Importance of Obstetrics in a Comprehensive Family Practice

Lewis E. Mehl, MD, Calvin Bruce, MD, and John H. Renner, MD
Madison, Wisconsin

Four family practices in the San Francisco Bay Area, two of which did not include obstetrics and two of which did, were examined with reference to their patient populations and to the number of families for which they provided comprehensive, continuous family care. The groups practicing without obstetrics were found to do acute care primarily and, to a lesser extent, long-term care internal medicine, with very little pediatrics or gynecology. The groups practicing with obstetrics did significantly more minor surgery, gynecology, pediatrics, and psychotherapy. During the six-week study, the group practicing with obstetrics saw five times as many patients who were members of families receiving continuous, comprehensive care from the practice under observation. Psychotherapy done by the group including obstetrics was primarily family therapy; for the other group, individual therapy. If larger studies support these findings, then important implications are suggested for training programs in family practice and for the resident deciding to enter practice.

With the inception of training programs in family practice, many authors began to question the content of family practice. How much obstetrics, pediatrics, internal medicine, psychiatry, and surgery should the family practitioner know and practice? The range of opinion has varied from defining the family practitioner as a primary care internist to including the entire spectrum of medical practice within the family practitioner's domain, with the question of when to refer left to the discretion of the individual practitioner. Wilson[1] and Deisher[2] have seen the family physician as a synthesizer assisting the patient in integrating his personal health needs with his other needs and aspirations within his family and his community. Deisher calls for training in family practice to curb the tendency to teach ever more deeply in limited specialties and instead to promote the development of connecting insights which link one intensive discipline with another.

From the Department of Family Medicine and Practice, University of Wisconsin, School of Medicine, Madison, Wisconsin. Requests for reprints should be addressed to Dr. John H. Renner, Chairman, Department of Family Medicine and Practice, University of Wisconsin Center for Health Sciences, 777 South Mills Street, Madison, Wis 53715.

Haggerty[3] defines the family practitioner "as a medical specialist in the care of the family, doing little surgery and usually little or no obstetrics. They are primarily concerned with adult and child medical care . . . in ambulatory settings." McWhinney[4] describes the primary attribute of the family physician as commitment to the person rather than to a body of knowledge or a branch of technology. He states, "To a physician who achieves fulfillment from human relations it may not make much sense to say, 'I will commit myself to people provided they are over 14, or under 65, or under 14, or male, or female, or provided they are not pregnant.' "

In our opinion, the family physician's domain is the full range of health and emotional problems of the family and the relation of these problems to the family's cultural milieu. Whatever the family requires professional assistance or intervention for becomes the domain of the family physician – from delinquency to pregnancy, from well-child care to coronary care – with the family practitioner personally guiding the family through any further specialized care which may be required. This is a kind of family systems approach, synthesizing the general practice ethic of concern and commitment described by Balint[5] and the family systems approaches developed by Bowen,[6] Glick and Haley,[7] and Minuchin,[8] as well as many others.

We felt the need for a pilot study directed at determining how the inclusion or exclusion of obstetrics affected a developing family practice with regard to the configuration of patient problems encountered, the delivery of comprehensive, continuous family care, and the personal interest and satisfaction of the physician. We examined this in the context of several relatively new family practices in an area with easy access to specialists and a wide variety of health-care alternatives: the San Francisco Bay Area. It was felt that, as McWhinney[4] noted, trends in patient preference and selection procedures would be reflected in such a diverse area.

Methods

Four San Francisco Bay Area practices were chosen for this, two which offered obstetrical care and two which did not. The physicians' intentions upon entering practice and their training were otherwise similar. All had entered practice with plans to deliver comprehensive, continuous family health care. A brief interview with each group was obtained to document any differences between the groups in their philosophy toward health care, importance of obstetrics, the role of the obstetrician and the pediatrician, and their satisfaction with their practices.

