Integrating the Family into Routine Patient Care
A Qualitative Study

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BACKGROUND. The field of family medicine has been enriched by a family-oriented approach and the inclusion of family systems concepts. Keeping the family as a central focus of care has been a fundamental commitment of family medicine. This research examines how exemplary physicians ("exemplars") integrate a family-oriented approach into the routine care of individual patients.

METHODS. Four family physician exemplars were observed. A total of 16 days was spent observing the physicians; 137 physician-patient encounters were audiotaped, transcribed, and analyzed. Grounded theory was used for analysis, and a model of a family-oriented approach was developed.

RESULTS. Visits were classified by the reason for visit and the intensity of family-oriented talk and actions. There was modest variation among the physicians in terms of intensity and time spent with patients. Overall, 19% of patient encounters had a high intensity of family-orientedness; 34% were of low intensity. The average time spent with patients was 13 minutes, with visits ranging from 3 to 39 minutes in length.

CONCLUSIONS. Our study demonstrated that physicians integrate family systems concepts into routine individual patient care. The findings identify characteristics of the family-oriented approach and those circumstances that promote and hinder it. Family physicians can adapt specific components of the family-oriented approach into their routine individual patient care.

KEY WORDS. Family practice; physician-patient relations; office visits; family. *(J Fam Pract 1998; 47:440-445)*

This book is dedicated to primary physicians with a family orientation in all countries, who have unstintingly and without many rewards kept the torch of healing burning, by remembering that the most important person in the medical system is still the individual patient with his/her family.

Jack Medalie wrote these words in his seminal book, *Family Medicine: Principles and Applications*.[1] Medalie joined others as the architects of a new perspective within primary care that places the patient and his or her family in the focus of care.[1-6] During the past 15 years there has been an explosion of activity linking the fields of family systems and family therapy with the field of family medicine.[7-13] The collaboration has created a distinct perspective known as family systems medicine. Family systems medicine articulates the importance of incorporating concepts from family systems thinking into family practice, and promotes an integrative, systemic, and family-oriented approach to patient care.

One of the most recognized contributions to family systems medicine was Baird and Doherty's 1986 article[13] that provides a key to explaining physicians' involvement with families by describing developmental levels in family-centered medical care. This influential work stimulated the research by Marvel and colleagues[14] that applied the levels to actual practice situations.

While numerous articles in the family medicine literature identify the family as the patient, or as the unit of care, there is little description of exactly what the family-oriented physician does. Recent findings from a study of 138 community family physician practices report a significant amount of emphasis on the family.[15] What is missing is an understanding of what specifically constitutes the components of the family-oriented approach. Is it only gathering a family medical history, or does it involve constructing a family genogram?

The majority of the thinking and writing in family systems medicine addresses the application of its concepts to the whole family. Little is known, however, about how physicians can apply these concepts in community family practice. How do family physicians who are sophisticated in family thinking and theory integrate the family into the routine care of their patients?

The goals of our paper are to present a description and to provide an understanding of what occurs in

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selected physicians' offices, and to learn what other steps are possible. The research addresses 3 questions: (1) Do family physician exemplars routinely integrate family systems concepts into the care of individual patients? (2) What constitutes a family-oriented approach? and (3) What circumstances promote or discourage a family-oriented approach?

METHODS

Our study took place from April 1996 to August 1997. This research used direct observation that entailed observing and audio-recording physician-patient encounters in the physician's office. We selected 4 exemplary, community-based family practice physicians. These physicians ("exemplars") were selected as role models of a family systems approach within family medicine. Observing exemplars offers the best possibility for gathering a grounded understanding of the integration of family systems thinking into routine patient care.

Data Collection*

Physician-patient encounters were observed and audiotaped over the course of 4 days. Physicians were aware of the researcher's general interest in family systems; patients were informed that the investigator was interested in how physicians conduct routine office visits. All patient visits for that day made up the study sample. Consent was obtained from patients before they entered the examination room. During the encounter, observers took cursory field notes, or jottings,[16] which supplemented the transcribed audio recording.

The researchers conducted audiotaped debriefing interviews with physicians at the end of an extended observation period at least once during the 4-day period. These discussions were a rich source of information regarding the extent of the physicians' knowledge of their patients and their patients' families.

