# Attitudes of Patients Toward Family Care in a Family Practice Group

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There is little information documenting the extent to which the ideal of whole family care is represented in the real world of family practice. A previous study of a suburban family practice group revealed that only 28 percent of families obtained whole family care from a single physician. Interviews were conducted on a sample of 97 of these patients in an effort to gain insights into the factors influencing the choice of a single physician or more than one physician providing their health care. There were no significant differences between same-physician and different-physician families with respect to demographic factors or attitudes toward physician characteristics and family care. Most families had no insights into the potential value of having a single physician for the whole family; indeed, only one family specifically selected a single physician with the belief that it would thereby gain better care. If the observations reported here are representative of the situation at large in the country, family physicians have an important task ahead in patient education.

As a specialty, family medicine embraces the ideal that health care for individual persons can best be given through an awareness and concurrent care of other members of their family.[1-6] There is little systematic evidence, however, documenting how closely the real world of family practice approximates this ideal. With rare exceptions, investigations of the use of family physicians have avoided the question of whether all family members obtain care from the same physician.[7] McKenna and Wacker[8] surveyed a closed-panel comprehensive group practice in a university setting and found that only 20 percent of adult couples voluntarily established a relationship with the same primary physician. More directly, Fujikawa et al[9] performed a detailed chart analysis of a suburban group family practice that actively encouraged patients, both by a policy statement in its new patient brochure and through scheduling procedures, to select one physician for the entire family. Despite these efforts, in only 28 percent of

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the families did all members obtain their care from the same physician. Since there is considerable evidence to support the benefits of whole family care,[6] it would be valuable to search for factors that might account for the discrepancy between the ideal and observed behavior.

This study was undertaken as a follow-up of the previous report of Fujikawa et al and consists of interviews with patients designed to identify factors and attitudes that might influence family care patterns.

## Methods

This study was conducted at the same group private practice in a suburban community contiguous with San Diego, California, previously described.[9] The community in which the practice is located is composed of 97 percent whites having a median income of $10,481; only 6.7 percent of the residents had household incomes below the poverty level, and over a majority of households (69.2 percent) consisted of a married couple with children (ie, traditional nuclear families). In the two years between the first study and the present one, the composition of the patient population has remained largely white and middle class; the group practice has grown from 9 to 12 family physicians.

The original design of this study was to interview a random subset of the 500 patients in the previous study. Because there was no assurance that a random subset would make office visits during the available period of the study, an attempt was made to interview families at home. Because such a large proportion of the random sample refused to cooperate with this effort, however, it was concluded that the results obtained might not be representative of the original group; therefore, an alternative study plan was devised.

Between December 1980 and March 1981, 127 patients were interviewed subsequent to an appointment with his or her physician. No effort was made at randomization. Instead, interviews were conducted on different days of the week and at various times of the day with patients whose family members all shared the same physician and with patients whose family members were cared for by different physicians in an attempt to gain a representative sampling of all patients seen by the group family practice. The patient was introduced to the interviewer (LB) by the patient's physician following a medical consultation or while waiting for test results. The project was briefly described to the patient by both the physician and the interviewer, and any questions were answered. No patient refused to be included in the study. The interviews lasted from 6 to 15 minutes.

To be included in the study, the patients had to fulfill the same criteria as those in the previous study: they had to be at least 16 years old and treated by their primary physician for at least two years. A "family" consisted of a household with two or more members and included married and nonmarried couples, single parents with children, and married couples with children. In the previous study, the subjects were those who had made a medical visit at any time during a three-year period. In this study the subjects were actively consulting their physician for health care problems. Of the 127 people interviewed, 27 lived in single-person households and were not included in the analysis. Upon reviewing the cases, three other subjects were found to be outside the definition of the study group—leaving 97 cases for analysis. The family physician was defined as "treating the whole family" when the subject stated that all other members of the household were cared for by the same physician. All data were numerically encoded and statistically analyzed by chi-square and *t* tests.

