Multiple Family Member Visits to Family Physicians

Terminology, Classification, and Implications

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A study was designed to investigate "the family as the unit of care" in family medicine consultations from the patient's end of the physician-patient axis, unlike most previous related studies, which have concentrated on it from the physician's perspective. During 2 separate weeks in November 1987 and February 1988, nine Israeli family physicians collected demographic and family-related data concerning the spontaneous visiting patterns generated by 1156 persons (899 patients and 257 nonpatients) who attended 796 separate consultations at their clinics during this time. More than one patient attended 12% of the consultations, and more than one person, patient or nonpatient, was present at 36%. At 31% of the consultations children alone or children and adults were recorded as patients (child consultations), and at 69% only adult patients were present (adult consultations). Adults were recorded as second or third patients at 19% of the child consultations but at only 5% of the adult consultations. The child consultations alone yielded 86% of all the nonpatients documented.

Basic terminology and methodology for investigating such multiple family member visits to family physicians is discussed as well as the composition of the different family units encountered and their possible significance. *J Fam Pract 1991; 32:57-64.*

"The family as the unit of care" has been a key theme of family medicine over recent years,[1–4] and for many it constitutes the underpinning of the specialty. Its focus, however, has invariably centered on the physician's end of the physician-patient consultation axis. Much less attention has been paid to what it means from the viewpoint of patients and their families. This lack of attention is surprising in light of the general shift in emphasis from physician to patient-centered medicine.

One way in which patients in family medical practice might call attention to their own wish or need for family-oriented care or signal their recognition or endorsement of its value could be through the spontaneous visiting patterns generated by their attendance, along with other members of their families, at consultations with their family physician—encounters designated "multiple family member visits" in this study. Until now, however, no studies related to the family as the unit of care have looked systematically at patient-initiated family physician visiting patterns.

The organizational and administrative structure of the primary care clinic network operated by the Israel General Federation of Labor Health Insurance Plan (Kupat Holim) offered an almost ideal economic and logistic bias-free setting in which to carry out just such a study. This report details the results of a preliminary investigation into multiple family member visits in family medical practice that a family physician research group carried out at their Kupat Holim clinics in Israel. This study includes basic terminology and methodology developed for examining multiple family member visits, provides the first-ever detailed classification and analyses of such visits within family medical practice, and discusses their possible relevance and importance for all medical practitioners interested in the family as the unit of care.

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Terminology

The definitions developed for use in the study were as follows:

1. *Family Consultation Unit (FCU)*: A visit or consultation with a family physician at which one or more visitors were simultaneously present
2. *Attender*: Any person present, apart from medical staff, at an FCU
3. *Patient*: An attender who presented any form of medical problem to the physician for advice or treatment during an FCU
4. *Nonpatient*: An attender who did not present any medical problem to the physician during an FCU
5. *Child FCU*: An FCU at which at least one child was present as a patient
6. *Adult FCU*: An FCU at which no child was present as a patient (for study purposes, *children* were defined as attenders younger than 16 years of age)

Kupat Holim

Kupat Holim is the largest medical insurance plan in Israel, providing health services to more than 70% of the population. Its coverage is roughly similar to that of a prepaid group practice in the United States. For a monthly premium, comprehensive medical care is provided either directly through the health plan itself or indirectly through contracts with government or voluntary agencies. All primary care is provided through an extensive network of clinics in both urban and rural areas staffed by salaried physicians and nurses. All visits to these physicians are free of charge and can usually be made without any prior appointment on a walk-in basis.

Methods

The study was carried out by nine Kupat Holim family medicine physician specialists, all men, working in six different Israeli urban and rural practices during two separate periods of 1 working week (6 days) in November 1987 and February 1988. Five physicians participated during only one of the study periods. Five of the physicians worked in urban areas and four in rural areas. Eight physicians provided care for all members of the families in their care, and one physician provided care for the adult members only. Two of the physicians worked partly in kibbutzim (collective communities) in which the children lived separately from their parents in purpose-built children's houses. These communities were excluded from the study.

