Family Care in a Family Practice Group

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A fundamental claim of family medicine is that the family physician treats the "whole" family—an ideological principle that guides undergraduate and residency education. Using archival data obtained from a random sample of 500 patients in one group of family physicians, this study analyzed the extent to which this principle is carried out in practice. Physicians trained in family practice residency programs were compared with their colleagues. Family types and marital stability were also examined.

Results indicate that in only 28 percent of families (excluding single person households) were all family members seen by the same family physician. This occurred despite the high preponderance and stability of traditional nuclear families in the practice. There was no significant difference in this rate between graduates and nongraduates of approved family practice residency programs.

One of the ideological underpinnings of the specialty of family medicine—indeed what is often presented as its distinguishing feature—is the concept of family care. Simply stated, this is the belief that care for an individual can best be realized through an awareness of and the concurrent care of other members of the individual's family.[1-5] A typical expression of this view can be found in a standard textbook in the field:

> The specialist in family practice expects to perform a complete medical interview and physical examination periodically on each family member. The data obtained permit him to identify medical, social, and economic problems of each family member and of the family as a whole. Only with such a data base can the family be attended comprehensively and wisely.[6]

In addition to being an ideological guidepost for the development of the specialty, this emphasis on family care has given rise to an entire family oriented medical technology. For example, there is a growing literature about the use of family diagrams, family records, and family summary cards designed to provide the data base for family practice.[7,8] Researchers have begun to speculate about the elaborate variation of social interactions that might be achieved between members of a given family and members of a well-developed health care team led by a family physician.[9]

Surprisingly, despite the integral importance of the concept of total family care in family medicine, its underlying empirical assumptions have never been verified. Instead, the relationship between family physicians and entire family units has largely been taken for granted. Where attempts have been made to document the extent to which "whole" families are involved in family medicine, insufficient or inappropriate data, coupled with a biased research focus—usually departing from the unexamined assumptions—have interfered.

For example, 58 percent of all families comprising the patient population of the Family Medical Center at the University of Rochester's Highland Hospital were found to have all of their individual members registered at the clinic, but the extent to which all family members of a unit were seen by the same resident or faculty physician was not

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made clear.[10] Similarly, a study of ten neighborhood health centers revealed that 27.2 percent of the families (n = 206) had all of their members seen by physicians at one of the centers within a year of the first visit by a family member, but again whether the same physician was involved in the provision of such family care is not known.[11] In a study limited to married couples (n = 457) in a prepaid health plan, only 19.9 percent were found to use the same physician, but here the study was limited to only one type of family unit.[12]

Thus, despite the fundamental appeal of the total family care idea, there is only limited information concerning the extent to which family physicians engage in such care. The stimulus for this study was the desire to gain insight into the actual—as opposed to the ideal—relationship between family physicians and "whole" families. Using archival data on a random sample of 500 patients from a "model" family practice, this investigation explores the extent to which family physicians provide care to all members of a household or family. It also seeks to determine factors which may influence this process.

Methods

The Setting

Data for this investigation come from the charts of a group private practice in a suburban community contiguous with San Diego, California. The practice serves a predominantly white, middle class, and relatively stable population. According to the 1970 census, the community in which the practice is located is comprised of 97 percent whites having a median income of $20,481; only 6.7 percent of community residents were found to have household incomes below the poverty line. Well over a majority of households (69.2 percent) in the area are comprised of a married couple with children, ie, traditional nuclear families.

The practice, which was established just after World War II, is currently comprised of nine family physicians and one surgeon, complemented by full radiological and laboratory support services. Eight of the nine family physicians in the group are board certified, while the two newest (and youngest) are graduates of approved family practice residency programs. The brochure given to new patients makes it clear that the practice has a formal commitment to family oriented primary medical care: "Every family should have one doctor whom they regard as their family physician," and (the patient will have) ". . . the continuity of a physician who knows all the members of the family and their interrelated problems." The policy is implemented by instructing the group's receptionist(s) to schedule the appointment of family members with the same practice physician, unless that physician is unavailable, or the family member specifically requests otherwise.

Data Collection

This study is based on information obtained from an analysis of 500 individual patient charts. These charts were selected randomly from the population of 55,210 active charts comprising the practice in the summer of 1977. An active chart was defined by the practice as one in which the patient charted had been seen at least once within the past two to three years. Previous studies of this group practice showed that the adult married patients made an average of 5.5 physician contacts per year,[13] slightly higher than the national average for all patients of between four and five visits per year.[14-16]

The process of determining the extent to which practice physicians were involved with entire families was accomplished in a series of stages. First, for each chart sampled, a determination of the primary family physician was made. For the purposes of this study, the primary family physician of the patient (as well as other family members) was defined as the physician in the group who treated the patient continuously for at least the past two years, and was the patient's physician for at least 75 percent of visits to the practice. If these criteria could not be established from an analysis of individual charts, the case was dropped from study. Two years of continuous involvement with one family physician was used as the minimum period of observation in order to provide a reasonable length of time for the physician to make contact with all other members of the family. Approximately one out of two charts chosen had to be eliminated because a determination of the patient's primary physician, using the above criteria, could not be made. The final sample of 500 patient charts thus represents approximately one percent of the active charts.

