Five Areas of Questioning to Promote a Family-Oriented Approach in Primary Care

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The basic tenets of the biopsychosocial model remain critically important in primary care medicine, especially in this era of managed care. In this new era, primary care providers are responsible for an ever-increasing number of patients with less time for patient care. Families continue to be the main context of care for individual patients. A challenge for primary care physicians can be how to pursue the family content in the 15 minute visit with the individual patient. This paper presents a family-oriented approach to the individual patient. Five areas of family-oriented questioning guide the primary care physician to an efficient and comprehensive pursuit of family contextual considerations. The benefits of these questions are presented as well as a decision tree to facilitate effective intervention with the patient and family members.

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The basic tenets of the biopsychosocial model (Engel, 1977) remain critically important in primary care medicine, especially in this era of managed care. Primary care providers are now responsible for an ever increasing number of patients who are seriously ill and have complex medical problems. Primary care is also the de facto mental health system in the United States. Twenty to thirty-three percent of primary care patients meet criteria for at least one DSM psychiatric disorder. As many as fifty to seventy percent of these patients initially present to their physician with a physical symptom such as headache or fatigue (Katon, Walker, 1998). Patients depend on their primary care provider not only for treatment of serious medical conditions but also often psychosocial support.

The other system that is being most effected by the changes in healthcare is the family. It is the family that has the greatest impact on its members' health beliefs and health behaviors (Doherty and Campbell, 1988). And it is the family who cares for its ill members. The family turns to primary care, as well, for guidance and support when a family member is ill. As the baby boomer generation ages, the family is called upon to provide long years of care to members who are chronically ill. The pressure on the family, especially the caregiver, is great. Only 5% of the elderly live in institutions (Zopf, 1986). The vast majority live with or near a family member (Smallagen,1985).

The dilemma faced by primary care physicians is that they must see more patients who have a broader range of problems. Unfortunately, there is no additional time to take a broader history in order to understand the patient's full story. This then brings us full circle to the biopsychosocial model. Engel's model is based on the idea that if the physician listens closely to the patient's story, the biopsychosocial nature of the problem will emerge on its own. The question is: How does one do this?

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Often the primary care physician approaches his or her patient from a "split biopsychosocial model" (Doherty, Baird, Becker, 1987). All of the biomedical concerns are assessed first and then, if there is time, psychosocial concerns are addressed. This is a challenge for any physician and still divides the patient's experience in two, reflecting a mind-body split that dominates western medicine. What is needed is a method for interviewing that integrates biomedical and psychosocial concerns without unduly overburdening the primary care provider. Recent research reveals that family physicians do gather family information, both family history and details of family members' health (Medalie, et al. 1998; Flocke et al. 1998). In this paper we are emphasizing a family-oriented 15 minute interview approach, since the family has greater influence on the individual patient than any other system.

We define family as any group of persons who are related biologically, legally, or emotionally (McDaniel, Campbell and Seaburn, 1990). A family-oriented approach does not ignore that the vast majority of patient encounters are with individuals. Rather it underscores that reality and offers the physician a way of understanding the relational context of the patient's life. It is based on a belief that understanding that context (family of origin and current social context) is helpful for multiple reasons. First and most obvious, gathering family information can let the physician know who else in the family might have had the same illness or presentation and what was done about it. Gathering this information can go beyond the basic family history and can help the physician recognize family factors that may influence the patient's attitudes and actions regarding the illness. In addition, learning about the family from the patient can help the physician know who:

1) the potential collaborators are in the family and who could sabotage the patient's adherence with a new medical regimen;

2) is contributing to the patient's explanatory belief about his/her illness;

3) might be rallied for support while the patient copes with a difficult medical situation;

4) could be contributing stress that is playing a role in the patient's current situation.

By approaching the patient with a brief family-oriented set of questions, the physician can effectively collect important information that will contribute to the patient's healthcare. In this paper we will delineate five key questions that can be used in any patient interview. The questions bring the patient's family "into the room" in a relevant and timely way. We will apply these questions to clinical examples. Finally, we will propose a decision tree for what to do with family information that is gathered from the individual.

A PATIENT VIGNETTE

In an outpatient clinic visit Dr. Baltiera meets Ms. Vasquez for the first time. Ms. Vasquez comes to see him as he has been recommended by another physician.

"Dr. Baltiera, I have had my stomach scoped, poked, X-rayed. I still feel so sick...can't you do something for the pain—I feel it right here (pointing to her stomach). I just want to feel better so I can be of some use at home."