All four practices included individuals with one or two years of post-medical school training. Practice 1 was composed of three physicians, ages 30, 34, and 38; practice 2, two physicians ages 28 and 32; practice 3, three physicians practicing as part of a multispecialty group, ages 34, 35, and 36; and practice 4, two physicians, ages 30 and 32. Practices 1 and 2 included obstetrics and are designated as group A; practices 3 and 4 did not and are designated as group B. Practice 1 had been in existence for five years, practice 2 for two years, practice 3 for eight years, and practice 4 for three years. A medical student was usually involved with practice 1. It is interesting to note, also, that practice 1 began with the intention of excluding obstetrics, but decided to include it

	Practice 1	Practice 2	Practice 3	Practice 4
Role of obstetrics in family practice	Integral; key to successful general practice of medicine	Very important; only way to provide total health care to a family	Not necessary for a successful family practice	Important, but obstetrician better trained to handle obstetrics
Relation of the obstetrician to family practitioner	Should be hospital based consultant	Should be hospital based consultant	Handles all obstetrics	Better able to handle obstetrics
Relation of pediatrician to family practitioner	Should be hospital based consultant	Special consultation only	Should handle some of pediatrics family practitioner not trained to handle	Better than family practitioner at handling pediatric problems
Satisfaction with practice	Very satisfied	Very satisfied	Mildly dissatisfied	Somewhat dissatisfied
Plans for the future	No change	No change	Considering more acute medicine and emergency medicine	Considering specialty training
Attitude toward obstetrics beginning practice	Not sure if wanted to be involved	Wanted to be very much involved	Wanted to be involved but practicalities made it difficult	Did not feel competent to be involved but would have liked to
Role of family practitioner	Comprehensive family care	Comprehensive family care	Comprehensive family care	Comprehensive family care

Table 1. Attitudinal Differences Between Family Practices Including and Excluding Obstetrics

Table 2. Frequency Distribution of Office Visits by Diagnostic Category

	Practice 1 %	Practice 2 %	Practice 3 %	Practice 4 %
Pregnancy	21.6	18.3	0.3	0.2
Pediatric health maintenance	7.4	6.0	0.9	1.2
Pediatric sick visits	18.0	12.8	2.3	1.2
Gynecology visits	12.7	17.8	10.3	6.1
Geriatric visits	7.6	6.7	25.1	16.1
Adult medicine visits	7.2	12.7	22.0	23.2
Adult acute or episodic visits	13.5	16.5	29.4	50.8
Orthopedic visits	4.1	4.0	0.1	0.2
Dermatology visits	2.7	0.6	0.4	1.7
Minor surgery	3.0	2.5	0.1	0.2
Psychotherapy	2.2	2.1	0.2	1.3
Total	100.0	100.0	100.0	100.0

during the first year of practice. Practices 3 and 4 were willing to provide prenatal care, but not delivery care. Given the availability of obstetricians, most patients did not elect this. All groups followed the recommendations of the American Academy of Pediatrics for well-child care.

Acute, episodic adult medicine visits for such ailments as sore throats and upper respiratory infections were defined as non-persistent adult medical problems. Adult medicine visits were defined as including problems requiring long-term care. Pediatric sick and health maintenance problems were differentiated in the same manner. Diagnostic categories for other problems are self-evident. Orthopedic problems included bruises, falls, back pain, fractures, and other musculoskeletal problems. Lacerations were considered under episodic care. Minor surgery included such procedures as breast biopsy, needle aspiration and removal of subaceous cysts. Procedures such as vacuum aspiration abortions, cervical cryocauterization, and

intrauterine device insertions were defined as gynecological procedures. Skin biopsies were considered dermatological procedures.

For each practice, the reasons for patient visits over a six-week period were reviewed, and analyses of the frequency distributions of visits were carried out. The percent of patients seen who were members of families for which the group was providing continuous, comprehensive family care was calculated. Continuous, comprehensive family care was defined as care in which all members of the immediate family were seen for at least six months by the practice group. The communities in which the practices were located were similar in terms of ethnic and age composition and socioeconomic status.

Categories of office visits were defined so as to be mutually exclusive. Dermatological visits included skin problems in both geriatric, pediatric, and adult populations, with the exception of vulvovaginal problems which were included under gynecological visits. Orthopedic problems included those problems occurring in pediatric, geriatric, and adult populations, as did minor surgery and psychotherapy. Thus, pediatric, adult medical, and geriatric problems were defined as medical problems occurring in those specific age groups exclusive of dermatologic, orthopedic, minor surgical, psychiatric (meaning those problems to which therapy was applied), or gynecological problems.