Next, a determination of the patient's other family members was made. The use of the term

"family" refers to all members of the same household listed by the patient on the information sheet in the chart, regardless of whether or not they were related by marriage. In this research, therefore, the concept of family does not refer solely to the traditional nuclear family. Also included are households comprised of married and nonmarried couples; single parents with children; two married adults living with children; and a small number of households in which there are adopted or foster children. The decision to include in the analysis nontraditional households, as well as more traditional nuclear families, was based on a recognition of the many changes which have overtaken the character of family life in the United States during the last two decades.[17,18]

Once the other "family" (ie, household) members of patients were determined, it was then possible to establish which of these individuals was also seen by the physician of the patient. This was done by going back to the master file of the practice and seeing if each family member was registered. If so, his chart was pulled and the name of his primary physician recorded. Thus, for each patient in the sample, both the number of family members and information on each one's physician was documented.

Background data including age, sex, place of residence, marital status, past marital status, and number of years in the practice were also obtained for each patient in the sample. Additional data on general characteristics of the patient's family, other than physician utilization, were also recorded. Included was information concerning the patient's role in the family, the type of family structure, eg, nuclear or not, and family size. A family physician in the practice was defined as treating the "whole" family of a given patient in instances where analysis revealed that all other members were also found to be under the physician's care. For purposes of the analysis the small number of single person households included in the sample (n = 53) were excluded from consideration.

Results

Characteristics of the Patient Sample

Patients ranged in age from 2 to 93 years, with the median age of the sample being 30 years ($\bar{X}$ = 35 years). (Children under two years of age were excluded since they did not meet the minimum criterion of being in the practice at least two years.) The sample is almost evenly split between men (46.6 percent) and women (53.4 percent). Nearly half of those sampled are married (48.7 percent), while a majority of the remainder are single (42 percent of the whole sample).

Characteristics of the Practice

The practice can best be described as community based and stable. Nearly a third of the sample resides in the community in which the practice is located (28.7 percent), while an additional 68 percent resides in adjacent suburban communities or the city of San Diego.

Patients sampled have been associated with the practice between 2 and 26 years, with 7.5 years being the average length of time individuals have been under care at the practice. Given the extent to which Southern California, and San Diego in particular, have grown in recent years, these figures reflect the extent to which the practice is a well-established community institution. Stability of the practice is also indicated by the lack of frequency with which patients are found to change their primary physician. Only one out of ten patients (10.5 percent) sampled was found to have switched physicians for voluntary reasons.

The practice is fairly evenly divided among member physicians, although the physician treating the largest share of the sample sees over twice as many patients as the physician with the smallest number (14.3 percent and 6.0 percent). This differential can be explained in part because the physician with the smallest share of patients has been with the group for the least length of time.

Characteristics of Patient "Families"

The character of family life among patients served by this family practice group is remarkably traditional and stable, tending to reflect the nature of community life. Well over a majority of the sample (63.6 percent) lives in the traditional, nuclear family setting, ie, a conjugal unit with offspring. This figure is considerably higher than for both San Diego City (47.8 percent) and San Diego County (53.1 percent). It is also considerably greater than the 30 percent of adult Americans cited as living in nuclear family households in a recent study of alternative life-styles.[19] In contrast, only 0.8 percent of the sample was found to

Table 1. Pattern of Family Utilization of Family Physicians (n=447)

Pattern	Number of Families	Percent of Total
All family members see the same family physician	125	27.7
Some family members see the same family physician		
A. All other members see another physician in same practice	60	13.5
B. Only some other members see different practice physician	182	40.7
No family members see family physicians in the practice	81	18.1

Excludes patients in sample who are "single person" households.

Table 2. Rates of "Whole Family" Physician Utilization, by Family Size

Family Size	Number of Families	Number of Families Seeing Same Physician	% of Families Seeing Same Physician
2	125	55	44.0
3	89	28	31.4
4	97	19	19.5
5	81	18	22.2
6	27	6	22.2
7	18	0	—
8	7	0	—
9	1	0	—
10	1	0	—

live in family units with two nonmarried adults, while only 4.2 percent lived in single parent units. The last figure is particularly striking, given the recently acknowledged and documented rise in single parent births and life-style.[17]

Stability of family life associated with the practice is also suggested by the lack of change in the marital status of patients comprising it. No change in marital status was indicated in the records of a full 94 percent of those patients sampled, while only 1.6 percent were found to have divorced or separated since becoming patients. These figures must be considered remarkable in light of the 50 percent (or higher) divorce rate found in Southern California.