The total population eligible for inclusion in the study was approximately 10,000. All attenders in this population who visited their family physician in his clinic at least once during the period(s) of his participation were included in the study except for those involved in scheduled visits routinely comprising more than one attender (eg, developmental pediatric examinations) and those attending prearranged physician-initiated visits to which more than one person had been specifically invited by the physician in advance. Although the number of these excluded visits varied between the participating physicians, on no occasion did they exceed 10% of any physician's total consultations during any of the study periods.

At each FCU included in the study, a separate questionnaire was completed by the physician for each patient present. This questionnaire recorded the date and time of the FCU; demographic data about the patient, including position in family, information about current problem or illness, any background illnesses, parental employment status (in the case of children); and whether any other patients or nonpatients were also present at the FCU. The family relationship(s) to the patient of any other attender(s) present, and in the case of nonpatients, the reason for their presence at the FCU were also recorded.

At the end of the study all the questionnaires were analyzed to determine the general patterns of attendance at the FCUs, and to describe in detail the FCUs at which one, two, or three patients, respectively, were present.

Children make up the largest group of patients requiring adult (parental) supervision at visits to the family physician, although such action does not necessarily indicate a family-oriented care preference on their part. Child FCUs were therefore analyzed separately, where appropriate, to determine to what degree this primarily supervisory role was exploited by such accompanying family members or other adults so that they might become patients as well.

The findings obtained from all the FCUs in general, and from the child FCUs in particular, form the basis of this report.

Results

The Overall Patterns of Attendance at All FCUs

Altogether 796 FCUs were documented, at which there were a total of 1156 attenders. Of these, 899 (78%) were patients and 257 (22%) nonpatients. Two hundred forty-seven (96%) nonpatients were members of the patients' immediate families. Three hundred eight-nine (43%) patients were male, and 510 (57%) were female. At 702 (88%) FCUs one patient was present, at 85 (11%), two were present, and at 9 (1%), three patients were present. No FCU was attended by more than three patients or four attenders.

Between 6% and 20% of the participating physi-

Table 1. Distribution of 1156 Patients and Nonpatients (Attenders) at 796 Family Consultation Units (FCUs)

At the FCU (No.)				
Patients (P)	Nonpatients (N)	No. of FCUs	(%)	Attenders (P + N) × FCUs
1	0	512	(89)	512
1	1	159		318
1	2	27		81
1	3	4		16
2	0	57	(10)	114
2	1	26		78
2	2	2		8
3	0	7	(1)	21
3	1	2		8
Total		796	(100)	1156

Note: For study definitions of the terms patient, nonpatient, *and* attender, *see Terminology.*

Table 2. Overall Attendance Characteristics at Child and Adult Family Consultation Units (FCUs)

FCU Attendance Characteristic	Child FCUs (n = 248) No. (%)	Adult FCUs (n = 548) No. (%)	Total (N = 796) No. (%)
Patients*			
1 patient only	183 (74)	519 (95)	702 (88)
>1 patient	65 (26)	29 (5)	94 (12)
Nonpatients			
No nonpatient	63 (25)	513 (94)	576 (72)
At least 1 nonpatient	185 (75)	35 (6)	220 (28)
Attenders			
1 Attender (ie, patient)	27 (11)	485 (89)	512 (64)
>1 attender	221 (89)	63 (11)	284 (36)

**Does not exclude the possibility of nonpatients also being present.*
Note: For study definitions of the terms patient, nonpatient, *and* attender, *see Terminology.*

cians' FCUs were attended by more than one patient, the study average being 12%. At 220 (28%) of the FCUs, at least one nonpatient was present, the interphysician range being 9% to 38% of FCUs. Similarly, the proportion of FCUs at which more than one attender was present ranged from 14% to 51%, with a study average of 36%.

The distribution of patients and nonpatients at FCUs is shown in Table 1.

The Overall Patterns of Attendance at Child FCUs

There were 248 child FCUs, which constituted 31% of all the study FCUs. At 226 (91%) of these there was one child-patient present, at 21 (9%) there were two, and at 1 FCU there were three child-patients present. Altogether, however, there were 65 (26%) of these FCUs at which there were more than one patient—child and/or adult—present. At 43 (17%) FCUs these additional patients were adults, at 18 (7%) they were children, and at 4 (2%) FCUs they were both children and adults. Thus, when there were more than one patient present at a child FCU, the additional patient was most likely to be an adult rather than another child.

