Perceptions of the Family Physician by Patients and Family Physicians

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The professional definition of the family physician is not based on research that considers both patient and family physician perceptions. Questionnaire responses from 86 family physicians and 287 patients from ten family practices in Los Angeles were analyzed to compare their attitudes, perceptions, and expectations of the family physician. Both groups agreed the family physician could handle most medical problems (including hospital care), should provide continuity, should emphasize preventive medicine, and should be caring. The physician's manner and skill were felt equally important. Family physician and patient expectations conflicted in four major areas: referral, the handling of emotional problems, concern with and care of family, and the issue of autonomy. Such research may help the development of family practice and improve the patient-family physician relationship through improved graduate and continuing medical education for family physicians.

Much of the early structural and organizational support and definition of family practice has come from within the medical profession.[1-4] Critics charge that this one-sided development of family practice has neglected the perceptions and behaviors of the intended patient population, and thus, family practice and primary care programs "meet the needs of the providers and their speculations about consumers."[5] A few studies have specifically explored patient opinion about family practice.[6-10] Fewer have studied the special attitudes that exist between the patient and the family physician.[11,12] This study explores whether patients and family physicians agree or disagree in their perceptions and expectations of the family physician. Results that identify areas of conflict may then be used to improve the family physician-patient relationship and family practice.

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Methods

Two questionnaires were developed and tested at the University of California, Los Angeles (UCLA) Family Practice Center. Each a mirror of the other, one was for family physicians and the other for their patients. Two subgroups of family physicians were surveyed by mail. Group I is a random sample of 210 of the 790 family or general practitioners included in the 1978 membership roster of the California Academy of Family Physicians (Central, North, and South Bay Los Angeles Chapters) and the Los Angeles County Medical Association Sections of Family or General Practice (Districts 1, 5, 8, and 9), which covers the larger part of metropolitan Los Angeles. Group II

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Table 1. Profile of Family Physicians Surveyed

	Mean Age (Range)	Male (%)	Board Certified (%)	Under 10 Years in Practice (%)	Practice Forms				
					Solo	Partnership	FPG	MSG	Other
Group I (N=76)	56 (27-86)	88	18	43	63	7	11	11	9
Group II (N=10)	44 (32-56)	90	100*	70**	60	10	10	20	0

FPG=Family practice group MSG=Multispecialty group
*P <0.001
**P <0.05

consists of ten practicing family physicians who are clinical faculty at UCLA and practice within the same geographic area as Group I, and who volunteered to complete questionnaires.

Patient questionnaires were distributed to 60 *consecutive* patients (or parent if under age 17) in nine of the ten Group II practices, and were mailed to a *randomly* selected sample of 60 patients from the tenth Group II practice during October 1978. Those returned by November 30, 1978, are included in the results.

Data were analyzed by the Pearson chi-square method with Yates' criteria. For the analysis, Group I plus Group II is used as one sample of all family physicians. Furthermore, even though all patients have been selected from Group II practices, their responses are treated as representative of all patients when compared to the combined family physician group. This bias is discussed later.

The Family Physicians

Of the 210 physicians surveyed in Group I, 10 were excluded because of wrong address or death, and 76 were completed (36 percent response rate). All ten Group II questionnaires were completed.

As shown in Table 1, Group I physicians are older, have practiced longer, are less likely to be board certified, but are engaged in similar practice forms as Group II. Nine tenths of all family physicians graduated from US medical schools. None of the physicians of Group II and only 11 percent of Group I completed a family practice residency, but this difference is not statistically significant. Eighty-seven percent of Group I physicians are actively practicing. Weekly office hours for Group I and II physicians average 36.4 and 41.2 hours, respectively, with 80 percent of all physicians claiming four to six patient visits per hour.

No significant differences exist between the two subgroups regarding why they are in Los Angeles, their activities prior to their present practice, or what influenced their office locations. The availability of specialists was not a primary reason for practicing in Los Angeles for eight of the ten Group II and for 55 percent of the Group I physicians, but this is not significantly different. Except for factors related to age, Group II will be considered as representative of the larger group of family physicians, permitting their addition to Group I when compared with patient responses.

