FAMILY INTERVIEWS IN GENERAL PRACTICE

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IT IS well known that many families have problems of which the family doctor is unaware and which influence the presentation and course of illness. Even though a doctor may be suspicious of family problems he is often kept in the dark, sometimes for years. The seriousness of their outcome (Colling 1964) led us to ask whether anything could be done about them. In many disturbed families trouble is not even suspected (Miller *et al.* 1960) so any screening technique must involve normal families. A possible approach would be to interview all the families under the care of a family doctor but this would, of course, include many families who appeared to be without special problems.

We decided to plan an experiment to answer four questions:

1. How many families would respond to an enquiry?
2. What would be the best interviewing method, and how long would it take?
3. How would the families who came differ from those who did not?
4. If the scheme were extended how valuable would it be?

We could find no record of the interviewing of healthy families by general practitioners though a technique for examining families had been developed at the Peckham Health Centre over 40 years ago (Pearse and Crocker 1943).

Method

We first selected families whose members, so far as we knew, were all looked after by the practice. From these, 100 were chosen, 50 predominantly under the care of each of us. This final selection was based on social grouping, conforming to the social structure of the practice (Colling 1963).

A letter setting out the purpose and form of the investigation was sent to all selected families. It was decided to see a maximum of two families on Sunday mornings giving approximately 30 minutes to each interview.

The aims of the investigation were discussed with local health

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departments and a health visitor was invited to take part in the interviews. It was proposed that the interview should be an informal ' round table ' meeting with both doctors and health visitor present, but that the doctor whose family was under scrutiny would initiate the discussion.

After five meetings we felt that there was a brake upon discussion, and soundings, *via* a questionnaire, were taken of those families already interviewed. As a result of the inquiry and our own observations the health visitor was excluded from subsequent meetings, with only one or both doctors present.

Interviews

Out of 100 families invited 19 made appointments and were interviewed. The whole family came to the surgery though we allowed the parents to decide whether children were admitted to the consulting room. Older children were usually left in the waiting room; toddlers accompanied their parents though we found their restlessness often upset parents' concentration.

The average length of interview was 40 minutes, varying from 25 to 55 minutes. Seventy per cent were between 35 and 40 minutes.

Our interviewing technique had to be developed. In this unusual situation we tried to put patients and ourselves at ease by first recording simple family data—age, work, schools, immunization state etc., Then we asked for more details of work and if possible about attitudes to it. The children were then discussed in turn. We were sometimes able to talk about family relationships. Though we recorded our information under the headings of Family Data, Work, School, Family, Marriage, and Special Points, we allowed the interview to develop and expand in its own way. Afterwards the recording doctor wrote a summary of his impressions. We gave plenty of opportunity for patients to question us on medical or paramedical problems. For example, a family with a mentally subnormal daughter of 20 (I.Q. 65) asked, " Should she be allowed to go out with boy-friends; should she be given the pill; could she marry and could they stop her anyway? "

At first the interviews were tape-recorded with the full knowledge of the families concerned who readily appreciated our experimental interest in the interviewing technique. As we gained in confidence and when the interviews became more intimate with only a single doctor present we stopped recording.

Social groups

The families interviewed were compared to those invited and to the practice as a whole.

	Social group				
	I	*II*	*III*	*IV*	*V*
Practice 1963 (per cent)	*4*	*20*	*60*	*12.5*	*4*
Invited 1965 (per cent)	*6*	*28*	*52*	*11*	*3*
Interviewed (per cent)	*10.5*	*35.5*	*58*	*0*	*0*

Though the numbers are small the results are as expected with more of the higher social groups attending. No families in social groups IV and V came for interview: 58 per cent came from social group III and there was a relative excess of social groups I and II.

Families not interviewed

Families not interviewed were sent short questionnaires asking their reasons. Two further letters were posted to those who did not reply. 84 per cent answered.

12 intended to make an appointment but never got round to it.
13 said the time was unsuitable.
1 thought the interviews a waste of time.
3 wives couldn't persuade their husbands to come.
17 could see no point in coming as they had no special problems.
28 said their problems were dealt with adequately in the ordinary way.

