Caring for families is one of the defining characteristics of family practice, and interviewing patients’ families is an essential skill for family physicians. Families are the primary context within which most health problems and illnesses occur. Research has demonstrated that the family has a powerful influence on health and illness. Most health beliefs and behaviors (e.g., smoking, diet, exercise) are developed and maintained within the family. Marital and family relationships have as powerful an influence on health outcomes as biological factors, and family interventions have been shown to improve health outcomes for a variety of health problems. 

Unlike patient-centered interviewing, there is little empirical research on specific aspects of family interviewing and its relationship to patient and family satisfaction or health outcomes. However, a number of studies have examined the ways in which family physicians and other primary care physicians communicate and interact in their offices with families. These areas are relevant to family interviewing and include such topics as genograms and family history taking, physicians’ family orientation or level of involvement with families, and family conferences or meetings. This article reviews the research on topics related to family interviewing and communication in primary care settings and suggests the next steps for research on family interviewing in primary care.

Methods

A preliminary search of MEDLINE (1966–present) and PsychINFO (1967–present) using the term family interviewing yielded only 10 papers, none of which were empirical studies. We therefore conducted a more comprehensive search to find any studies related to family interviewing. We chose MeSH headings under which known family interviewing studies have been listed. We also chose a broad array of search terms that we thought
might be related in any manner to family interviewing. These included professional-family relations (MeSH heading), family health (MeSH heading), family history, genogram, family interviewing, family conference, family meeting, family orientation, family involvement, family care, and family support. We narrowed the search by including the terms primary care or family practice (both MeSH headings). We reviewed the titles and abstracts of these papers and included all qualitative or quantitative studies related to family interviewing that were conducted in primary care. We excluded all non-English papers, clinical reports, letters, reports of educational programs, and studies not related to family interviewing. We also examined the reference lists of reviewed articles. One of the authors keeps an extensive database on family and health studies, which was also searched. As a final check, we conducted a second search of MEDLINE and PsychINFO using the terms professional-patient relationship (MeSH heading) and family (MeSH heading).

Results
The initial MEDLINE search generated 28,551 citations, which were reduced to 519 when limited to primary care or family practice. Of these articles, 29 fit our inclusion criteria (empirical studies that fit into the four areas outlined in the next paragraph). The PsychINFO search did not identify any additional studies. Several other studies were found by reviewing reference lists. The second search, using two additional MeSH terms (professional-patient relationship and family) produced 219 citations but no new studies pertinent to our search. Less than 25% of the references identified in the search were empirical studies. Many of the articles were related to genetics in primary care. The other articles were mostly clinical articles on how to care for families, conduct family conferences, and interview families.

We reviewed the identified studies for common themes and were able to categorize them into one of the following areas: (1) physicians’ family orientation or level of involvement with families, (2) family genograms, (3) family members who accompany patients to the physicians’ offices, and (4) family conferences or meetings. We will review each of these areas.

Physicians’ Family Orientation or Level of Family Involvement
A physician’s family orientation refers to how often the physician asks questions about the patient’s family, obtains a family history or a genogram, interviews family members, or makes some type of family intervention. Several researchers have examined how much attention family physicians pay to family issues in clinical practice. Crouch and McCauley analyzed audiotapes of visits of new patients with family practice residents and concluded that most residents had little “family awareness,” although the patients felt that the residents showed more interest in family matters than they usually expect from their physician.

The most comprehensive and representative study of family orientation by community family physicians was conducted by Medalie et al at Case Western Reserve University. In the Direct Observation of Primary Care (DOPC) study, they directly observed more than 4,000 patient visits to 138 community family physicians and reviewed their charts. They found that 10% of each patient visit was devoted to addressing family issues, including obtaining family histories, genograms, and discussing family concerns or problems. The researchers concluded that family physicians in this sample had a high degree of emphasis on the family but had two different styles of family orientation that were associated with different patterns of care. One group of physicians focused on family history as part of health risk screening and preventive services, while the other group had a more in-depth knowledge of family interactions and relationships. Patients of physicians with a family history style rated their physicians lower on their in-depth knowledge of the patient and family and higher on preventive services. There were no differences between the two groups in patient satisfaction with continuity of care or interpersonal communication. The strengths of this study are the number of family physicians and patients studied and the systematic documentation of different elements of family orientation.