The Patients

Of the 287 patient responders (47 percent return), the average age is 45 years, and 69 percent are female. About half of the patients come from a childhood hometown of less than 100,000 people, and 82 percent have at least a high school diploma or more education. One fourth have lived in Los Angeles less than ten years and one half for more than 20 years, yet only 22 percent of the patients have been with their family physician for more than ten years. Two thirds found their present family physician upon recommendation of a friend or relative, 17 percent were referred by another physician, and 2 percent chose the family physician from the telephone book. Most patients, 68

percent, live within nine miles of their physician, and 62 percent visited him/her one to four times during the last year. Of the patients who have a physician in solo practice or in group practice, 77 percent prefer the practice form of their own physician. Almost all patients as well as physicians prefer the patient to see the same physician each time.

Almost 50 percent of the patients see their family physician for all medical care, and only 16.5 percent also have an obstetrician-gynecologist. Seventy-one percent live with at least one other adult, and one third have at least one child. Forty-one percent of the other adults at home also see the same family physician, ranging from almost 90 percent in a prepaid multispecialty group to 6 percent in the newest solo practice.

Results

Role, Skills, and Competence

Over 90 percent of patients and physicians agree that a family physician (1) could handle most medical problems; (2) should care for the patient who is hospitalized; and, importantly, (3) should encourage a patient to take steps to preserve his health, such as to stop smoking, exercise, and lose weight. Fewer patients believe a family physician should take care of *all* members of the family, 50 percent compared to 62 percent of the physicians ($P<0.001$). Significantly more physicians than patients value the family physician taking account of family circumstances in dealing with patients (Figure 1A).

Significant differences exist when assessing specific skills a family physician might handle *without referral,* especially regarding most emotional and behavioral matters which patients accept much less often than physicians (Figure 2). More agreement exists over certain clinical skills such as vasectomy, nutrition, genetic counseling, drug abuse, and abortion. While three fourths of patients accept the family physician's primary role with birth control, this is still significantly fewer than the family physicians themselves. Only one fifth of both groups feel a family physician should deliver babies, which may reflect the urban sample. Of the emotional problems, depression is most considered within the scope of a family physician

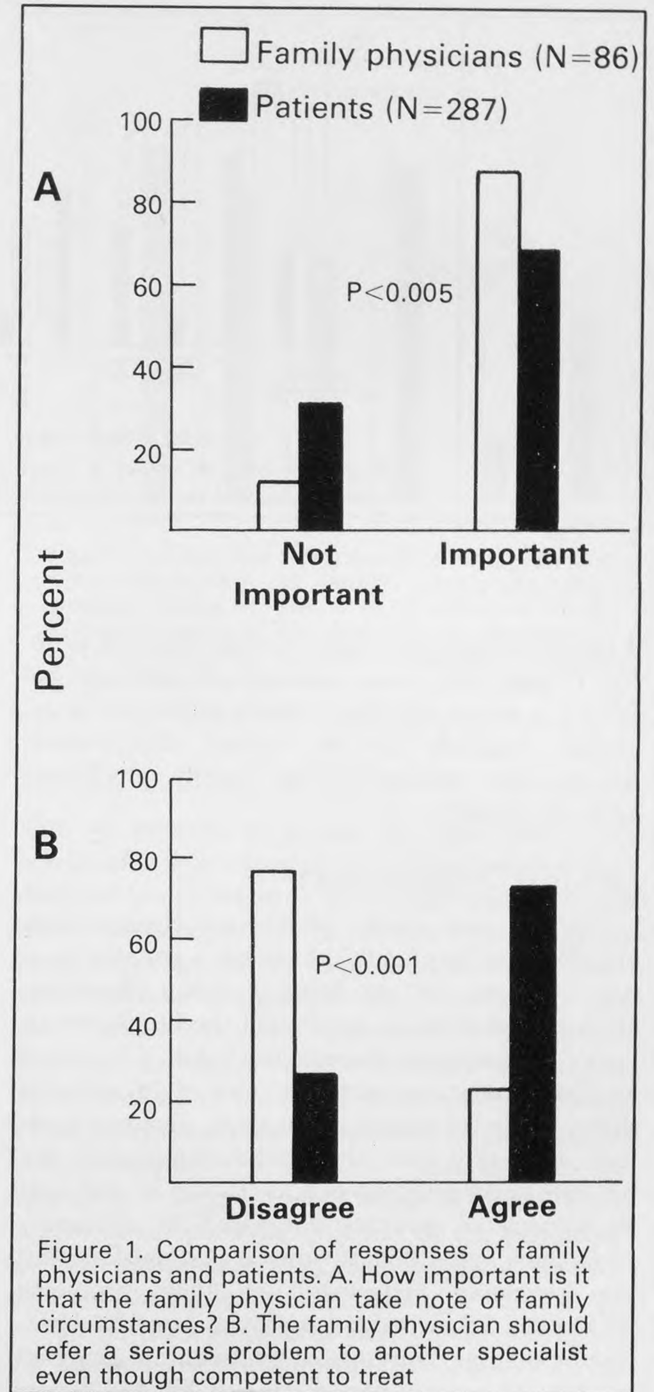

Figure 1. Comparison of responses of family physicians and patients. A. How important is it that the family physician take note of family circumstances? B. The family physician should refer a serious problem to another specialist even though competent to treat

