Characteristics of Patients Seeking Family-Oriented Care

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A self-administered questionnaire was distributed to 570 adult patients at three family practice centers to identify the demographic characteristics of those whose entire household was cared for at the same facility. Two of the three centers were free-standing community-based ambulatory care sites, and the third was situated adjacent to a community hospital. Although 95 percent of respondents considered the family practice center their usual source of care, only 54 percent sought care for every household member. Among this latter group, marital status (divorced patients) and race (white) were shown to be significant determinants of health care utilization by families. The implications of these findings are discussed with recommendations for further research to better define the characteristics and expectations of the population served by family physicians.

Family practice has long been concerned with providing continuous, comprehensive, and personalized health care to families. In fact, it is this family-oriented approach that is said to be the hallmark of the discipline.[1] Family-oriented health care may be understood in several ways. The particular attitudinal approach of family physicians that views the person in the context of family or community has been difficult to capture for rigorous study. For the purposes of this study, family-oriented health care is taken to mean that every member of the patient's household is seen by the same provider (provider continuity) or by several providers at the same geographical site (site continuity).

A 1978 survey by Hyatt[2] noted that only 50 percent of patients felt that a family physician should care for all family members. Fujikawa et al[3] reported that only 28 percent of families (excluding single-person households) received care from the same physician in a private practice setting. More recently, Chatterton et al[4] reviewed their experience at the Duke-Watts Family Medicine Center. In their study, only 63 percent of respondents using the Family Medicine Center considered it their usual source of care and only 35 percent of their other household members shared this perception. The conclusion of these authors was that family medicine may well set higher expectations for family care than are realized in practice.

Family practice patients fall into at least two groups with regard to their health care utilization

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and preferences. First, there are those seeking comprehensive, continuing care for themselves and their families. The ability of family physicians to respond to the needs of this idealized population has been heralded by the American Academy of Family Physicians and family practice educators for some time. The second group consists of episodic users, who for a variety of reasons do not share this family-oriented approach. It is not at all clear what characteristics, if any, distinguish these two populations.

The purpose of this study was to examine the demographic characteristics of patients who prefer family-oriented health care. Presumably, if family physicians can identify these individuals, they could better target their special skills to a more receptive and appreciative population.

Methods

The study utilized the patient populations from three family practice centers affiliated with the San Bernardino County Medical Center. All patients aged 18 years and older who visited these centers during a one-month period (January 18 to February 19, 1982) were included (n = 625). Patients were regarded as "established" if they had visited the same facility at least once previously (n = 570, 91 percent). Only these established patients were included in the analysis.

A self-administered questionnaire was distributed to patients while they waited to be seen by their family physicians. The questionnaire was available in both English and Spanish, and an assistant was available if patients had any difficulties in responding to specific questions. All questionnaires were subsequently returned.

In addition to demographic information, respondents were asked to list the number of adults and children in their households as well as the number of household members who utilized the Family Practice Center. In this manner, respondents whose entire household was reported to have been seen at the Family Practice Center could be compared with those where at least one household member was not utilizing the same facility. The standard chi-square test of association was used to measure the relationship of demographic characteristics to household utilization (every member seen, not every member seen).

Results

While the vast majority of those sampled (95 percent) considered the Family Practice Center their usual source of care, only 54 percent sought care for every member of their household. Among the demographic characteristics expected to influence the utilization pattern of the Family Practice Center, only marital status and race were shown to be significant determinants (Table 1). Respondents who were divorced or white tended to have every household member seen at the same Family Practice Center. Another determinant appeared to be the race or ethnic background of the patient's physician. Patients seeking family-oriented care tended to be of the same racial background as their physician.

Age, sex, employment or payment status, and prior health care experience were not found to be associated with the pattern of utilization by families. The distance of the patient's home to the Family Practice Center, the number of previous visits to the Family Practice Center, the number of physicians seen by the patient at the same Family Practice Center, and whether the Family Practice Center was considered to be the usual provider of health care were found of little importance in determining the health care preferences of this sample.