Data Analysis

Data analysis proceeded in a multistage manner, using insights and techniques from grounded theory, content analysis, and an editing style of analysis.[17-20] Our goal was to discover, through a recursive and iterative analysis process, the dominant themes and categories the family physicians used when integrating the patient's family into routine care. Emergent themes regarding physican style and approach to patient care were identified. A model for the family-oriented approach evolved.

RESULTS

Our 4 physicians (2 men and 2 women) are board certified in family practice and work in busy group practices; each reports seeing 20 to 32 patients in the typical day. For ease of presentation, we have provided pseudonyms. Dr Steele and Dr Wood practice in urban communities and describe their patient populations as ethnically and socioeconomically diverse. Dr Lake describes his practice as located in a "rural village." The patient population is diverse in terms of age, educational level, and occupations, but is ethnically homogeneous. Dr Hill described her patient population in essentially the same manner as Dr Lake, but described the community as "increasingly suburban." Dr Lake and Dr Wood do obstetric procedures.

A total of 137 encounters were recorded. Only 13 patients (7%) refused to be observed. The length of the encounters ranged from 3 minutes to 39 minutes (average = 13 minutes). There was modest variation among the physicians: Dr Hill's and Dr Steele's visits averaged 12 minutes and 12.5 minutes, respectively; Dr Wood and Dr Lake averaged 14 minutes and 15 minutes for each visit, respectively. Family members were present during 39.4% of the encounters. Among the physicians, Dr Wood had the most visits with family members present (58.3%), which is explained by the fact that he saw more children than the other physicians; 42% of his patients were children compared with 22% to 26% for the other physicians. Family members were present in 26% of Dr Steele's patient encounters and for Dr Hill and Dr Lake family members were present for 37.5% and 39% of their office visits, respectively.

Encounters were classified in terms of the primary reason that the patient was seeing the physician. Overall, 53% of the visits were for acute problems, 23% for chronic problems, and 23% were well-visits. Two visits (1%) warranted an "other" classification. If a visit was a follow-up visit, we classified that encounter according to the nature of the problem.

Table 1 summarizes the intensity, range, and duration

TABLE 1

Intensity Level of the Family-Oriented Approach for All Visits to 4 Physicians in Study Sample

Intensity Level	Patients No. (%)	Visit Length, in Minutes Range (Average)
High	26 (19)	6 - 39 (18)
Medium	25 (18)	3 - 25 (13)
Low-medium	15 (11)	5 - 29 (13.5)
Low	46 (34)	3 - 17 (10)
Absent	25 (18)	3 - 18 (11)
Total	137 (100)	3 - 39 (13)

*For additional information on research methods, data collection, data analysis, and physician style, please refer to the *Journal*'s Web site at www.jfp.denver.co.us.

TABLE 2

Intensity Level of the Family-Oriented Approach for All Visits to 4 Physicians in Study Sample, by Reason for Visit

	Reason for Visit			
Intensity Level	Acute No. (%)	Chronic No. (%)	Well-Visit No. (%)	Other No. (%)
High	8 (11.1)	10 (32.3)	7 (21.9)	1 (50)
Medium	14 (19.4)	5 (16.1)	5 (15.6)	1 (50)
Low-medium	6 (8.3)	2 (6.4)	7 (21.9)	
Low	27 (37.5)	8 (25.8)	11 (34.4)	
Absent	17 (23.6)	6 (19.4)	2 (6.2)	
Total	72 (100)	31 (100)	32 (100)	2 (100)

of the family-oriented approach for the 4 physicians. Those encounters characterized as high-level intensity were "drenched" with family talk and actions and averaged 18 minutes, which was significantly longer than visits characterized as lower levels of intensity. However, 2 visits in this high-level category were 38 minutes and 39 minutes in length, and these inflated the average. Excluding these visits, the mean duration of high-level visits was 14.3 minutes. The other categories ranged from 10 minutes to 13.5 minutes. It is noteworthy that in the 18% of the visits where family talk and actions were absent, visits averaged 11 minutes. The highest proportion of all visits were identified as having a low level of family talk and action (34%).

There was variation among the 4 physicians in the distribution of encounters by the intensity of the family-oriented approach. Dr Lake had the largest proportion of visits classified as high (35%), followed by Dr Wood (25%), Dr Hill (19%), and Dr Steele (7%). Dr Lake and Dr Wood had comparatively higher proportions of visits that were drenched with the family-oriented approach and had smaller percentages of visits where family talk was absent (9% and 8%, respectively). In terms of visits rated at low intensity, Dr Hill and Dr Steele had similar distributions: 38% and 33%, respectively; their numbers of visits without any family talk or action were also similar: 22% and 28%, respectively.