Table 3. Intergroup Differences in Absolute Number of Patients Seen by Main Diagnostic Category of Visit[2]

	Group A Practices Including OB	Group B Practices Excluding OB
Pregnancy	612	11
Pediatric health maintenance	216	26
Pediatric sick visits	500	45
Total pediatric visits[1]	716	71
Gynecology visits	500	187
Geriatric visits	225	524
Adult medicine visits	271	565
Adult acute or episodic visits	411	776
Orthopedic visits	122	6
Dermatology visits	37	26
Minor surgery	85	5
Psychotherapy	64	20
Total	3,058	2,199

[1] The sum of pediatric health maintenance and pediatric sick visits.

[2] All differences are statistically significant to $p<0.001$ except for psychotherapy where $p<0.01$ and dermatology where p is NS.

Results

Table 1 illustrates attitudinal differences among the practices. Practices 1 and 2 were convinced of the importance of obstetrics in family practice, although practice 1 had excluded obstetrics at first. When questioned regarding this change, members of practice 1 stated that they had realized that "obstetrics was essential in the general practice of medicine." All practices felt that the role of the family practitioner was to provide continuous, comprehensive family care. Practices 1 and 2 were satisfied with their practices and desired no major changes. Neither practice 3 nor practice 4 was satisfied with their practice. Practice 3 was considering changing their practice to encompass more acute and emergency medicine, while members of practice 4 were considering specialty training in internal medicine.

Table 2 presents the frequency distribution of various categories of office visits, and Table 3 and Figure 1 summarize the differences between groups including and excluding obstetrics. Certain differences are apparent. Practice group B saw fewer children than practice group A ($p<0.001$), and saw many more adult medicine and acute, episodic problems ($p<0.001$). Group A saw twice as many gynecological problems ($p<0.001$), fewer geriatric problems ($p<0.001$), more orthopedic problems ($p<0.001$), an equivalent number of dermatological problems (not significant), more minor surgery ($p<0.001$), and more psychotherapy ($p<0.01$). Psychotherapy performed by group A was primarily marital and family counseling; that by group B was primarily individual counseling.

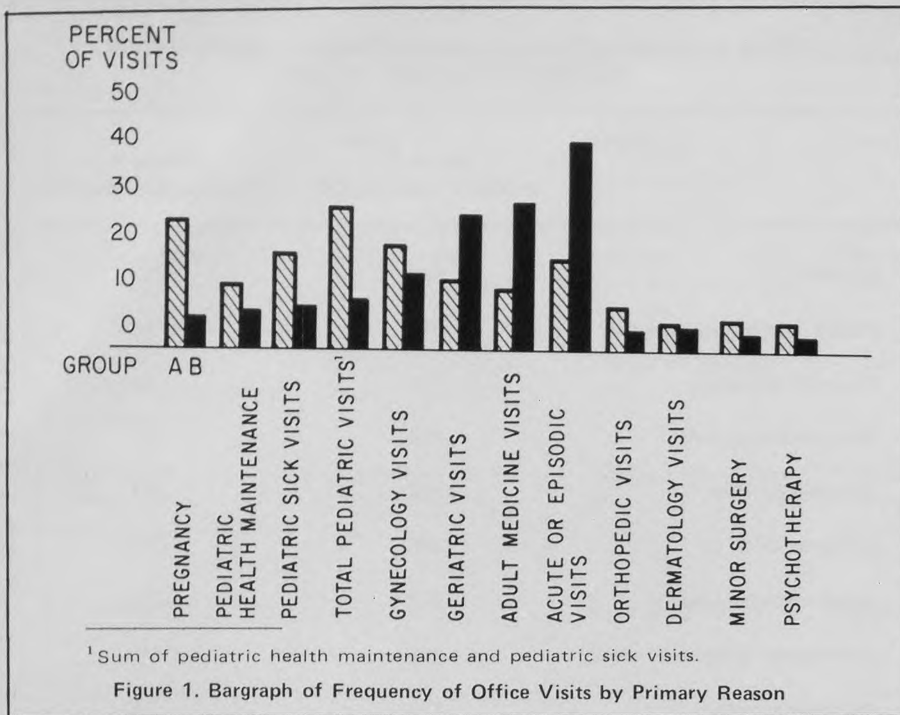
Table 4 and Figure 2 illustrate the percent of patients in each category of visit in which the patient seen was a member of a family receiving its comprehensive care from the practice listed. From these tables it is seen that certain reasons for visit are much more likely in group A, including family therapy, minor surgery, pediatric care, and pediatric health maintenance. Table 5 illustrates the reason for visit of those patients who were members of families receiving their comprehensive care from the practice group. The