by patients. Almost 25 percent of all patients have consulted their family physician for nonmedical problems, but half feel another person or agency would be more helpful.

In marked disagreement with the physicians, patients feel strongly that a family physician should refer a serious problem to a specialist even

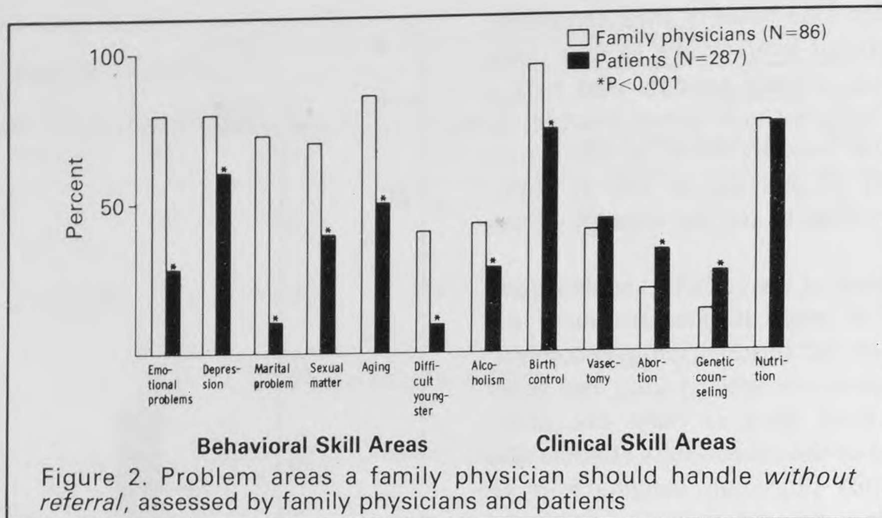

Figure 2. Problem areas a family physician should handle *without referral*, assessed by family physicians and patients

if the physician were competent to treat the problem (Figure 1B). More patients, 86 percent, believe it is important that a family physician be assessed regularly as to his/her competence. Seventy-five percent of the family physicians agree (P<0.005).

Personal Characteristics

Patients and family physicians clearly place emphasis on the family physician's general manner, conduct, and on being a caring physician. Both groups strongly agree that the family physician's manner is as important as skill, 87 percent and 94 percent, respectively. Out of 16 attitudes that a family physician might have, personal qualities and skill are also rated comparably by patients and family physicians (Figure 3). Yet only 70 percent of patients compared to all family physicians agree that at times it is important that the physician just listen to their problems (P<0.001). Likewise, sympathy, as a personal gesture or an important form of treatment, is accepted by only 24 percent of the patients but by 76 percent of the physicians (P<0.001).

In testing the attributes of honesty, patients are significantly more adamant that it is wrong for the family physician to let a patient believe the physician can do something he/she cannot do. Forty-two percent of the patients disapprove of the family physician seeming hopeful no matter what he/she thinks, compared to only 12 percent of the family physicians.

Control and Negotiation

Disagreement exists within the power relationship between patients and physicians. Compared to only 14 percent of the family physicians, 38 percent of the patients feel the doctor should not try to pressure the patient who chooses not to accept the physician's advice (P<0.005). More patients, 36 percent, insist that a patient should be seen by his family physician even though he/she may be short of time; only 14 percent of the physicians strongly agree (P<0.005). More than 70 percent of the physicians feel a patient prefers to be told what to do, while only half of the patients would agree (P<0.001). Nine tenths of the physicians believe in using their own discretion in deciding how much is good to tell a patient about his illness, but over half of the patients disapprove. Only when a patient is seriously ill do almost all patients agree with the family physician's role to help the family adjust.