Dr. Baltiera, notes he has a full schedule. He intends to keep the patient visit to 15 minutes. The chart's thickness belies Ms. Vasquez age—a 48 year-old woman. She is the mother of three who has been seen multiple times for the same symptoms. To date, no treatment has been successful in reducing her discomfort. Dr. Baltiera is committed to taking a family-oriented approach to the individual patient and decides to learn more in his limited time with her. He wants to figure out why

this woman keeps getting physically sick, medically assessed, and has such limited and frustrating results.

"Ms. Vasquez, I want to help you with your stomach pain. As you already said, other physicians have scoped, x-rayed, poked and I'll add, medicated to the extreme...so now, keeping the pain in mind let me just ask you some other questions," Dr. Baltiera said, speaking fluent Spanish to this Puerto Rican woman. "I know a lot about your physical symptoms, but I don't know that much about other parts of your life." The physician knows that later he will want to pursue when Ms. Vasquez came to this country. Right now, being aware of the time constraints, he limits his questions.

"'Ms. Vasquez, I'd like to start with a brief family tree—just to give me a better picture of who you are and with whom you live."

Dr. Baltiera asks several family-oriented questions to enhance his ability to understand her stomach pain more fully. As he gets family tree information, he learns that she has two crack-dependent daughters. She mentions that she finds her pain comes when she goes to sleep at night, worrying that she will get a disturbing phone call. Ms. Vasquez also talks about her stress from taking care of her five grandchildren. Her own mother died in Puerto Rico two years ago, and Ms. Vasquez was unable to attend the funeral due to crises with her daughters.

All this information comes from Dr. Baltiera's brief gathering of the family tree. Much has been written about the value of using family trees in clinical practice (McGoldrick, Gerson, Shellenberger, 1999; Christy-Seely, 1984; McDaniel, Campbell, Seaburn 1990). Dr. Baltiera uses the family tree as his initial avenue of exploration of the patient. This is one fundamental approach to gaining family information. In addition to the use of the genogram, there are some additional basic family-oriented questions that can enhance care of the individual patient. Family-oriented questions metaphorically bring the patient's relational context into the office visit. These questions are designed with a 15 minute interview in mind. Any or all of them can provide information that will be useful in understanding the patient's illness experience better.

FIVE FAMILY-ORIENTED QUESTIONS

Family History

1. Has anyone else in the family had this problem?

This question will give the physician two domains of important information. It will reveal:

a) whether or not there is a family history of the illness

b) how the family has responded to this problem in the past

Often, the treatment used in one generation or with one member of the family will be a guide for the patient's approach to his/her illness (Seaburn, Lorenz and Kaplan, 1992). A family-oriented physician, on learning that Mr. Fagan's aunt has diabetes, inquires as to how the aunt took care of it and how that seemed to work. The physician can then take this history into consideration when making his/her treatment plan for Mr. Fagan's diabetes.

Similarly, when the physician is confused as to why Jenny Frank is so upset about her sore throat, the family-oriented question could shed important light on the intensity of her worry. In response to the question: "Has anyone else in the family had this problem?" Jenny relates a story of her uncle who just died of throat cancer. Jenny is concerned because her uncle's problem

started with similar symptoms. The physician is much better equipped to respond to Jenny's concerns now that he knows the association she is making. Addressing and allaying Jenny's fears could reduce both her anxiety and her unnecessary return visits to either urgent care, an emergency room, or an outpatient clinic.

Explanatory Models and Health Beliefs

2. What do family members believe caused the problem or could treat the problem?

Often family members have a unified family explanatory model. "All my husband's family is blaming me for the baby having cystic fibrosis because there are a lot of people with asthma in my family. I feel so guilty about that." Had the family physician not inquired about the family's belief about the baby's cystic fibrosis, the mother of the new baby might have been carrying around unfounded guilt for a long time. It was only as a result of this family-oriented question that the physician could allay her guilt and explain to the new mother that it takes genetic contributions from both sides of the family to create cystic fibrosis.

In addition to family members having explanations for causes or exacerbation's of illness, they also may have beliefs about what constitutes appropriate treatment (Marvel, 1998). Family members may have competing beliefs for either the cause or the cure. This can create confusion and other deleterious effects for the patient and the medical care.

Family members who have competing explanatory models can create other dilemmas for patients that are important for the physician to understand. When Dr. Schaffer asked the mother of the baby, recently hospitalized for Failure to Thrive, what she and her family thought had caused the baby's weight loss, she tearfully replied:

"My mother told me there could not be anything wrong with the baby when I said I thought I should take it to the doctor. She said if there was anything seriously wrong, she would probably have a heart attack. She couldn't take another problem in the family. My mother-in-law, who lives next door, told me that my husband was just as skinny when he was a baby. She said I was crazy if I took the baby in. She told me to just feed it as I was because the worst thing in the world is to have a fat baby."

