Understanding How Physicians and Patients Communicate About Family History.

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Objectives

- To examine the prevalence of family health history discussions in a low-income primary care setting.
- To identify the process, content, context, and outcomes of those discussions.

Background

- Family health history provides important info. for clinicians to use when making recommendations and decisions about patient care.
- Chart reviews & observational studies have shown that family history is often collected in primary care.
- No studies examined 1) what was collected 2) how discussed 3)context or outcomes of the discussion.

Methods

Population: Family medicine residents and patients from a single primary care practice in Detroit, MI.

Design: 90 videotaped primary care sessions from an ongoing study were reviewed. Visits were recorded between 2005-06.

Procedures: The 90 visits were reviewed for instances in which a Family History Discussion (FHD) occurred.

- *Content Analysis*: Developed a codebook in order to code process, content, context, and outcomes of FHDs.
- Two independent coders used codebook to code FHDs

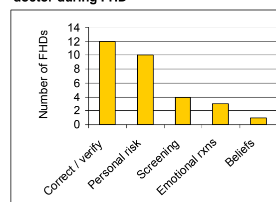
Results

Table 1. Characteristics of visits & FHDs

Characteristics of visit	n	mm:ss
Appointment time	90	38:40
Provider time	90	17:45
Wait time	90	20:56
Visits with ≥ 1 FHD	20	---
FHD time/person	---	01:02
Total # of FHDs	31	---
Avg. FHD time	---	00:40
Characteristics of FHD(s)	**n**	**%**
Timing of FHD †	*31*	*100%*
Beginning of visit	18	60.0
Mid-visit	8	26.7
End of visit	4	13.3
Person initiating FHD		
Physician	21	68.0
Patient	10	32.0

† 1 missing value

Figure 1. Types of information provided by doctor during FHD



Total # of FHDs=31; Overall info was provided in 12/ of the 20 visits. Docs did not talk about genetic testing, family member risk or general risk with patients.

Table 2. Characteristics of patients and physicians.

Patient characteristics	n	(%)	Physician characteristics	n	(%)
Total	90	(100)		28	(100
Age (yrs)			**Age (yrs)†**		
Avg. age (SD) [range]	46 (15) [20-82]	------	Avg. age (SD) [range]	31 (3.2) [26-41]	------
Gender			**Gender**		
Female	68	(76)	Female	16	(57)
Male	22	(24)	Male	12	(43)
Race			**Race†**		
Black	92	(91)	Asian	13	(46)
Other	8	(8)	White	6	(21)
			Other	7	(25)
Education			**Residency**		
< High school	22	(25)	Year 1	2	(7)
HS degree	20	(23)	Year 2	11	(39)
Some college	29	(33)	Year 3	15	(53)
≥College degree	17	(19)			
Income			**Med School †**		
< 40K	58	(64)	U.S.	3	(12)
≥ 40K	24	(27)	Not U.S.	23	(89)
Refused	8	(9)			
Satisfaction w/ medical care			**Discussed family history**		
High	60	(68)	Yes	14	(50)
Low	28	(32)	No	14	(50)
General Health					
Poor/Fair	41	(46)			
Good	34	(38)			
Very good+	14	(16)			

† There were 2 missing values for patient satisfaction. There were 5 missing values for physician age, and 2 missing values each for physician race and graduated from US medical school.

Screening:
Quote

Emotional Reactions:
Quote

Personalized Risk:
Quote

Personalized Risk:
Quote

Beliefs:
Quote

Table 3. Different types of conversational contexts in which FHDs occurred.†

Conversational Context	n	(%)
Symptoms	8	*(25.8)*
Risk Factors	6	*(19.4)*
Changing behavior	4	*(12.9)*
Physical exam	2	*(6.5)*
Breast health	5	*(16.1)*
Colonoscopy	1	*(3.2)*
Relative's cancer	1	*(3.2)*
Annual physical	1	*(3.2)*
Disease beliefs	1	*(3.2)*

† Denominator is # of family history discussions (n=31); 2 missing values.

Table 4. **Types of recommendations provided during FHDs.†**

Information type	n
Mammography/Breast exams	2
Colonoscopy	1
Follow-up testing	2
Follow-up information	1
Medication	1
Diet/vitamin supplements	1
Exercise	0
Genetic testing	0

† Recommendations were made in 5 visits (25%).

Conclusions

- Family history discussions (FHD) were infrequent (22%), and short (44 s).
  - •32% of the time the patient initiated.
- No significant differences between those with FHD and those without (results not shown).
- Multiple, varied contexts for the FHD.
  - •Changing behavior as a context suggests that FHD may be used to motivate change.
- Personalized risk & screening information were more common types of info provided.
  - •FHD may be discussed in terms of motivating/reinforcing behavior.
- Recommendations provided infrequently.

Future Directions

- Examination of how cultural and social factors impact FHD in the clinical context.
- Formative research into how/whether to systematize FHD and collection.

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