Discussion

The conclusions and recommendations of the influential reports of Millis,[1] Willard,[2] the World Health Organization,[3] and Folsum[4] on the need for primary care and family practice in the United States seemed already predicated on that need. Unlike previous research with the exception of a Vancouver study,[11,12] the present study compares the perceptions and expectations of patients *and* family physicians in Los Angeles about the family physician, identifying specific examples of agree-

ment and disagreement. Bias must be considered in the results because of the urban sample and because the patient group is selected only from ten practices and compared to a larger group of physicians.

Patients in this study and Cahal's[8] were very concerned about physician competence in clinical skills but still believe the family physician can handle most medical problems (including hospital care), should provide continuity of care, and should emphasize preventive medicine. Patients and family physicians markedly disagree, however, on whether a family physician should refer a serious problem to another specialist even when the physician is competent to treat. This patient view may reflect a basic expectation of the family physician as a referring physician and/or that patients perceive their own medical problems as more serious and complicated than they appear to the physician. Unless recognized by the physician, perceptual differences can contribute to a fragile physician-patient relationship, with the patient underestimating the physician's skills.

The professional literature describes the family physician's ability to recognize problems in the context of the patient, family, and environment.[2,13-15] In this study and Warner's,[11] however, fewer patients than physicians expected a family physician to take into account family circumstances when caring for the patient, except during a serious illness. Why patients feel this way about the family physician is unclear. An urban family practice population in a specialist medical environment may feel differently about the family physician. Patients may be stating a preference for a personal physician rather than a family physician with the expanded definition. Or they may be strictly interpreting the question and simply mean they prefer a physician to focus on their immediate problem rather than show concern through inquiries into family matters. The true meaning of these points, which is essential to the definition of family practice, requires clarification in other studies.

Cahal reported that only one fifth of patients felt it is important for a family physician to know how to get along with a patient or family and concluded that a good manner is of little importance to patients in a physician-patient relationship.[8] Warner felt that patients seemed more interested in skill than in a pleasing personality,[11] agreeing

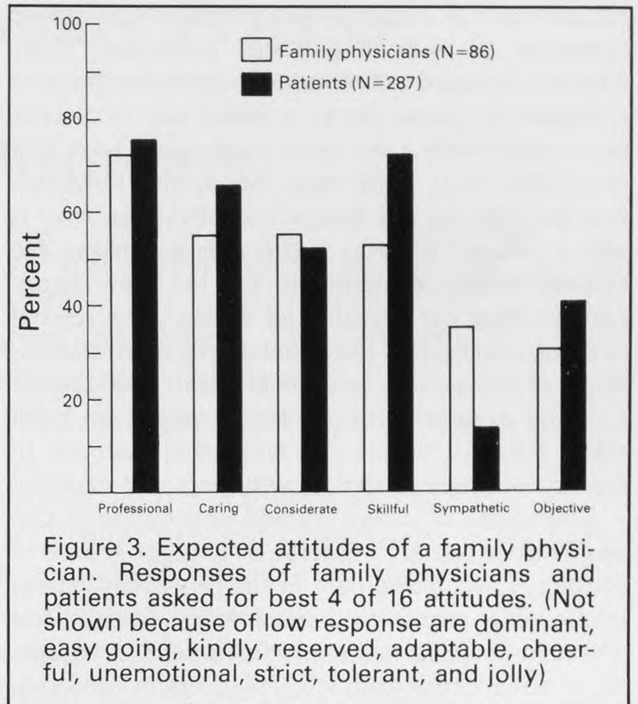

Figure 3. Expected attitudes of a family physician. Responses of family physicians and patients asked for best 4 of 16 attitudes. (Not shown because of low response are dominant, easy going, kindly, reserved, adaptable, cheerful, unemotional, strict, tolerant, and jolly)

with 41 percent of Koos' 70 rural New York households who changed physicians because they doubted the physician's knowledge and skill.[7] On the other hand, Doyle and Ware report that the most important factor associated with consumer satisfaction with medical care is physician conduct, which takes into account both the art and technical aspects of care.[16] Kasteler also recognized that two of the major reasons for patients to change physicians are related to personal qualities and competence.[17] Women, who consult the physician more than men, seem to place greater emphasis on personal qualities of the physician-patient relationship than male patients who emphasized competency and efficiency.[6,9] But in this study, in which 70 percent were female, the family physician's manner and skill seem equally important to both the family physicians and patients.