These data strongly suggest that traditional family life is very much alive and thriving in the practice (and the community) selected for this investigation. The family physicians under study must therefore be viewed as having a very favorable situation in terms of the extent to which they face the opportunity for total family medical care.

Physician Utilization by "Whole" Family

Table 1 presents data on patterns of physician utilization by families in this sample, where such units are comprised of two or more individuals. All individuals in the family unit are seen by the same family physician in just over one quarter (27.7 percent) of the households. At the other extreme, in nearly one fifth (18.1 percent) of the family units, no other individuals are seen by the family physi-

Table 3. Rates of "Whole Family" Physician Utilization, by Selected Factors

Factor	Number of Families	Number of Families Seeing Same Physician	Percent of Families Seeing Same Physician	χ^2
Physician Status				
Nonresidency trained	369	107	29	1.726
Residency trained	70	15	21	P=.19
Patient's Length of Time in Practice				
3 years or less	117	30	25.6	.232
4 years or more	329	94	28.5	P=.65
Patient's Place of Residence				
Practice Community	127	36	28.3	
Other San Diego Suburb	195	55	28.2	
City of San Diego	107	30	28.0	.4
Other California Community	16	3	19.0	P=.94
Patient's Marital Stability				
No Change	420	117	27.9	
Single to Married	17	6	35.3	
Married to Single	6	—	—	5.40
Divorced to Married	2	—	—	P=.15

cian of the index case. In the remaining 54.2 percent of the family units of patients in the sample, some, but not all, other individuals are treated by the same physician.

These data suggest that the actual relationship between family physicians and entire family units is not as strong as the professed intent. In less than one third of the patient-household units sampled is the "whole" family (ie, the entire unit) being cared for by the same family physician. Moreover, the concept of total family care is further challenged by the fact that in nearly one fifth of the family units, no other member is seen by the patient's physician. It should be noted, however, that these data are more encouraging, if only the rate of partial utilization is considered, since in over half of the family units, at least some other members are seen by the physician of the patient.

Family Care and Family Size

Table 2 shows the extent of whole family care in family units of varying size. The percentage of families in which all members see the same physician declines as the family size increases from two to four member units; from four to six member units, the percentage remains about the same. It can be assumed, of course, that not all family members have equality of choice. Thus, these data probably reflect the increasing proportion of children—whose decisions about medical care are presumably made by their parents—in the larger families. Families larger than seven showed no whole family care; however, it should be noted that at this point the sample size decreases considerably.

Impact of Related Factors

Table 3 presents data on rates of "whole family" utilization in terms of physician and patient characteristics which could potentially bear upon them. To ensure that observed differences in such rates are not an artifact of differences in family size, a chi-square analysis of the distribution of household unit size for each variable was performed. This testing procedure revealed no statistically significant differences ($P > .05$) in the distribution of the size of family units in the subgroups of each of the four factors considered.

Naturally, there was curiosity about the possible impact of family practice residency training on the relationship between family physicians and entire families, since the emphasis placed on

the whole family, prevalent in residency training, may have affected the orientation of those physicians having completed it. However, as Table 3 shows, residency trained physicians do not see more (in this sample, they see fewer) "whole families" than those who are not residency trained ($P>.05$).

As Table 3 also indicates, the rate at which "whole families" are likely to see the same physician is not greatly affected by characteristics of patients comprising the practice. No significant differences in the rate of utilization of the same physician are found ($P>.05$) between patients in the practice less than, and more than, four years; between patients living in communities at varying distances from the practice; and between patients from stable and not so stable marital environments.

Discussion

Data from this investigation indicate that in less than one third of the family units examined, family physicians provide care to all family members. These findings also indicate that "whole" family treatment by the two residency trained physicians was not more common than such care by family physicians without family practice residency training. Nor was whole family care significantly influenced by patient characteristics such as place of residence, marital stability, or length of time in the same physician's care.

This study, of course, was limited to family physicians in one urban group practice. Situations where the family physician is the only available provider—such as in certain isolated rural areas—would necessarily be more likely to permit total family care. But these data would certainly call into question the basis of such care. Would it be the achieved ideal of the physician(s) in question, or simply an artifact of the character of the setting?

Data contained in this research do not allow for a thorough analysis of the reasons for the incomplete relationships between family physicians and entire families. However, they do expose several possible explanations that can be discounted. In particular, the common notion of the "death of the family" cannot be offered as an explanation, since this was a practice setting in which traditional families predominated. Moreover, the classification of household units used in this study included life-styles other than the traditional nuclear family. Additionally, practice factors such as differences in proximity to the physician, or length of time in the practice, must also be eliminated, since controlling them did not significantly increase the rate of "whole" family utilization of physicians.

Exploration of the possible attitudinal factors (on the part of both family physicians and patients) which might explain the lack of total family care found in this study will require further interview research.

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