Discussion

As in all such residency programs, the Family Practice Program at the San Bernardino County Medical Center highly values comprehensive and continuing care as integral to the philosophy and teaching of family medicine. Given that this is a large training program (48 residents distributed among three family practice centers), the emphasis has been on site continuity as a necessary first for a group family practice. The provision of care in a single location ensures continuity of information[5]; that is, a single medical record is accessible

Table 1. Characteristics of Respondents by Household Utilization of Family Practice Center

Respondent Characteristics	Utilization of Family Practice Center*	
	Every Household Member Seen	Not Every Household Member Seen
	No. (%)	No. (%)
Age (yr)		
18-29	70 (23)	71 (28)
30-49	74 (25)	71 (28)
50+	156 (52)	115 (45)
Sex		
Male	67 (26)	53 (20)
Female	238 (74)	207 (80)
Marital status**		
Single	48 (16)	51 (20)
Married	134 (44)	134 (52)
Divorced	122 (40)	71 (28)
Ethnic background†		
White	161 (53)	109 (43)
Black	34 (11)	30 (12)
Hispanic	90 (30)	91 (36)
Other (Asian, etc)	16 (5)	26 (10)
Payment mode		
Self	30 (10)	35 (14)
Private insurance	24 (8)	25 (10)
Medi-Cal	251 (82)	199 (77)
Employment status		
Employed	58 (19)	34 (13)
Unemployed	240 (81)	220 (87)
Prior health care		
Private physician	113 (38)	90 (36)
Other (clinic, etc)	182 (62)	161 (64)
Sex same as physician		
Yes	79 (26)	86 (33)
No	226 (74)	174 (67)
Ethnicity same as physician†		
Yes	152 (50)	106 (41)
No	153 (50)	154 (59)

*Totals by category differ because of incomplete items on questionnaires
**$P < .01$
†$P < .05$

to all providers when the patient's personal physician may not be available. This informational continuity has been easier to ensure than has provider continuity, perhaps because of the varying responsibilities of the resident physicians.

The majority of respondents identified the

Family Practice Center as their usual provider of care, yet only one half of these sought similar care for their entire families. As mentioned earlier, a possible explanation is that few patients may be aware of the range of services provided by family physicians. Alternatively, many household members may be already established with other providers and unwilling to change for reasons of family-oriented care alone. To be sure, individuals value this approach to health care to varying degrees. Unless the index respondent holds an influential position within the household structure and highly values this family orientation, he or she may be unable or unwilling to direct each household member to receive care by the same physician.

Patients who were divorced tended to seek family-oriented care more than single or married individuals. These individuals may be in need of a support system and incorporate their health care provider in this network. An alternative explanation is that the psychophysiologic stress associated with divorce influences the health or health behavior of each family member.

The tendency of white patients to have all household members seen by the same provider may be due in part to the large number of resident physicians of similar race. It is also possible that these individuals have more exposure to medical care than minority groups. It is well documented, for example, that the Hispanic population tends to utilize medical care to a lesser degree than other groups.[6] The finding that patients with the same ethnic background as the physician tended to have increased family utilization indicates that interactions between patient and physician may have an important bearing in identifying persons who will seek total family care. Moreover, this finding may have implications for the location of practice sites for family physicians.

A limitation of this study could involve the self-reporting of health care utilization by single family members. No attempt was made to verify that every household member had actually been seen at the Family Practice Center.

There are few, if any, demographic characteristics that might distinguish patients seeking family-oriented care. Perhaps there are other determinants that were not examined such as educational background and patient knowledge of the services provided by family physicians. In a recent study using a similar sample in the same care setting, patients completed an average of 11.1 years of school.[7] There is every reason to believe that the patients included in this study were of comparable educational background and socioeconomic status (low).

The findings of this study support the conclusion of Hyatt[2] that there are a number of people who simply prefer to obtain health care for their family members from multiple sources. Recognizing this, two categories have been established for charting patient visits. Temporary charts are used for patients who are first seen, for those seeking episodic care, and for patients who, for whatever reason, do not wish to identify a single physician as their health care provider. Permanent, family charts are designed for established patients (those who have made more than two visits to the same practice) and their household members who expressly desire a personal physician.

The reasons behind these patient preferences are as yet unknown but are undoubtedly complex. It is clear that further studies in this area are needed to define both the characteristics and expectations of this family practice population. The positive factors that may contribute to the attraction of patients to family-oriented care, a process that may still be going on in San Bernardino, need to be explored. The long-term survival of the discipline may well depend on its ability to identify and respond appropriately to those seeking family-oriented care.

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