At 221 (89%) of these child FCUs there were more than one attender present, compared with only 63 (11%) at the remaining 548 adult FCUs. This finding is a result of the almost routine supervisory role adults have of accompanying members of this age group to physician visits. This role is demonstrated further by the related study finding that 185 (75%) of these child FCUs had at least one nonpatient also present, compared with only 35 (6%) of the adult FCUs. Altogether 220 (86%) (184 adults and 36 children) of the 257 nonpatients recorded in the whole study were found at these 248 child FCUs, compared with only 45 (14%) at the 548 adult FCUs.

A comparison of the attendance characteristics at child and adult FCUs is shown in Table 2.

One-Patient FCUs

At 512 (73%) of the 702 one-patient FCUs, no nonpatients were present. At 159 (23%) one nonpatient was also present. On 103 occasions this nonpatient was the patient's mother, on 20 occasions the father, on 7 occasions the sister, on 6 occasions the wife, on 5 occasions the son, on 4 occasions the daughter, on 3 occasions the husband, and on 2 occasions the brother. At the 9 remaining FCUs a more distant relative (eg, a cousin) or other person (eg, a neighbor) was present.

At 27 (4%) of these FCUs two nonpatients were present. On 9 occasions the nonpatients were the patient's mother and father, on 9 occasions the mother and brother, and on 5 occasions the mother and sister. Four other different combinations were present on one occasion each.

At four (<1%) of these FCUs three nonpatients were present. On one occasion the nonpatients were the patient's father, mother, and sister; on one occasion, the patient's wife and two sons; and on two occasions, the patient's mother and two siblings.

These nonpatient combinations are summarized in Table 3.

Two-Patient FCUs

At 57 (67%) of the 85 two-patient FCUs no nonpatients were present. Twenty-six (31%) were attended by one nonpatient and 2 (2%) by two nonpatients. A husband

Table 3. Nonpatient Combinations at One-Patient Family Consultation Units (FCUs) with One or More Nonpatients Also Present (n = 190)

Number of Nonpatients Present at the FCU					
One		Two		Three	
Nonpatient	No. of FCUs	Nonpatients	No. of FCUs	Nonpatients	No. of FCUs
Mother	103	Mother, father	9	Mother, father, sister	1
Father	20	Mother, brother	9	Wife, two sons	1
Sister	7	Mother, sister	5	Mother, two brothers	1
Wife	6	Other combinations	4	Mother, brother, sister	1
Son	5	—		—	
Daughter	4	—		—	
Husband	3	—		—	
Brother	2	—		—	
Others	9	—		—	
Total FCUs	159		27		4

Note: For study definitions of the terms patient, nonpatient, *and* attender, *see Terminology.*

and wife unit accounted for 19 (22%) of these two-patient FCUs. At none of these was any nonpatient present.

At 19 (22%) of these FCUs a mother and her son were the patients concerned. They were unaccompanied on 17 occasions, and joined twice by a daughter-sister.

A mother and her daughter accounted for 16 (19%) of this type of FCU. At 12 of these, no nonpatient was present, on two occasions another daughter, and on two occasions their husband-father was present.

At nine (11%) of these FCUs a father and his son were the patients. They were unaccompanied on six occasions, accompanied by another son-brother on one occasion, by their wife-mother on another, and by both their wife-mother and son-brother on another.

Other two-patient combinations, each occurring less than eight times, accounted for the remaining 22 (26%) FCUs of this type.

Three-Patient FCUs

The nine FCUs in this category were made up of the following family units: a father, mother, and daughter (2); a mother, son, and daughter (2); a father, mother, and son (1); a father, son, and daughter (1); a mother and two sons (1); a mother and two daughters (1); a sister and two brothers (1).

Two (22%) of these FCUs were also attended by one nonpatient. One trio of mother, son, and daughter was accompanied by the mother-grandmother, and another trio made up of a sister and her two brothers was accompanied by the mother.