Doherty and Baird first developed the concept of levels of physicians’ involvement with families as a way to describe the degree to which physicians interact with families and deal with family issues. Marvel and Morphew developed a rating scale to assess clinicians’ level of involvement with families through direct observation. They used this scale to examine how involved family practice residents were with their patients’ families. In a series of videotaped patient interviews, the residents asked about family issues or spoke directly with family members in 41% of the visits. A more recent study of family practice residents found that information about the family was found in 61% of visits. A small study of family physician faculty used the same methodology and found that discussion of the family context of the visit occurred in 58% of all visits, primarily during preventive care visits and when another family member was present. On the other hand, Shapiro found that family-oriented transactions by family practice residents were uncommon and were associated with longer interviews, more physician questions and clarifying behaviors, and greater tendency to elicit the patient’s agenda. In another study of family physician faculty, half of all the visits showed minimal or no family involvement. Family issues were discussed in only 18% of the visits involving adult pa-
tients. However, in reviewing the audiotapes, the authors of this study believed that the observed level of family involvement seemed to be appropriate for the situation in most of the cases. These studies on family involvement suffer from too few physicians and interviews being studied, and most of them were conducted in academic settings.

Two studies have tried to examine the components of family-oriented care by analyzing the practices of exemplars in the field. Marvel et al compared the verbal exchanges of nine family physicians who had received family therapy training with 20 control community physicians. The exemplars involved their patients more in the medical interview, offered more emotional support, and showed more family involvement. The length of visits did not differ between the two groups.

In a qualitative study, Cole-Kelly et al examined the core components of a family-oriented approach with individual patients. They observed and audiotaped 157 patient encounters with four family physicians who were considered exemplars in family-oriented care. Grounded theory was used to identify themes and patterns in their approaches. They found that these family physicians used both global family questions ("How's everyone doing at home?") as well as focused family-oriented questions ("How is your wife doing with that new treatment?"). The exemplars frequently inquired about other family members and were able to keep a storehouse of family details in their minds that they frequently referred to in the visits.

Becoming triangulated between family members—one speaking to the physician and to another family member—is an important risk of a family orientation with an individual patient. In the Cole-Kelly et al study, the exemplar physicians were sensitive to the dangers of colluding with the patient and were facile at avoiding these traps. The exemplars often explored family-oriented material during physical exams or while doing procedures, thus not using extra time for these areas of inquiry. Visits with high family-oriented content occurred 19% of the time, and family-oriented talk was low or absent in 52% of the visits. The visits that had the highest degree of family-oriented content were chronic illness visits and well-baby and child visits.

These studies as a group suggest that family orientation is a useful concept that refers to the extent that family physicians ask about family issues, obtain a family history or genogram, and discuss family problems or concerns. Marvel’s method for measuring levels of physician involvement with families offers promise as a method for assessing family orientation, but it needs to be used in larger studies of community physicians, such as the DOPC study. Qualitative studies, such as the Cole-Kelly et al study, are helpful for discovering the elements of family-oriented interviewing. However, there is no agreement as to what are the appropriate, ideal, or minimal levels of family orientation that family physicians should have or that yields the best health or family outcomes.

Family Genograms

Genograms or family trees are considered by many to be a key component of a family-oriented interview, yet there is little research on their usefulness. Genograms are the simplest and most-efficient method for understanding the family context of a patient encounter. Genograms provide information about genetic risks and any family history of serious illnesses. With advances in genetic research, detailed genograms will become essential components of every patient’s medical evaluation.

A series of studies have been conducted on genograms in family practice. In the DOPC study, a family history was obtained during 51% of visits by new patients and 22% of visits by established patients. However, a genogram was present in the medical records of only 11% of these patients.

The reliability of the genogram obtained in family practice has been examined in two studies. In a small, homogeneous sample, Jolly et al concluded that family practice residents could obtain and accurately record basic family information on a genogram during a 16-minute interview. Rogers and Holloway found a high level of test-retest reliability of a self-administered genogram when completed 3 months apart. These studies suggest that the genogram is relatively accurate and reliable, but the studies are limited by small and homogeneous sample sizes.

Two studies have examined the relationship of obtaining a brief genogram to patients’ perceptions of their health care and relationships with their physicians. In the first study, by Rogers and Durkin, patients reported that they felt the genogram would help their physicians understand them better and thus provide better health care. In a subsequent study, Rogers and Rohrbough were unable to demonstrate any effect of taking a brief genogram on the patients’ perceptions of their health care or doctor-patient interaction. In this study, the genogram interview was brief and limited to factual information about the family. The physicians in the study reported that they felt that the genogram was more relevant and helpful when they collected the information themselves, as compared to a self-administered genogram completed by the patient and placed in the chart. Both studies were limited by small sample size and insufficient power to detect meaningful effects.

A few studies have examined the usefulness of the genogram in predicting health outcomes. Rogers found that family information collected on the genogram could be used to identify patients at high risk for anxiety and depression. In a separate study, a medical assistant
completed a screening genogram with the patient and placed the information in the chart. Although this resulted in more family information getting into the chart, there was no discernable effect on physician behavior. Specifically, the physicians were not more likely to explore family issues or refer the patient for counseling for emotional problems. Finally, Rogers et al used a panel of physician experts to examine genograms to see if they could predict health outcomes and utilization. Based on the genogram readings, they were able to make general predications about overall health care use in the subsequent 3 months.