Each person was interviewed with the aid of a structured and open-ended questionnaire divided into three parts. The first part was designed to collect demographic data: age, education, occupation, residency, health insurance, other family members, names of physicians, and length of time under the care of these physicians. The second part consisted of a ranking on a four-point scale (not important, somewhat important, very important, and extremely important) the value given to various aspects of family care and physician characteristics. The last part consisted of open-ended questions, allowing the patient to describe how he or she had chosen a physician, why the household did or did not use a single family physician for the entire family's health care, and other matters the patient volunteered with respect to his physician and family care.

**Table 1. Characteristics of Families Obtaining Care From the Same Family Physician and Families Obtaining Care From Different Physicians**

| | Same Physician Mean (range) or Number (%) | Different Physician Mean (range) or Number (%) | P* |
|---|---|---|---|
| Number in family | 3 (2-6) | 3.2 (2-6) | NS |
| Number of years under physician's care | 9.46 (2-20) | 8.22 (2-20) | NS |
| If children, number under 16 years | 1.68 (1-4) | 2.12 (1-4) | NS |
| Age (yr) | 43 (16-74) | 36.5 (19-67) | NS |
| Distance to clinic (mi) | 4.7 | 5.4 | NS |
| White collar or professional | 39/65 (60%) | 15/32 (47%) | NS |
| Retired | 13/65 (20%) | 6/32 (19%) | NS |
| Medicare | 7/65 (11%) | 3/32 (9.5%) | NS |
| Group (HMO) | 9/65 (14%) | 8/32 (25%) | NS |
| Major medical | 12/65 (18%) | 10/32 (31%) | NS |
| None | 4/65 (6%) | 3/32 (9.5%) | NS |

*Differences of values expressed as means were tested by *t* test with separate group estimates of variance to adjust for unequal numbers. For values expressed as percentages, differences were compared by chi-square

## Results

Of the 97 subjects whose interviews were analyzed, 65 claimed that their families used a single physician for all members in the household, and 32 stated they had different physicians for different members of the family. The demographic and insurance characteristics of both groups were nearly identical (Table 1).

There were no significant differences between the two patient groups with respect to the wide range of family care and physician characteristics surveyed (Table 2).

An analysis of correlations of demographic data with family care and physician characteristics, however, showed several interesting associations: older patients tended to believe that having a single family physician was more important ($r = .3155$, $P < 0.001$). Patients whose families were under the care of a single family physician tended to prefer a physician who related to them on a "personal" level ($r = .3805$, $P < 0.001$). As the number of children in a family increased, the proximity of the family to the physician's office became an important factor ($r = .3022$, $P < 0.001$).

Perhaps the most interesting data were collected during the third portion of the interview, the open-ended questioning phase, at which time several areas of discussion were raised. These areas included how and why the patient originally selected his physician, the ideal traits of a family physician, the reasons the household did or did not use a single physician for their entire family's health care, and what, if any, were the advantages of having a single physician providing care for the entire family.

Most families chose their physicians based on recommendations from friends or family (60 percent of the same-physician group and 40 percent of

**Table 2. Mean Values Assigned to Family Care and Physician Characteristics**

| | Same Physician (n = 65) | Different Physician (n = 32) | P* |
|---|---|---|---|
| To see the same physician as seen earlier in life, eg, childhood, before marriage | 1.77 | 2.17 | .198 (NS) |
| For the entire family to see the same physician | 2.12 | 1.79 | .145 (NS) |
| That the physician is close to home or office | 1.95 | 2.09 | .465 (NS) |
| To see a different physician from rest of family | 1.01 | 1.13 | .224 (NS) |
| To see same physician each time | 2.70 | 2.55 | .318 (NS) |
| To see specialists for each problem | 1.45 | 1.88 | .049 (NS) |
| To like your physican | 3.14 | 3.12 | .910 (NS) |
| To feel physician is competent | 3.19 | 3.12 | .653 (NS) |
| For physician to know you as a person | 2.88 | 2.61 | .088 (NS) |
| To have a family physician, not a specialist | 2.52 | 2.58 | .742 (NS) |
| To have insurance coverage for the office visit | 1.40 | 1.55 | .425 (NS) |