Attenders at Child FCUs

At the 248 child FCUs the child's (children's) mother was the only adult present on 157 occasions; at 31 of these occasions (20%) she was also a patient. Similarly, the father was a patient at 7 (26%) of the 27 FCUs at which he was the only adult present. Both father and mother were present at 16 child FCUs, the mother being a patient on 1 occasion, the father on 4, and both the mother and father on 1 occasion. At 9 FCUs one other adult only was present, twice as a patient. At 3 FCUs the mother and another adult were present, the mother being a patient on one such occasion.

At the remaining 36 child FCUs where no adults were present, another child-nonpatient was present on 8 occasions, and on 28 occasions the child-patients attended alone.

In summary, therefore, at least one adult was also a patient at 47 (19%) of the 248 child FCUs, and at least one adult attender was present at 212 (83%).

Discussion

This study of patient-initiated multiple family member visits to family physicians adds a new perspective to the current literature about family care in family medicine. In a previous survey of 1126 encounters by a group of family physicians, Beasley[5] found that in 33% of the cases no other family members had ever been seen by the same physician. Similarly, Fujikawa et al[6] found that in only 28% of the families belonging to their very stable practice population did all family members receive their medical care from the same physician. In a follow-up study carried out in the same practice,[7] 97 members of this group of patients were interviewed in an attempt to identify factors and attitudes influencing family care patterns. Few of these patients were found to have any insights into the potential value of having a single physician for the whole family, and only one family inter-

viewed had specifically selected a single physician with the belief that it would thereby gain better care. Important as such studies may be, they are nevertheless of only general interest to family physicians practicing in countries such as the United Kingdom and Israel, where the care of all family members by the same family physician specialist is the rule rather than the exception.

Simultaneous visits by more than one family member to the family physician have previously been considered within the context of physician-initiated conferences. The indications for the physician convening the family in family medical practice were reviewed by Schmidt in 1983.[8] He put forward 14 medical situations in which he considered a medical conference of family members beneficial. These situations were selected on the basis that the conditions in question had either a major influence on the family, or that the family's functioning contributed in some way to the presence of the condition and its perpetuation.

Physician-initiated family visits have also been considered from the patient's point of view. Kushner et al[9] asked 276 patients about their past experience, if any, of family conferences with their physicians and their opinions about participating in them in the future. Eighty-three (30%) of the subjects had in fact previously taken part in at least one such physician-initiated family conference, most commonly for either an obstetric or behavioral problem. These patients' views on the perceived value of future family conferences were assessed, and the results were found to be similar to those reported previously by Schmidt and others.[8,10,11]

This study is thought to be the first ever to have been devoted entirely to patient-initiated multiple family member visits in family medical practice, although one recent investigation into 57 family conferences recorded over a 1-month period at a hospital-based family practice residency in New England did include in this number 10 conferences (18%) that resulted from chance encounters with patients.[12] No separate analysis of the participants at this subgroup of (patient-initiated) encounters was provided in this report, however.

Considering the almost barrier-free access to primary medical care in Kupat Holim with its absence of logistic and financial obstacles, the patterns of multiple family member visits described here are likely to represent as closely as possible the natural, unrestricted, and even instinctive preferences for care of the individuals and family units in the practice populations observed, even allowing for the primarily supervisory role of many attenders at visits involving, in particular, young patients. Self-referral rates of individual patients to Irish general practitioners have been shown to be negatively related to the proportion of the practice population eligible for obtaining free medical services,[13] and this negative relationship probably represents physician self-interest in generating, or not generating, a demand for their services. It is likely that in fee-for-service systems there are disincentives to physician visits in which additional family members participate, regardless of whether these are associated with extra payments, ie, there is a disincentive to the physicians if the additional patients are not required to pay extra, and to the families if they are. The socioeconomic status of the populations involved, as well as perhaps specific cultural characteristics of the ethnic groups of which they were composed, probably exerted additional influences on the patterns of the multiple family member visits observed.

Other variables such as the employment status of the attenders, the nature of the medical complaints initially presented, and the presence of any background illness or disability in the attenders could have similarly affected the attendance of the other family members at the encounters. Such factors obviously merit further clarification and study. For example, an association between the frequency of visits to physicians and unemployment levels has been clearly demonstrated within some cultural groups in various settings.[14]

Further, general practitioners and family physicians who have not had residency training who work in a salaried framework such as Kupat Holim, where there is no financial reward for increasing their workload (ie, by seeing additional patients), would also tend to discourage families or their subunits from attending the same consultation. This approach probably contrasts with family physician specialists in a similar type of setting who would view such an approach as emulating an ideal type of medical practice in keeping with professional attitudes and responsibilities acquired during their years of postgraduate training or residency program in family medicine.