table also illustrates the relative contribution of each diagnostic category to the total number of families seen. The number of entire families cared for by practice group A is approximately five times greater than for practice group B. The role of adult medicine visits in drawing families to the practice seemed to be the same for both group A and group B; the factor contributing to the greater number of families seen by practice group A seemed to be visits for pregnancy, pediatric health maintenance, pediatric sick visits, gynecology visits, and minor surgery visits.

Discussion

From the data presented the hypothesis can be supported that obstetrics is of key importance in the establishment of a comprehensive family practice. Practice group B very much resembled the practice expected of a primary care internist, while practice group A better resembled the usual descriptions of a family practice, with a large pediatric population and seeing many problems other than internal medical problems. The data seem to support the hypothesis that without obstetrics a developing family practice becomes indistinguishable from the practice of a primary care internist. The study group was small, so that this hypothesis must be tested with a larger number of participants in a wider range of geographic areas. With only four practice groups, the attitudes of the practitioners may have had much to do with the characteristics of their practices. We think it is significant, however, that all practice groups began with the same overall goal – providing comprehensive family medical care – and that three of the four began practice with plans to exclude obstetrics.

The dissatisfaction of members of practice group B may relate to the discrepancy between the type of practice they had anticipated and the characteristics of their existing practice. All had begun practice planning to treat entire families and to have a practice consisting of at least one-quarter pediatrics. The small numbers of families and children seen may have contributed to their dissatisfaction. This also relates to anthropological views of the function of the family and its clear relation to the begetting, bearing, and rearing of children. Varia-



[1] Sum of pediatric health maintenance and pediatric sick visits.

Figure 1. Bargraph of Frequency of Office Visits by Primary Reason

Table 4. Percentage of Times for Category of Visits in which the Patient Being Seen was Part of an Entire Family Receiving Comprehensive Care

	Practice 1 %	Practice 2 %	Practice 3 %	Practice 4 %
Pregnancy	84.1	79.5	12.11	51.31
Pediatric health maintenance	98.2	98.0	98.0	97.0
Pediatric sick visits	70.3	80.3	47.5	12.3
Gynecology visits	54.4	33.2	9.0	10.1
Geriatric visits	89.9 12.1[3]	69.6 1.9[3]	75.7 0.6[3]	11.9 0.1[3]
Non-acute adult medicine visits	57.6	45.2	14.5	12.2
Episodic adult visits	65.7	46.3	12.1	3.1
Orthopedic visits	80.3	49.6	22.5	5.0
Dermatology visits	81.1	75.0	14.9	10.1
Minor surgery	100.0	86.0	81.3	88.0
Psychotherapy	98.2	93.0	8.1	6.2

[1] Referred after diagnosis of pregnancy ascertained
[2] Care involving grandparents, parents, and children of one family

