3)

Interviewing When Family Members Are Present

FORREST LANG, M.D., East Tennessee State University, Johnson City, Tennessee
KIM MARVEL, PH.D., Fort Collins Family Medicine Residency Program, Fort Collins, Colorado
DAVID SANDERS, PSY.D., St. Anthony Family Medicine Residency, Denver, Colorado
DAEL WAXMAN, M.D., Carolinas Medical Center, Charlotte, North Carolina
KATHLEEN L. BEINE, M.D., East Tennessee State University, Johnson City, Tennessee
CAROL PFAFFLY, PH.D., Fort Collins Family Medicine Residency Program, Fort Collins, Colorado
ELIZABETH MCCORD, M.S., M.D., East Tennessee State University, Johnson City, Tennessee

The presence of family members at an office visit creates unique opportunities and challenges for the physician while interviewing the patient. The physician must address issues of confidentiality, privacy, and agency. Special skills are required to respectfully and efficiently involve family members, while keeping the patient at the center of the visit. A core set of interviewing skills exists for office visit interviews with family members present. These skills include building rapport with each participant by identifying their individual issues and perspectives, and encouraging participation by listening to and addressing the concerns of all persons. Physicians should also avoid triangulation, maintain confidentiality, and verify agreement with the plan. It may be necessary to use more advanced family interviewing skills, including providing direction despite problematic communications; managing conflict; negotiating common ground; and referring members to family therapy. (Am Fam Physician 2002;65:1351-4. Copyright© 2002 American Academy of Family Physicians.)

Physicians interact with family members in a variety of situations, such as routine prenatal visits involving both of the expectant parents, well-child visits with parents, and follow-up visits for hypertension in an elderly patient accompanied by a family member. Research[1-3] shows that family members are present in about one third of office visits; however, most of the literature on medical interviews has focused on the physician's relationship with individual patients. This article will identify the unique characteristics of interviews that include family members and will describe the necessary skills for conducting an effective family interview.

Unique Characteristics of the Family Interview

The presence of a family member at the office visit presents several issues that can make the interview more complex, including: (1) additional concerns or questions about the patient's health from the family members; (2) ethical dilemmas involving confidentiality and privacy; and (3) legal issues of agency[4] in situations involving a third party who handles financial or legal decisions for the patient (e.g., the mother of a child or the guardian of an adult who is impaired or has dementia). One study[4] found that a third person in the examination room decreased the amount of time the patient talked to the physician.

Conversely, family members can be a valuable resource of information and can help in the implementation of and compliance with a treatment plan.[5,6] The presence of a family member strengthens the alliance between the physician and the patient without lengthening the office visit.[7] One study[3] showed that physicians rated family involvement as having a positive influence in 95 percent of office visits.

Description of Family Interviewing Skills

Family interviewing skills require a foundation of individual interviewing skills, including data gathering (i.e., open-ended questions, facilitation, and identifying and exploring clues),[8] responding empathetically, and reaching common ground.[9,10] These skills can be divided into core and advanced skills of family interviewing *(Table 1)*.

See editorial on page 1277.

TABLE 1
Core and Advanced Family Interviewing Skills

Core skills	Advanced skills
Greet and build rapport	Guide communication
Identify each person's agenda	Manage conflict
Check each person's perspective	Reach common ground
Allow each person to speak	Consider referral for family therapy
Recognize and acknowledge feelings	
Avoid taking sides	
Respect privacy and maintain confidentiality	
Interview the patient separately, if needed	
Evaluate agreement with the plan	

Core Family Interviewing Skills

Core family interviewing skills are used in routine interviews in which another person accompanies the patient. Core skills suffice when family members communicate effectively and when minimal differences exist between the family members, patient, and physician. Using these skills, the physician can conduct an efficient and productive interview that involves everyone present.

GREET AND BUILD RAPPORT

The physician should greet and establish a rapport with everyone present. Personal introductions to persons who are accompanying the patient provide an important foundation for future interactions. Extra attention may be given to establishing a rapport with a new member.

IDENTIFY EACH PERSON'S AGENDA

A major objective of a successful interview is to clarify and prioritize the objectives of everyone involved.[11,12] First, the patient's agenda should be established, and then the family members should be asked if they have any additional concerns. Identification of everyone's expectations early in the process can help to avoid concerns that arise late in the interview.[13] Summarizing agenda items can help to organize the interview and validate everyone's interests. Multiple agendas should be prioritized to keep within the time limits of the visit. As with an interview with just the patient, it may be necessary to discuss the most pressing issues first, and to schedule future sessions to cover the remaining concerns.