Some families gave more than one reason. One man wrote an abusive letter which was an indication of his sickness and soon afterwards he received treatment for alcoholism and depression. Two families had changed doctors unknown to us. One family was afraid to come because they didn't know what to say. Another thought we were too busy to add to our work. However, judging by supporting remarks on their replies, 40 per cent of those who did not attend said they would have liked to come.

Families interviewed (19) compared to those not interviewed (79)

The difference in social groups has already been mentioned.

The families were compared in respect of age of father, age of mother, parental age difference, number of children, number of consultations in the year before and after interview (or invitation), the presence of chronic illness, adopted or handicapped children in the families. There was little difference in the age of parents or the numbers of children: 1 in 2 families with adopted children came for interview compared to 1 in 6 of others. There was no significant difference between the two groups when chronic illness or a handicapped child was present in the family. The number of consultations in the year before interview (or invitation) was about the same in both groups. In the following year there were fewer consultations

in both groups, but a greater decrease in the group *not* interviewed (highly significant at five per cent level). Some of the difference may be explained by the fact that medical problems arising at the interview were dealt with later.

Discussion

Because of the way the family doctor works there is rarely an opportunity for whole families to be seen when they are apparently healthy. This was an experiment to see how valuable such interviews might be. We would have preferred to precede them by physical examination and the recording of simple data (height, weight, blood pressure, urinalysis and haemoglobin estimation) but shortage of time precluded it. Although only 19 families attended for interview many others showed interest. At least half of those invited either attended or expressed interest in the scheme. The response was disappointing but it was achieved by a single letter of invitation. We did not encourage families to come even when they asked us 'whether they should'. To the families there might have seemed more point to the interviews if a physical examination had been included.

We think the interviews were best conducted by one doctor though families would accept the doctor's partner in addition. The health visitor was not accepted but perhaps in a practice where she was part of the health team the attitude of patients might have been different.

We are well aware that families will only tell what they think we should know and the interviews could only be considered as putting a foot in the door. However, they did allow families to begin to think about health in a different way.

We discovered many gaps in our knowledge of families. Inadequate follow-up of medical problems was a common finding. Most families had gaps in immunization. We gained a better understanding of the families though serious marital disharmony was not discovered. One husband returned alone a few days later to say he had not had sexual relations with his wife for three years and had found he couldn't discuss this in front of the health visitor. He may equally well have refused to discuss it in front of his wife.

The husband's attitude to work was usually eagerly discussed once initial reticence had gone, wives frequently taking the lead. We were interested in this as we thought it could affect the presentation of illness and absence from work. We also asked mothers about their work before and since marriage. A serious degree of mistrust in a family business and ignorance of its affairs had prevented one husband from having a necessary operation.

Though we called them Family Interviews they were essentially Parent Interviews. Older children did not participate but we saw

and spoke to them all though sometimes only for a minute or two.

We were concerned that our interviews might make families disease conscious. There was an average of two more consultations per family in the year after interview when compared to those not interviewed, which can be partially explained by the problems raised at interview which had to be dealt with (many simple, such as immunization procedures).

We have already answered the first three questions we set ourselves. The fourth is more difficult. 'If the scheme were extended how valuable would it be?' To discover whether family interviews could promote health or even uncover disease, disorder or disharmony, would take an elaborate organization many years to answer. A simple physical examination of each family member followed by family interview would take at least an hour (even allowing for nursing help with weighing, measuring, urinalysis and haemoglobin estimation). A general practitioner with 2,500 patients, interviewing one family a day, would take four years to cover the practice. The time of day of the interviews would raise difficulties because of work and school. Under present conditions extensive interviewing could only be done in academic centres or by enthusiasts. Ideally, each family should be interviewed once a year. This could be achieved in certain groups of families, though by being selective the advantages of general screening would be lost. However, there are some families in whom the doctor suspects problems from the pattern of illness or their reaction to it and it would be reasonable to suggest a family consultation. Though there are many difficulties we believe family interviews could be a help both to patients and to doctors studying the studing of family medicine.

Summary

One hundred families were invited to interviews by their general practitioners. The response, the form and length of interview, social groups and general impressions are recorded. It is believed that an extension of these interviews could be of help to families and to doctors studying family medicine.

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