Because this area of family medicine research was new, an original and appropriate terminology had to be constructed. The expression "family consultation unit" (FCU) was not only a convenient phrase for the family unit meeting professionally with their family physician, but also a conceptually important term emphasizing that care and counseling in family medicine are potentially sought by and provided for all those present at a consultation, and sometimes for some of those not present. This last possibility justifies why the term is not necessarily inappropriate even when applied to a consultation at which there is only one person present. Nevertheless, the division of attenders into patients and nonpatients, although useful practically for descriptive reasons, is still an arbitrary distinction that may often mask the underlying reality and dynamics of any particular consultation.

For example, an FCU comprising a husband with a complaint of chest pain accompanied by an anxious wife could be classified by the current definitions as either a one-patient or two-patient FCU depending on whether the wife spontaneously voiced her anxiety as a problem or whether this problem was elicited by the physician's probing. It therefore follows that many attenders defined here as *nonpatients* may still often constitute different degrees of potential patienthood, and thus form a more integral part of the FCU than the term *nonpatient* might imply. In the study it was interesting to detect considerable interphysician variations in both the proportion of FCUs with more than one patient present and those with nonpatients present. While geographic and other population characteristics may account in part for these differences, the individual physician's consulting style[15] also plays an important role here. In practical terms, discussing these rates with family physicians might be a useful method for promoting a more family-oriented approach among those with fewer multiple family member visits among their consultations.

At 12% of the 796 FCUs documented, more than one patient was present (Table 2). This figure incorporates what is arguably the single most important finding to emerge from this study, namely, that whereas at only 5% of the adult FCUs were one or more additional adult patients also present, adults were patients at 19% of the child FCUs, the adults in question invariably being accompanying parents.

Among family physicians there seems to be a widely accepted but largely unresearched philosophy maintaining that many initially reluctant parents often use the visits of their children to seek medical advice or care for a perhaps less urgent problem of their own.[16] Since this study demonstrates that to become patients themselves, such adults (parents) were proportionately almost four times as likely to use a visit of one of their children to the family physician as that of an adult family member, it provides persuasive objective evidence that such child visits are indeed an important mechanism through which such adults may obtain medical care. This finding also underlines the value and desirability of there being available a family physician with whom all family members are registered, since this form of practice is most capable of meeting such requests effectively. A pediatrician, for example, would be unequipped to respond as appropriately as a family physician in similar circumstances.

The percentage of visits with at least one nonpatient present (28%) was more than twice that of visits with more than one patient present. Not surprising is that 86% of these nonpatients were in attendance at child FCUs, and the nonpatient involved was usually the mother or, less commonly, the father, both parents, or a sibling of the children concerned (Table 3). The presence of such nonpatient attenders at an FCU may nevertheless be of special importance to family physicians. In particular, the appearance of an unusual nonpatient in this situation, such as a father or husband and wife, may represent a covert request for support by that person, or may point to some hidden stress or problem at home affecting the other members of the family.

Finally, this 28% overall "surplus" of nonpatients at the FCUs clearly demonstrates that a large potential basis on which family conferences can be readily built already exists in the practices studied regardless of the basic reason for their attendance. This considerable extended professional access to other practice patients constitutes an extraordinary opportunity for offering anticipatory care to those other family members on such occasions. One of the family physician's more important skills, if not obligations, is to assume an active role in exploring the possibilities of converting such nonpatient attenders into patients when deemed appropriate. A more detailed analysis of FCUs involving specific subgroups of the study populations and of family medical practice populations elsewhere should provide additional clues and information for recognizing such covert requests for care. In this way a greater understanding of multiple family member visits could evolve that would help family physicians exploit "the family as the unit of care" more fully, thereby enhancing their proficiency at pinpointing not only the hidden patients in their practices[17] but perhaps the hidden families as well.