The ability to deal with nonmedical and behavioral problems is held to be important in training new family physicians.[3,13-15,18,19] As in the present study, only about one fourth of patients in England and Canada consult the family physician with their personal problems,[6,11,12] but the family physician should be totally prepared to deal with them. Why more patients do not expect this of a family physician may depend on the limited time for some

patient visits or the physician's manner and lack of openness to discuss personal problems. Cartwright concluded that a patient was more likely to consider the physician as a friend and to discuss personal problems the more years spent with that physician.[6] It is clear from this study, however, that patients do not accept the physician who is just a listener or who substitutes sympathy for clinical action or treatment. On the other hand, patients may not perceive an illness to be related to emotional factors even though the interrelationships of stress and disease are well recognized. Training programs for the family physician must teach effective verbal and nonverbal methods to convey willingness to deal with personal matters.

The issues of autonomy and negotiation in this and Warner's study[11] emerge as a major source of conflict. Each participant in the physician-patient relationship seems to expect more control and power in decision making, referral, and in accepting or not accepting advice. This conflict conforms to the basic models of therapeutic interaction of Szasz and Hollender,[20] with patients calling for the mature physician-patient relationship based on mutual participation and respect, in contrast to a parent-child relationship, which physicians seem to prefer. To improve patient understanding and compliance, family physicians must continue to learn to recognize and encourage patient involvement in the therapeutic process.

Conclusion

The importance of patient perceptions in shaping a specialty has been described.[21] Just as patients of a physician in solo practice tend to prefer solo practice, and those of physicians in a group practice prefer that, individual physician differences may also determine each practice to be different and influence how patients define the family physician. By including both physicians and patients in the present study, concordant and conflicting views of the family physician can be identified. Intervention designed to change perceptions and improve patient satisfaction could be directed to two areas: patient education about family physicians and physician education to improve physician attitudes and conduct.[16] In this way, family practice will develop by taking into account the perceptions and expectations of its patients.

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References

1. Millis JS (chairman): The graduate education of physicians. Report of the Citizens Commission on Graduate Medical Education. Chicago, American Medical Association, 1966
2. Willard WR (chairman): Meeting the challenge of family practice. Report of the Ad Hoc Committee on Education for Family Practice of the Council on Medical Education. Chicago, American Medical Association, 1966
3. Training of the physician for family practice. Geneva, World Health Organization, 1963
4. Folsum MB (chairman): Health is a community affair. Report of the National Commission on Community Health Services. Cambridge, Mass, Harvard University Press, 1966
5. McKenna MS, Walker WEC: Do patients really want "family doctors?" N Engl J Med 295:279, 1976
6. Cartwright A: Patients and Their Doctors: A Study of General Practice. London, Routledge and Kegan-Paul, 1967
7. Koos EL: The Health of Regionville. New York, Columbia University Press, 1954
8. Cahal MF: What the public thinks of the family doctor—folklore and facts. GP 25:146, 1962
9. Hulka BS, Kupper LL: Correlates of satisfaction and dissatisfaction with medical care: A community perspective. Med Care 13:648, 1975
10. Kaim-Caudle PR, Marsh GN: Patient satisfaction survey in general practice. Br Med J 1:262, 1975
11. Warner MM: Family medicine in a consumer age: Parts 1-4. Can Fam Physician 23:569, 706, 809, 925, 1977
12. Warner MM: Consumers, family physicians, allied health workers, and sociomedical problems. JR Coll Gen Pract 27:431, 1977
13. Report of the Committee on Preparation for General Practice, Organizational Section. JAMA 170:681, 1959
14. The core content of family medicine. Report of the Committee on Requirements for Certification (joint committee of the American Academy of General Practice and the AMA section on General Practice). In Transactions of the 1966 Congress of Delegates of the AAGP, Kansas City, Mo, 1966. Reprinted in: GP 34:225, 1966
15. Bryan JE: The Role of the Family Physician in America's Developing Care Program. St. Louis, Warren H. Green, 1968
16. Doyle BJ, Ware JE Jr: Physician conduct and other factors that affect consumer satisfaction with medical care. J Med Educ 52:793, 1977
17. Kasteler J, Kane RL, Olsen DM, et al: Issues underlying prevalence of "doctor shopping" behavior. J Health Soc Behav 17:328, 1976
18. American Medical Association: Special requirements for residency training in family practice. In Essentials of Approved Residencies. Chicago, American Medical Association, 1968
19. Hornsby JL, Kerr RM: Behavioral science and family practice: A status report. J Fam Pract 8:299, 1979
20. Szasz TS, Hollender MH: A contribution to the philosophy of medicine. Arch Intern Med 97:585, 1956
21. Goode WJ: Community within a community: The professions. Am Sociol Rev 22:194, 1957