CHECK EACH PERSON'S PERSPECTIVE

The physician can facilitate the discussion of an agenda item by asking for each person's perspective on the issue or problem. These additional perspectives may broaden the physician's differential diagnosis, including those related to family dynamics.[14]

ALLOW EACH PERSON TO SPEAK

During a family interview, one member may exhibit patterns of ineffective communication, such as monopolizing the interaction, expressing thoughts and feelings for others, or speaking directly to the physician about a family member who is present. In these situations, the physician should provide each member an equal opportunity to speak. If ineffective communication patterns persist, the advanced interviewing skills discussed later in this article may be needed.

RECOGNIZE AND ACKNOWLEDGE FEELINGS

Emotions expressed by the patient or their family members should be acknowledged and legitimized. This skill is challenging when a family member expresses concern about the health behaviors of the patient (e.g., inconsistently taking medication). Physicians should find a balanced approach that responds to the concerns but does not divert the focus of the discussion from the patient. The physician should also pay close attention to nonverbal clues, such as seating arrangements, physical closeness, eye gaze, and response sequence. Finally, the physician should communicate important emotional information and provide an opportunity to acknowledge and explore everyone's emotional reactions to the disease and its associated consequences.

AVOID TAKING SIDES

Occasionally, identifying everyone's perspectives results in a disagreement about the health of the patient, and the physician is asked to take sides. However, the physician-patient relationship can be negatively impacted by the physician's agreement with the family member. A helpful approach in these situations is to acknowledge the family

member's concern and then listen to the patient's response to that concern.[2]

RESPECT PRIVACY AND MAINTAIN CONFIDENTIALITY

The physician must be careful to avoid potential breaches of patient confidentiality that may arise when discussing diagnostic and treatment decisions in the presence of family members, especially with adolescent patients or with sensitive issues such as substance abuse and sexual history. The privacy of the patient must be respected at all times. Some patients may also be reluctant to provide accurate information about sensitive or embarrassing issues when other persons are present.

INTERVIEWING THE PATIENT ALONE

An optimal time to interview the patient alone is after the family interview has addressed the issues and agendas of the family members. The physical examination is a perfect opportunity to have a one-on-one discussion with the patient about issues that are private or confidential.

EVALUATE AGREEMENT WITH THE PLAN

The physician should work with the patient and family members to develop a plan that addresses the various concerns discussed during the family interview. After the physician describes the plan, the patient and then the family members should be asked how they feel about the plan. If differences exist, advanced family interviewing skills and additional office sessions may be necessary.

Advanced Family Interviewing Skills

Advanced family interviewing skills are useful in situations where the family exhibits ineffective communication, has difficulty resolving a conflict, or when intense emotions arise. The goal of these interviews is to assist the family in communicating or managing conflict sufficiently enough to address the immediate patient care issues; however, unlike therapy, the use of these advanced skills is not intended to create a permanent change in the family's interaction patterns. The physician may use techniques, such as reframing, decision analysis, criteria setting and brainstorming, to direct the interactions and conflicts, negotiate common ground, and, if needed, refer the family for more intensive family therapy.

GUIDE COMMUNICATION

Communication among family members can be ineffective when members exhibit the following behaviors: interrupting one another; showing poor attention or poor listening skills; monopolizing the discussion; using critical or sarcastic comments; making demands; or speaking for others. The physician can improve communication by recognizing these problems and providing guidance.

MANAGE CONFLICT

When addressing conflict among family members, the physician should first highlight the conflict in a professional way that encourages open discussion rather than personal attacks. Reframing is a method of restating a confrontational or demanding position in a way that allows each family member to understand and appreciate the others' viewpoints.

REACHING COMMON GROUND

Reaching common ground is a vital phase of the family interview in which there is strong disagreement.[11] Various tools are available to help everyone reach common ground, including reframing, brainstorming, decision analysis and criteria setting. The physician can use brainstorming methods to explore potential solutions after each person's perspective has been established. The process of decision analysis considers the perceived problems and benefits of the current situation, and the barriers and incentives of the proposed solution. In some cases, family members may need more time or more information to make a decision. It may be useful for the patient and the family members to write down suggestions for reaching common ground after the interview.