Jerusalem Multiple Family Member Visits Study Group

The Jerusalem MFMV Study Group consisted of the six authors of this article and three additional participating physicians: Ronald Ban, MD, Ralph Guggenheim, MD, and Uri Strauss, MD.

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Commentary

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The article by Knishkowy and colleagues[1] reporting on multiple family member visits to family physicians adds another link in a chain of evidence that strongly supports the concept that the family is an appropriate unit of care in family practice.

Ten years of rhetoric and a few solid works of research were reviewed 18 months ago in this journal.[2] There are many unique features of this study, however, that warrant the authors' claim that "the patterns of multiple family member visits described here are likely to represent as closely as possible the natural, unrestricted, and even instinctual preferences for care of the individuals and family units in the practice populations observed." The patients in this study were enrolled in an Israeli health care system in which one physician provides primary medical care for all members of the family. In addition, all primary care is provided by salaried physicians and nurses, and all visits are free of charge and can be made without an appointment on a walk-in basis. This arrangement is in marked contrast to the fee-for-service payment scheme in the United States in which the care of a family is frequently divided among the four primary care specialties: family medicine, pediatrics, internal medicine, and obstetrics and gynecology.

With virtually no barriers to medical care and the freedom to include multiple individuals at a single physician visit, patient and family behavior represents preference: the public have the opportunity to "vote with their feet." The study design and definitions bias the results in a manner that would minimize the quantification of "family care" at each physician encounter. First, those scheduled visits that routinely involved more than one family member, such as developmental pediatric examinations, were excluded from the study. In addition, physician-initiated prearranged visits to which more than one person had been specifically invited by the physician were also excluded. These excluded examples did not exceed 10% of the total physician consultations. Second, the patient in these encounters was narrowly defined as an attender at the consultation who explicitly presented a medical problem to the physician for advice or treatment.

Although these selection criteria would minimize the demonstration of family care, the results are remarkable. More than one person was present at 36% of all office visits, and at 12% of these consultations a second patient was identified as narrowly defined above. Ninety-six percent of the nonpatient attenders at these consultations were immediate family members. This study method, which simply counts the number of patients and nonpatients attending each consultation, does not credit the physician for the "family care" rendered in such common situations as providing anticipatory guidance and reassurance to the parent who brings in the child (patient) for routine immunizations. Another example of not-included family care would be the reassurance of an anxious spouse accompanying a husband with chest pain. In these examples the second family member who attended the consultation would not be counted as a patient in this study.

That more than one family member received medical attention in at least 12% of the encounters, and family work was potentially being done in 36% of the encounters, is convincing evidence that the family is the unit of care in family practice. When a family physician provides care for an individual patient, that care is frequently rendered in the context of the family. For example, the physician might discover that a patient's epigastric pain frequency follows an upsetting argument with the patient's spouse. The physician's efforts to counsel the individual patient or urge the patient to become involved

in marriage counseling is family care even though only one member of the family has appeared in the consultation room.

Miller[3] describes three categories of physician-patient encounters: routine, ritual, and drama. The routine visit for a minor and self-limiting medical problem constitutes most visits to the physician. The physician-patient encounters involving patients with chronic conditions who require many visits develop ritual characteristics. In the relatively rare episode of a drama encounter, medical illness has its ripple effect on other family members or, conversely, family disruption is contributing to the cause of disease. I would intuitively estimate that major family work is needed in less than 10% of all medical encounters. The demonstration that family work is going on in from 12% to 36% of encounters in this study is reassuring that this need is being at least partially met.

One aspect of this study requires further explanation. During the first-week period, five physicians participated in the study, and during the second 1-week period, nine physicians participated in the study, which amounts to 14 physician-weeks of encounters in which 796 patients were seen. Thus it appears that each physician was seeing a low number of patients per week if all encounters were studied. This low rate of seeing patients is cause for concern. Either significant numbers of encounters were not included in the study, or the health care system is extremely underutilized. In the United States one has to see a minimum of 20 patients a day in order to make a living in the private sector setting. A physician who sees fewer than 15 patients a day would have a great deal of time available for "family work."

Because of the specific nature of the population studied and the unique characteristics of the health care system in which the study was conducted, the results may not be generalizable to other environments. Under these optimal conditions, however, patients demonstrated a desire for and received medical care as a family unit.

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