performed to determine which of the ten composite reason for involvement variables best predict the composite level-of-involvement variable. The following three of the composite reason-for-involvement variables, one from each of the conceptual areas operationalized in the questionnaire, contributed a total of 29.1 percent of the composite level-of-involvement variance: "I would want to discuss this with my family physician, since it is helpful for me to talk with someone about such things" (16.6 percent); "My family physician would have time to help me with this" (7.3 percent); and "This would likely affect my health" (5.2 percent).

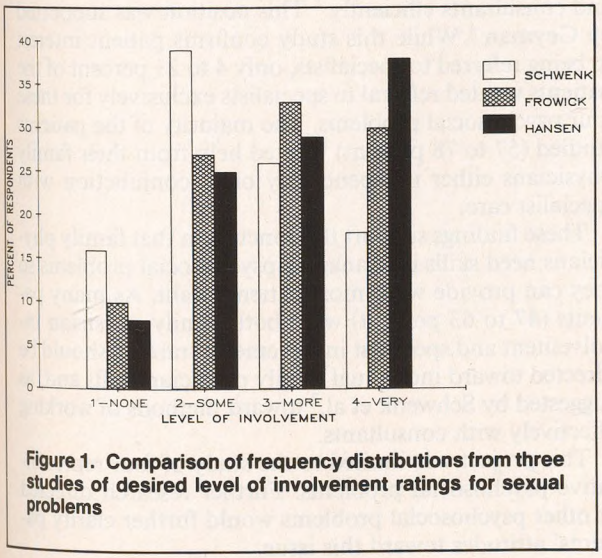

Figure 1. Comparison of frequency distributions from three studies of desired level of involvement ratings for sexual problems

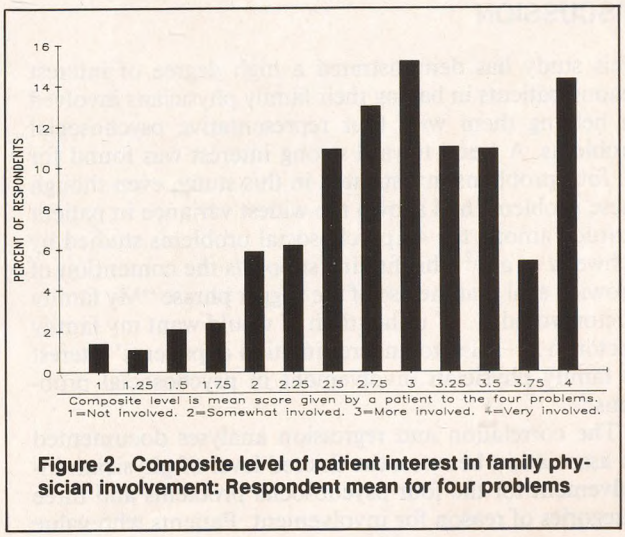

Figure 2. Composite level of patient interest in family physician involvement: Respondent mean for four problems

TABLE 3. PERCENTAGE OF RESPONDENTS WANTING REFERRAL OR HELP FROM THEIR FAMILY PHYSICIAN

Problem	Referral Only	Help Only	Want Both	Want Neither
Spouse abuse or neglect	21	6	57	15
Lack of exercise	4	15	63	18
Dying family member	11	10	47	31
Sexual problem	11	8	60	22

In contrast to the three conceptual areas operationalized in the ten reason-for-involvement statements, the conceptual area of patient disclosure was not predictive of level of involvement. There were no significant correlations between the self-disclosure scores (part 4) and the composite level of involvement variable. The self-disclosure scores also did not contribute significantly to the variance in the linear regression analysis.

The instruments used in earlier studies made family physician treatment of a patient's problem and referral to a specialist mutually exclusive choices.[1–3,6] This study sought to learn the extent to which patients might select either family physicians or specialists or both when given the opportunity. The part 3 statements, "I would want my family physician to give me advice or treatment" and "I would want my family physician to refer me to a specialist or other source for help," were analyzed by classifying strongly agree (1 rating) and agree (2 rating) as "want" responses and neutral (3 rating) through strongly disagree (5 rating) as "don't want" responses. The results, displayed in Table 3, indicate that most patients want their family physicians both to give advice or treatment and to make a referral when psychosocial problems are present.

DISCUSSION

This study has demonstrated a high degree of interest among patients in having their family physicians involved in helping them with four representative psychosocial problems. A trend toward strong interest was found for all four problems investigated in this study, even though these problems had shown the widest variance in patient attitude among the 45 psychosocial problems studied by Schwenk et al.[1,2] This finding supports the contention of Frowick et al that the use of the trigger phrase "My family doctor would . . ." rather than "I would want my family doctor to . . ." led to underestimation of patients' interest in family physician involvement in psychosocial problems.[3]

The correlation and regression analyses documented an association between the desired level of physician involvement for the four psychosocial problems and three categories of reason for involvement. Patients who value talking about their personal problems, who believe a problem is significant and worth the effort of seeking help (Health Belief Model), and who perceive their physicians as having time, interest, and relevant training want their physicians to assist them with psychosocial problems. This latter association is important, because it may be possible for physicians to increase their involvement in caring for psychosocial problems by educating the patients about their training and interests.

The finding that most patients want both advice or treatment from their family physicians and referral to a specialist for these four representative psychosocial problems supports the position that family physicians should be prepared to help patients with psychosocial problems and to make referrals to other professionals when those problems warrant specialized intervention or when patients indicate this preference. This position is consistent with the image of the family physician as a patient's personal health care manager.

Schwenk et al[1] concluded that teaching specific management skills and extensive understanding of many psychosocial problems, including three of the four in this study, seemed unwarranted and that there would be greater value in teaching ways to use auxillary services and consultants efficiently.[1] This position was supported by Geyman.[4] While this study confirms patient interest in being referred to specialists, only 4 to 21 percent of the patients wanted referral to specialists exclusively for these four psychosocial problems. The majority of the patients studied (57 to 78 percent) wanted help from their family physicians either independently or in conjunction with specialist care.

These findings support the conclusion that family physicians need skills in managing psychosocial problems so they can provide what most patients want. As many patients (47 to 63 percent) want both family physician involvement and specialist involvement, training should be directed toward individual family physician skills and, as suggested by Schwenk et al,[2] toward methods of working effectively with consultants.

This project was limited to the study of four representative psychosocial problems. Further research directed at other psychosocial problems would further clarify patients' attitudes toward this issue.

Acknowledgment

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