CONSIDER REFERRAL FOR FAMILY THERAPY

Referral to family therapy should be considered when a high level of unresolved conflict remains that affects individuals and the entire family. After a difficult interview, family members should be informed that participation in the office visit interview signifies a desire on their part to improve the relationship, and that family therapy may be appropriate. For families that decline family therapy, the interviewer can help members identify criteria[15] for judging whether or not their situation is improving.

Final Comment

Observations[2,7] of practicing family physicians show that family interviewing skills are used routinely. These skills can be incorporated into everyday practice by beginning with an introduction to the additional family members in the room, and then receiving the patient's permission to discuss substantive issues of their health with these persons. These preliminary steps set the stage for agenda setting and problem solving that involves the patient and family members. The skills described in this article should enable physicians to assist a family in reaching a decision about a specific issue; this process is not intended to "fix" family conflicts.

The authors indicate that they do not have any conflicts of interest. Sources of funding: none reported.

The Authors

FORREST LANG, M.D., is professor and vice chair of the Department of Family Medicine, James H. Quillen College of Medicine, East Tennessee State University, Johnson City, Tenn.

KIM MARVEL, PH.D., is associate educational director of the Fort Collins (Colorado) Family Medicine Residency program.

DAVID SANDERS, PSY.D., is currently the general manager of Mosaic TV, Denver, Colo. He was previously the director of behavioral science at the St. Anthony Family Medicine Residency, Denver, Colo.

DAEL WAXMAN, M.D., is the medical director of behavioral medicine in the Department of Family Medicine at Carolinas Medical Center, Charlotte, N.C.

KATHLEEN L. BEINE, M.D., is a clinical associate professor in the Department of Family Medicine at East Tennessee State University.

CAROL PFAFFLY, PH.D., is director of behavioral medicine at the Fort Collins Family Medicine Residency program.

ELIZABETH MCCORD, M.S., M.D., is the program director of the East Tennessee State University, Johnson City Family Practice Residency Program, Johnson City, Tenn.

Address correspondence to Forrest Lang, M.D., Department of Family Medicine, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70621, Johnson City, TN 37614 (e-mail: lang@etsu.edu). Reprints are not available from the authors.

REFERENCES

1. Medalie JH, Zyzanski SJ, Langa D, Stange KC. The family in family practice: is it a reality? J Fam Pract 1998;46:390-6.
2. Cole-Kelly K, Yanoshik MK, Campbell J, Flynn SP. Integrating the family into routine patient care: a qualitative study. J Fam Pract 1998;47:440-5.
3. Brown JB, Brett P, Stewart M, Marshall JN. Roles and influence of people who accompany patients on visits to the doctor. Can Fam Physician 1998; 444:1644-50.
4. Greene MG, Majerovitz SD, Adelman RD, Rizzo C. The effects of the presence of a third person on the physician-older patient medical interview. J Am Geriatr Soc 1994;42:413-9.
5. Baird MA, Doherty WJ. Risks and benefits of a family systems approach to medical care. Fam Med 1990;22:396-403.
6. McDaniel SH, Campbell TL, Seaburn DB. Family-oriented primary care: a manual for medical providers. New York: Springer-Verlag, 1990.
7. Marvel MK, Doherty WJ, Weiner E. Medical interviewing by exemplary family physicians. J Fam Pract 1998;47:343-8.
8. Lang F, Floyd MR, Beine KL. Clues to patients' explanations and concerns about their illnesses. A call for active listening. Arch Fam Med 2000;9:222-7.
9. Botelho RJ. Beyond advice: 3. Developing motivational skills. Retrieved February 2002, from: www.motivatehealthyhabits.com/bk3-contents.htm.
10. Stewart M. Patient-centered medicine: transforming the clinical method. Thousand Oaks, CA: Sage Publications, 1995.
11. Sunde ER, Mabe PA, Josephson A. Difficult parents: from adversaries to partners. Clin Pediatr 1993;32: 213-9.
12. Weber T, McKeever JE, McDaniel SH. A beginner's guide to the problem-oriented first family interview. Fam Process 1985;24:357-64.
13. Marvel MK, Epstein RM, Flowers K, Beckman HB. Soliciting the patient's agenda: have we improved? JAMA 1999;281:283-7.
14. Bullock D, Thompson B. Guidelines for family interviewing and brief therapy by the family physician. J Fam Pract 1979;9:837-41.
15. Fisher R, Ury W, Patton B. Getting to yes: negotiating agreement without giving in. 2nd ed. New York: Penguin Publishers, 1991.