Note: 1 = not important, 2 = somewhat important, 3 = very important, 4 = extremely important
*All comparisons were analyzed by *t* test with separate group variance estimates to adjust for unequal numbers

the different-physician group). The next largest group (20 percent of each category) had selected their physician at random. Ten percent of those whose families were cared for by more than one physician had been referred by a specialist. The remaining categories of choice were composed of widely varying reasons, including factors related to physician retirement and recent moves into the area. Only one patient expressed a desire to select a physician for the whole family as the reason for that choice of physician.

When asked to describe the most important characteristics in their physicians, the patients responded with a wide variety of descriptors (eg, "pleasing personality," "caring," "instills confidence," "easy to talk to"), with no clear pattern of differences between the two patient groups.

Of the 32 families using different physicians, 6 had their children under the care of a pediatrician, and 6 saw a specialist as their primary physician (obstetrics-gynecology, cardiology, rheumatology, and allergy). To ensure privacy, three subjects expressly did *not* want to share their physician with other family members. Five different-physician families could be considered failures of the group practice itself in that they were referred to different physicians as care became necessary and so developed relationships with physicians not seen

by other members of the family. Five subjects had their own physicians before marriage and chose to remain under these physicians' care.

Of the patients whose families were cared for by the same physician, almost one third had "no special reasons" for having a single physician for the whole family. Twenty percent cited "better care" as the reason, but when pressed to describe what they meant by this term, they were unable to do so. A smaller group (15 percent) stated that "it makes the family more comfortable," and 12 percent stated that "it keeps the family together." A similar proportion had a family physician simply because their family "always had one," and they saw no reason to change. A smaller group (6 percent) preferred a single family physician for economic reasons. Again, only one patient chose a single physician for the entire family intentionally with the belief that it would provide better care and a broader perspective on health and illness.

## Discussion

Demographic factors such as age, distance to the clinic, presence or absence of children, occupation, or health insurance coverage were not significantly different between same-physician and different-physician families. Nor were the attitudes expressed by the interviewed subjects toward family practice significantly different between the two groups. Most subjects expressed the opinion that having their entire family see the same physician was either not important or only mildly important regardless of the actual physician utilization pattern of their family.

Of the families who utilized multiple physicians, only one third had unavoidable circumstances necessitating such use. The other two thirds of families seemed to have misinformation concerning the role of the family physician (eg, "I didn't know he saw children"). Furthermore, only one half of the interviewed patients could list any advantages to having a single family physician.

Among those whose families were cared for by a single family physician, almost one half could provide no reason for seeing the same physician—it just happened. Only one person had intentionally sought a single physician for the whole family. Of the remaining families, judgments based on perceived competence, convenience, economics, and other related issues accounted for their decisions. When asked to consider the advantages of total family care, less than one half of those whose families saw a single physician actually thought that this pattern of utilization was beneficial.

This study is limited to a single group family practice in a suburban, predominantly white middle-class area; therefore, it is uncertain how widely these results can be generalized. Certainly in physician shortage areas families are more likely to obtain all their care from a single physician, but they have little choice. However, for the ideals of family medicine to be taken seriously by those outside the specialty, they also must be shown to work effectively in the majority of urban and suburban settings in the country. It is noteworthy that a majority of relatively well-educated patients, connected almost nine years with a group family practice that has made a strong effort to espouse the ideals of whole family care, do not seem to be strongly influenced by these ideals. If this is representative of the situation at large in the country, it would seem that family physicians, if they truly believe in the benefits of total family care, have an important task ahead in patient education.

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