Table 2 summarizes the levels of family-oriented approach according to the reason for the visit for all physicians. As expected, acute visits accounted for the lowest proportion of high-intensity level visits and had the highest proportion of classifications at the low or absent levels. Almost one third of chronic visits were classified as high-level.

DISCUSSION

> They did medicine at muscle memory so were free to think about other things, like family, at other times. —JC, physician observer

All 4 of the physicians felt very confident with their basic medical skills and knowledge. This confidence aided the physicians in being family oriented by "freeing" their minds to pursue family issues. These physicians performed a variety of procedures and appreciated the extra time with patients those procedures provided.

> Oh, the joy of nonabsorbable sutures as a way to insure patients will come back. —Dr Wood

This statement from Dr Wood came as he was reflecting on his decision to use nonabsorbable sutures on an adolescent from whom he had just removed a mole. The youngster was part of a family in turmoil with an erratic history of seeing the physician. Dr Wood hoped that by bringing the boy back, family issues could be further explored.

Many elements that influence the family-oriented approach during the physician-patient encounter can be summarized as aspects of physician style. Although there are myriad characteristics, 5 emerged as especially relevant in aiding the family-oriented approach. These characteristics are self-disclosure, positive talk, humor, physician as educator, and decision making. These characteristics are consistent with a patient-centered approach and effective communication skills.

During our analysis, a model emerged that we call the family-oriented approach. This approach incorporates family systems concepts through speech and actions. The physician integrated the concepts of a family system by tapping into the patient's everyday world through family-oriented talk. Family systems concepts were also manifest in the actions taken during the encounter.

FAMILY-ORIENTED TALK

Family-oriented talk involved both global and focused questions and statements. The global questions were often a general scan of how the patient and his or her family were getting along, such as "Is everybody surviving at home?" and "Is anything different in your life?"

These questions sought to gather a general update on the patient's family. The physician might move to more focused questioning if the general question stimulated a concern about the patient's family: "And how's mamahood treating your wife?" Focused questions could also be asked independently from global questions. Focused family questions were sometimes linked to gathering information for the genogram and clarifying relationships.

The family-oriented questions gathered information

about past and present family health history, family life cycle adjustment, and potential family health collaborators. By raising these questions, physicians discovered the patient's family and social context. Additionally, the physician may learn who encouraged the patient visit, who else in the family may need to come in, and whether family counseling could be beneficial. Finally, the family-oriented questions helped the physicians address family concerns about end-of-life decisions.

> Dr Hill: How's Rita doing?
> Patient: Good, real good.
> Dr Hill: And you guys sort of feel like you're over the hump? . . .

Family-oriented talk could be about family members not at the encounter. This type of talk gave the patient's visit the quality of a home visit because other family members were brought metaphorically into the room. Transcripts of physician-patient encounters provide "thick descriptions"[21] of how family members are included in a visit. This complements the results of a recent large study of 138 community-based family physicians.[22]

Closing the Family Talk Window

> Patient: . . .I won't do what she [family member] tells me.
> Dr Steele: Oh.
> Patient: She says it's like talking to the wall. . . . She left then and I said don't forget [to] pick me up.
> Dr Steele: Well, let's check that blood count again.

A companion skill to asking family-oriented questions is the ability to close the family talk window. Branch and Malik[23] describe the importance of physicians learning the skill of closing the patient conversation window. Without the ability to close the conversation, physicians fear time will elude their control. Physicians adept at asking family-oriented questions have developed strategies for closing the family talk window when necessary. Strategies include acknowledging a response, offering reassurance and follow-up, and switching to another topic or another action.

> Patient: See, my brother-in-laws' the only one who does anything for my mother and me [goes on to describe some details of family discord].
> Dr Hill: Yeah, I know there's been a lot of problems there with the rest of the family, hasn't there? That's a lot to handle. Well, let me write up that prescription for you . . .

Family Details

The 4 physicians had an impressive store of family details which they carried into each patient encounter. These stories would be laced into the patient encounter through family-oriented questions or statements.

> Dr Hill: Hey, how is your mother's nursing home placement going?

> Dr Wood: Did your father get his restaurant under way?

When the physicians were questioned during the debriefing session about what facilitated their retention of family details, they had an array of responses: "I'm just good, I guess, at retaining these family stories. They really interest me," "Having other family members as my patients helps me retain these family details," "Glancing at the genogram before I go into the room helps joggle my family memory."