Although research on the genogram is quite limited, several conclusions can be drawn from the studies reviewed. Most family physicians collect a family history, but few of them record it as a genogram. The genogram can be obtained reliably and accurately in a brief interview. Genograms obtained by the physician are likely to have more influence on physician behavior and health outcomes than those completed by the patient or a health assistant and placed into the chart. This argues for the use of a genogram as a way to record information and convey interest in a patient’s social context. However, the use of the genogram as a screening instrument and the benefit of obtaining a genogram on patient perceptions and physician behaviors is uncertain, since the existing studies are too small to make any firm conclusions.

Family Members Who Accompany Patients to Routine Office Visits

Studies have shown that family members often accompany patients to the medical office, either remaining in the waiting room or joining the patient in the exam room. In the DOPC study, Medalie et al found that another family member was present in the exam room during 32% of all office visits. This was most common when the patient was a child under 13 (97%) or elderly (25%) but also occurred 12% of the time with adult patients. Overall, another family member’s health problem was discussed in 18% of these visits. In a separate study, Botelho et al found that 39% of patients came to a family medicine center with a family member or friend and that 66% of these accompanied the patient into the examination room. In a study of family practices in Ontario, 33% of patients were accompanied by a family member or friend, who was usually described as an advocate for the patient.

Routine visits in which one or more family members are present are common and may be initiated by the patient, family members, or the clinician. These visits allow clinicians to obtain the family member’s perspective on the problem or the treatment plan and answer the family member’s questions. Several studies have shown that office visits that involve other family members last just a few minutes longer than other visits. In some situations, they may be more efficient and cost-effective than a visit with an individual patient, because a family member can provide important information about the health problem, or the physician may even provide care for the family member.

As part of the DOPC study, Flocke et al found that family physicians provided care to a family member other than the patient during 18% of the office visits. The family member was present for half of these visits. These visits were slightly longer (1.3 minutes) and included more time counseling and gathering family information. In these visits, patients were more likely to report that their expectations for the visit were met. The authors suggest that the care of secondary family members may be an “added value” to family practice. This may be comparable to the increased efficiency of group visits for chronic illnesses that have recently been promoted.

In another study in primary care, 83% of companions who accompanied patients to a medical visit were family members. They served various roles for the patients, including helping communicate patient concerns to the doctor, helping patients remember clinician recommendations, expressing concerns regarding the patient, and assisting patients in making decisions. The patients, companions, and clinicians all agreed that the companion’s presence was helpful. Specifically, the clinicians felt that the family member improved their understanding of the patient’s problem and the patient’s understanding of the diagnosis and treatment.

Several studies of family companions in office visits by geriatrics patients have found conflicting findings on the outcome of these visits. In an early study of family members accompanying cancer patients to outpatient visits, these triadic visits were longer, and the physicians provided more information but less emotional support than when the patient was unaccompanied (dyadic visit). Sicker patients were more likely to have family companions at their visit. There was no difference in patient satisfaction with the different types of visits. A second study did not find any increase in the length of triadic visits. Patients in that second study reported little effect on the content of the visit when a family member was present. Greene et al found that in triadic visits with elderly patients and family members, the patients were less assertive and expressive, and fewer topics were raised. There was also less joint decision making and shared laughter in triadic versus dyadic visits.

Family members commonly accompany patients, especially elderly patients, to their medical visits, and these triad visits differed from visits with just the doctor and patient. It is difficult to make any conclusions about the outcomes of these visits, since patients who are accompanied by a family member are likely to be quite different than unaccompanied patients in relation to their medical problems, functional abilities, family relationships, and attitudes toward family involvement.
in their care. None of these studies have actually observed or recorded what occurs during these triadic visits. There is much research that is needed in this area.

Family Conferences
A family conference is usually thought of as a specially arranged meeting requested by the physician, the patient, or the patient’s family to discuss the patient’s health problem or a family problem in more depth than can be addressed during a routine office visit. It is often longer than an office visit and involves more planning and structure. In a survey, Wisconsin family physicians reported that they found family conferences to be useful and one of the most commonly used family-oriented clinical tools.

In a series of studies, Kushner et al examined the perspectives of patients, residents, and community family physicians on family conferences. They discovered that family physicians tend to underestimate patients’ interest in participating in family conferences and that patients desire family meetings for serious medical and psychosocial problems.