These divergent messages from family members gave the family-oriented physician a much richer understanding of the reasons the mother had not brought the baby in sooner. Instead of feeling angry with the mother, the physician now can empathize with the mother's dilemma and understand the complexity of explanatory beliefs involved.

Understanding the Relational Context of Concern

3. Who in the family is most concerned about the problem?

The family-oriented physician may find important clues to a patient's presenting complaint or problem if s/he inquires as to whom is most concerned about the problem. Sometimes the patient in the office is not the most concerned family member. Finding this out can help the physician understand:

a) why the patient seems to be quite relaxed about the situation despite its seriousness;

b) why the patient may not be an adequate reporter about the problem;

c) why a patient might be making frequent unwarranted return visits;

d) who the important collaborators are for the physician to work with.

Adolescent problems often present in this way. An adolescent female may appear unconcerned about her health problem,

whether it is an exacerbation of her diabetes or related to her sexual behavior. But her parent continues to bring her in to see the doctor, hoping the doctor will "make" her take care of her diabetes or "make" her get on the pill. It is always useful for the physician to identify who the "customer" is for his/her services. The customer and the patient are often not the same person. When the motivation to seek medical help does not reside with the patient, then asking "who is most concerned?" becomes a key to understanding how to proceed with the patient. A family-oriented inquiry about those who are most concerned may reveal critical family information that can facilitate the physician working more successfully with the individual patient.

Family Stress and Change

4. Along with your illness and symptoms, have there been any other recent changes in your family?

Family-oriented questions about stresses or changes can include finding out about other health problems in the family and how they are affecting the patient. Additional sources of stress or change could include recent immigration or household move, death of a family member, violence, re-marriage, job loss and common life cycle transitions such as a first child going to school or leaving home, separation, or divorce. These questions can help the family-oriented practitioner learn important information that might provide the key to previously elusive illness problems.

Edith was in the hospital for an exacerbation of her congestive heart failure. She also had diabetes and a prosthesis for an amputated leg. When the physician asked Edith if she knew what medications she was on, she clearly named all her medications. When asked if she were taking her medications, Edith said "Sometimes." The family physician asked her why she answered 'sometimes' and she responded blandly that she didn't know why.

The physician remembered Edith's husband's health had been failing when she was last in for a visit. "Edith, how is your husband doing?" Edith became tearful and answered he was doing terribly. The physician searched for any connection between the health of the patient's husband and the patient's inconsistency regarding taking her medication. Edith stated:

"My husband spoiled me—he brought my medicines to me every day on a tray."

Once the physician understood the Edith's husband's role, a new plan could be considered. The physician could mobilize Edith's sister, who was at the bedside during this conversation, and lived next door. A plan was made for the sister and Edith's adult children to monitor her medicine intake. The physician also explored the impact of Edith's husband's failing health on her emotional life. Edith revealed how depressed she was and was interested in some counseling to help her cope with her feelings.

Family Support

5. How can your family be helpful to you in dealing with this problem?

The literature on social support makes a clear link between health and social connectedness (Cassel, 1976; Berkman and Styme, 1979; Broadhead, et al., 1983; Berkman, 1984; House, JS, Londis, CR, and Umbersin, D 1988). The most important social support for most patients is their family. In contrast to question four, this family-oriented question seeks to expose sources of support that can be used to help the patient with either a new medical regimen, a new nutritional program, getting to appropriate therapy, or getting additional important

information that the patient cannot recall. The response to this question can also reveal to the family-oriented physician other family members who could be invaluable supports in facilitating the patient's healing or coping.

Mr. Jackson talked frequently with Dr. Stein about his desire to stop smoking. On several occasions he tried but did not last longer than two days before smoking again. Mr. Jackson was concerned because his father had died of lung cancer at the age of 49. Like his father, Mr. Jackson, now 41, was a life-long smoker. Dr. Stein suggested that this was a significant step that called for as much support from others as possible. She asked Mr. Jackson if there was anyone who could help him get started. Mr. Jackson said his girlfriend of five years might be helpful, but he was not sure she would come in. Dr. Stein got Mr. Jackson's permission to call his girlfriend. He invited her to the next appointment.

Mr. Jackson returned with his girlfriend. During the interview, Dr. Stein learned that Mr. Jackson's girlfriend also smoked. She wanted to quit as well, which surprised Mr. Jackson. Together they developed a plan to gradually stop smoking with each other's and the doctor's support.