> Dr Lake: Okay. Well, hang in there. Give my best to Steve. Let me know if I can do anything.

Three of the 4 physicians routinely integrated a closing ritual into their visits. This family closing ritual reinforced the physician's commitment to family, reflected their knowledge of the people important in the patient's life, and solidified the overall tone of the patient visit.

Family-Oriented Actions

In addition to family-oriented talk, we observed 2 actions based on family systems concepts: the facile use of triangulation and the ability to juggle multiple systems. These family-oriented actions reflect the systemic thinking of these physicians.

The concept of triangulation from the field of family therapy[7] refers to the problem when an individual bonds closely with another person through the exclusion of a third person. A physician seeing multiple family members is vulnerable to becoming triangulated. Avoiding triangulation can occur through either words, behavior, or a mixture of the two.

Physicians also demonstrated systemic thinking by juggling multiple systems. Physicians juggled activities (eg, conducting physical examinations while talking), handled many different people in the room at the same time, and integrated multiple health care providers.

Family-Oriented Approach in Routine Care

Let us return to the primary research question: Can a family physician integrate family systems concepts in routine care with individual patients? The answer is a qualified yes. These exemplars do it some of the time but not all of the time. What promotes or discourages a family-oriented approach to the individual patient?

Many different circumstances encouraged the physi-

cian to ask family-oriented questions or make family-oriented statements.

> When the biomedical piece is minuscule, I think *great*! I'll have time to either talk more or to catch up and go on to see the next patient. —Dr Wood

This statement reveals a consistent theme: When the biomedical aspects of the patient were manageable, the physician had the opportunity to be more family-oriented. The biomedical problem could be medically complex (eg, asthma, complications of diabetes, and so forth), as long as it was well understood and confidently managed by the physician. But even when a patient presented with a symptom or illness that was challenging or ambiguous, family questions could facilitate a more thorough contextual understanding that aided in the differential diagnosis.

> I sort of take the time then to find out (more) especially when I know that there is something else going on in the family . . . and I think I was more sensitive to it with her because I knew some of her history. —Dr Hill

Established patients were consistently associated with a family-oriented approach. Although this was not always apparent if one looked only at the transcripts of a single encounter. Physicians, in their debriefing interviews, often provided detailed family stories about some of the patients whose visits were rated as low-intensity.

> I might just ask 1 or 2 family questions with this patient because I think in my head, "Well, I'll see you in 2 weeks." I might ask none because I know I'm behind today, but I can fill in the pieces next visit. —Dr Steele

Family-oriented questions were woven into new patient visits when time permitted. These questions revealed the value of family and social context in the physician's practice.

> . . . Often a patient will dangle something out there, some family thing and I have to decide to bite or not. Time influences that a lot. But when their spouse has said something that worries me about the patient, I then feel I need to pursue it. —Dr Lake

What the physician learns from seeing other family members may encourage family-oriented statements and questions, even if there are competing demands on the physician.[24] All of the physicians reported that taking care of an entire family or multiple members of a family encouraged a family-oriented approach.

A parallel goal was to determine what discouraged the physicians from being family oriented. Time was the critical factor: the time of day of the visit and the time the physician had available for that visit. As the day wore on and the physician wore down, there was less family-oriented talk. The physician's personal time needs also influenced the family-oriented approach.

> If my regular nurse who knows all the patients so well and sometimes prompts me isn't here, I may be less family-oriented. —Dr Wood

If the practice environment changes for a day it could hinder a physician from being as family-oriented as usual.[25] Finally, unsuccessful past efforts at trying to be family oriented with a patient might discourage a physician from continuing such an approach.

CONCLUSIONS

In this study we found that exemplary family physicians are able to routinely integrate family systems thinking into patient visits lasting an average of 13 minutes. These exemplars had longer visits than the 10-minute average found in a recent study.[26] We identified the characteristics of this family-oriented approach and the circumstances that support it. This approach has qualities that primary care physicians can incorporate into their practices.

This research has focused on how physician exemplars integrate family systems concepts into the routine care of their patients. A natural direction for future research would be to examine *how* patients respond to a family-oriented physician and whether it makes a difference for health outcomes. Currently, the literature on patient satisfaction has emphasized the global aspects of the physician-patient encounter, but little is known with respect to physicians who are family oriented.[27-29]

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