Family conferences occur less frequently than meeting with family members during routine office visits and usually require more time. Most family practice residents view family conferences as a valuable communication and clinical tool that is best taught experientially with physician role models. Family physicians in one survey, however, rated family conferences as highly useful but infrequently used.

Karofsky et al examined the effect of an initial family conference for new pediatric patients and their families through a randomized controlled trial. A total of 177 pediatric patients and their families were randomly assigned to a family interview or control group. The families who received the family conference had fewer subsequent visits for health problems or to the emergency room and more visits for health supervision (well-child visits). This well-designed study suggests that family conferences may be cost effective by reducing health care utilization.

Discussion
The various studies reviewed in this article suggest that three general types of family interviewing occur in family practice. The most common is a family-oriented interview with an individual patient. This type of interviewing differs from a patient-centered interview only in its emphasis on the family. It usually involves collecting information about the family, obtaining a family history or genogram, and discussing family issues.

Interviewing a family member who accompanies a patient to a routine visit is the second type of family interview. Although it occurs in 33% of all visits, little research has been done on what happens during these visits, and there are few guidelines on how to conduct such an interview.

Most of the literature on family interviewing has focused on the third and least common type of family interview, the family conference or meeting. These conferences are uncommon but well accepted by patients and play an important role in clinical practice. They may reduce overall health care costs, since managed care organizations have found that group visits for some chronic diseases can be cost effective. Family visits in which the health care needs of all members of the family are addressed may be similarly cost effective, but this needs to be studied.

Research on Family Interviewing
Despite the importance of the family in family medicine, there is little empirical research on family interviewing. More naturalistic studies should describe what occurs in family physicians’ offices. Both quantitative studies, like the DOPC study, and qualitative studies like Cole-Kelly et al’s study of exemplar family physicians, are needed. These studies will help answer some of the following questions: how often do family physicians gather family information, either medical (family history) or psychosocial (genograms, family relationships, strengths, stressors)? What are patients’ and physicians’ perceptions of gathering family information? Does it improve rapport or affect the doctor-patient interaction or any health outcomes? Under what circumstances do family members accompany the patient to an appointment? What are the reasons behind the family member’s visit? What are their expectations of the visit? How does the physician interact with the family members? How satisfied are the patient, family members, and physician with these interactions?

Audiotaping medical visits in which a family member accompanies the patients would provide valuable insights into family interviewing. How does the physician manage the interview when there is more than one person present? Is the accompanying family member included or excluded from the interview? How is patient confidentiality handled? How often do family problems or issues or other family members’ health problems get raised? What is the impact on the length of the visit when there are other family members present? How does the physician handle family conflict?

Basic data about family conferences also need to be collected. How often do they occur and in what settings? What are the reasons that they occur? Who (the physician, patient, or family members) requests family conferences? How satisfied are the patient, family, and physician with the family conference? Audiotapes or videotapes of family conferences would also be valuable to see how family physicians conduct these interviews.
Intervention studies are needed to examine the impact of different types of family interviewing on health and family outcomes. Karofsky’s randomized controlled trial of an initial family interview for pediatric patients offers a model for such research. The National Institute on Aging has shown interest in funding studies that examine the effect of inviting family companions to elderly patients’ medical visits. Randomized controlled trials of family conferences for different conditions (e.g., end of life, diagnosis of a life-threatening illness, hospital discharge planning, nonadherence to medical recommendations) are needed to examine when these intensive interventions may improve outcomes.

Multiple different outcomes need to be evaluated in these studies. Patient, family, and physician acceptance and satisfaction with different types of family interviewing (e.g., genograms, interviewing family companions, family conferences) are important but not sufficient outcomes to measure. Intermediate health outcomes may include improved adherence to medical treatment (resulting in lower blood pressure or diabetic control) or lifestyle changes. Mental health outcomes, such as reduced depression and anxiety, are important outcomes to study. It is critical to examine outcomes in both the patient and family members. Research on cardiovascular risk reduction has demonstrated that family members benefit from risk reduction strategies directed at an individual patient. However, any family intervention may improve the health of the patient while adversely affecting the physical or mental health of family members, especially caregivers. Health care utilization is another important outcome, especially since it influences the cost-effectiveness of different types of family interventions. Karofsky’s study suggests that a family interview may save money by reducing unnecessary utilization. Whether family interviewing saves time and money in the long run needs to be carefully examined.

Conclusions

The family is alive and well in family practice. Most family physicians are family oriented and use a wide range of family interviewing approaches with individual patients, with family members who accompany patients to office visits, and in family conferences. More research is needed to examine the process and outcome of these different types of interviewing. As research about communication with individual patients has increased, physicians have recognized that enhanced communication skills impact outcomes in history taking, patient satisfaction, and adherence. Expanding this research to the level of family interview is the next stage.

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