The skills required for being able to integrate family systems concepts in the 15 minute visit with the patient are not insurmountable. As with so many questions posed by a physician, one of the most important skills is the ability to "open the window and be able to close it" (Branch & Malik, 1993). Branch and Malik describe an important skill needed by physicians treating individual patients to ensure their confidence in opening up discussions: the complementary skill of closing conversations in ways that patients do not feel cut-off or abandoned. Family-oriented physicians need to feel confident that after asking a family-oriented question, the responses will not make the physician regret his/her systemic inclinations. So rather than fearing that family-oriented questions will open the lid on Pandora's box, the systemically-oriented physician will think of it as a controlled exploration that can be postponed or closed when necessary (Cole-Kelly et al., 1998).

THE DECISION TREE

As the physician listens to the patient's responses to family-oriented questions, the physician will face decisions about how to use the family stories s/he has elicited. A decision tree can be helpful at this time as a guide for the family-oriented physician to choose how to use this information. Doherty and Baird's "Levels of involvement in working with families" can be a very helpful guide that complements the decision tree. The following guidelines can be useful in helping the physician decide how to use the family-oriented information that s/he has gathered.

1. Keep this family information in mind or make a note of it in the chart.

When the information adds to the overall understanding of the patient's concerns and reveals family support regarding the problem, but does not call for physician to take action, the physician can note it and consider it for the future. Examples of this include family health history, recent changes in the family life (a move, job change), life cycle transitions (a child leaving home).

This information alone may help the physician shape his or her interaction with the patient. Knowing that a non-compliant diabetic patient comes from a family with many diabetic members who have all resisted treatment may help the physician manage his/her own expectations and pace his/her own interventions, including deciding when the patient may be open to involving other family members.

2. Explore whether or not this individual can talk to or suggest changes to other family members.

Sometimes, through just a brief exploration of a situation, the physician can help the patient devise a family-oriented intervention that the patient might want to try out as a first step to change. A patient, for instance, who is frustrated that people keep eating and making only sweet, sugar-filled desserts, may be coached on how to approach the other family members to talk about the dilemmas this creates for the patient and what compromises could be arranged to satisfy their taste needs and the patient's health needs. Other examples of issues a patient may want to talk to family members about would include additional life style changes or gathering support to help compliance with a treatment regimen.

3. Invite another family member in for the routine office visit.

This would be the action taken for purposes of gathering richer information, garnering support for the patient, and clarifying a medical situation for a family member. Sometimes the 'patient' has come in an effort to motivate another family member to get healthcare. The invitation to the other family member can be a mechanism for trying to involve this other family member to initiate healthcare questions. Involving a family member is also called for when it is necessary to gather information about the patient's functioning that the patient may not be able to provide (memory-loss, severe symptoms of depression, etc.). This step can also be taken when the patient tried step number two and comes back reporting to the physician that the patient's own efforts to talk to other family members about support or something else relevant to their healthcare failed to produce the desired outcome.

4. Convene a family meeting.

In contrast to the third step which is to get additional information or clarification from another family member, this fourth step is valuable for the patient whose health difficulties are embedded in family processes that are problematic to the patient's healthcare. In a variety of situations, the physician may benefit from convening a family meeting: airing disagreements of treatment recommendations, learning about how a patient's illness seems to organize family life; exploring issues about managing a complex problem; delivering a new diagnosis of an illness; when the patient and physician feel "stuck" in treatment; or when a psychosocial problem is identified as the primary concern of the patient.

5. Make a referral to a family-oriented mental health professional either within or outside the practice.

When the patient or family reports psychosocial or psychiatric problems that are chronic (greater than six months) or multiple in nature, then the physician should consider consultation with and referral to a family-oriented mental health provider. Common problems requiring consultation and/or referral include, most marital problems, substance abuse, suicidality, psychosis, physical and/or sexual abuse, prolonged grief reaction. In each case it is important that the physician develop and maintain collaborative relationships with mental health colleagues (Seaburn, Lorenz, Gunn, Gawinski, and Mauksch, 1996). When the physician has implemented medication treatment that has been ineffective or is considering medication for a patient, a referral to a psychiatrist for assessment, diagnosis, and medication is also warranted.

These broad guidelines can help the physicians titrate their involvement with family issues and with family members. They also enable physicians to assess when the best intervention is to collaborate with a "psychosocial specialist" much the same as they would collaborate with medical specialists regarding any number of biomedical problems.

CONCLUSION

The future of primary care will call for increased physician awareness of multiple influences on their patients' health and well-being. A high percentage of patient problems commonly involve the full range of biopsychosocial issues. To treat patients effectively, physicians need to assess a broad spectrum of the patient's experience. Unfortunately, this task must be accomplished in the break-neck pace of primary care practice. A few family-oriented questions woven into the 15 minute visit can be invaluable. The answers to these questions can help the physician understand the complexities of the patient's illness presentation and often identify viable directions for effective primary care treatment.

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