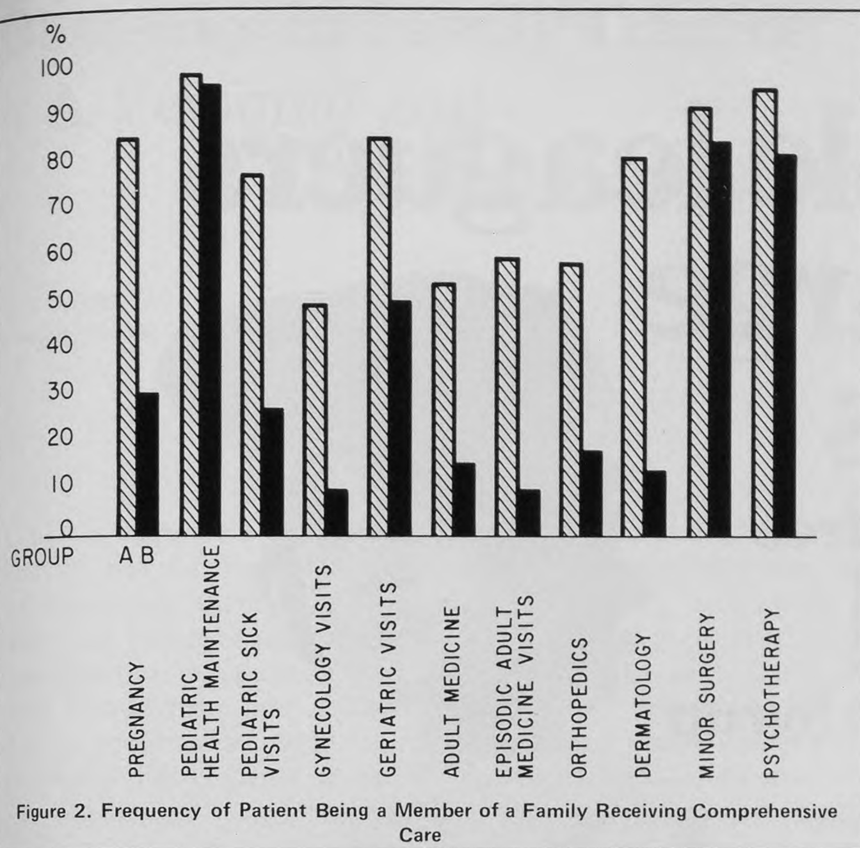


Figure 2. Frequency of Patient Being a Member of a Family Receiving Comprehensive Care

Table 5. Relative Contribution of Each Diagnostic Category for Visit to the Percentage of Families Receiving Comprehensive Care

	Group A %	Group B %
Pregnancy	16.6	0.1
Pediatric health maintenance	6.9	1.0
Pediatric sick visit	12.3	0.5
Gynecology visit	7.7	0.8
Geriatric visit	6.2	1.0
Adult medicine visit	4.6	3.3
Episodic adult medicine visit	8.0	3.3
Orthopedic visit	0.2	0.04
Dermatology visit	0.1	0.1
Minor surgery	2.6	0.2
Psychotherapy	2.0	0.6
Total of Families Seen	57.0	11.14

tions of this basic theme are observed in primates as well as humans.[9] For the family practitioner not to be involved in this basic process may make him superfluous to the needs of the family.

We hope that this small pilot study will have some important results – namely that family practitioners will examine our conclusions in the light of their own personal experience and that directors of residency training programs will begin to explore the implications of this important factor. If larger studies support our hypothesis, then there are important implications for health-care planning and resident education in family practice. For the concept of comprehensive family care to remain viable, it would seem that obstetrics must remain an important part of family practice. For residents not planning to include obstetrics in their future practice, training needs will be different, and might best be met by a program resembling the primary care internal medicine training programs. For residents planning to include obstetrics in their future practices, then a broad-based training program is needed with much emphasis on obstetrics and gynecology, pediatrics, internal medicine, orthopedics, minor surgery, family psychotherapy, and other medical specialties. Future studies should utilize the independent physician profile or similar data for developing practices, and might also be able to ascertain the relation of geographical area of practice to the kind of resident education required.

References

1. Deisher JB: What is so special about a family physician? West J Med 121: 521-529, 1974
2. Wilson VE: Family practice – pioneer or slave to the past. Am Fam Physician 1(4): 131-138, 1970
3. Haggerty RJ: Family medicine and pediatrics. Am J Dis Child 126: 13-14, 1973
4. McWhinney IR: Family medicine in perspective. N Engl J Med 293: 176-181, 1975
5. Balint M: The Doctor, His Patient, and the Illness. New York, International Universities Press, 1957
6. Bowen M: The use of family theory in clinical practice. Compr Psychiatry 7:345-374, 1966
7. Glick I, Haley J: Family Therapy and Research. New York, Grune and Stratton, 1972
8. Minuchin S: Families and Family Therapy. Cambridge, Mass, Harvard University Press, 1974
9. Morris D: Primate Ethology. New York, NY, New American Library, 1969