German Family Physicians’ Attitudes Toward Care of Involuntarily Childless Patients

Edith Ittner, PhD; Wolfgang Himmel, PhD; Michael M. Kochen, MD, MPH, PhD, FRCGP

Background and Objectives: Many family physicians regard fertility counseling out of their scope of practice, although key elements in the care of involuntarily childless couples fall within the theoretical framework of family practice. This study analyzed the doctors’ value system concerning the care of infertile patients and whether a personal interview leads to a greater sensitivity toward fertility issues.

Methods: We conducted 57 baseline and 51 follow-up interviews with family physicians in the area of Göttingen, Germany. We performed quantitative and qualitative analyses.

Results: During the baseline interview, all family physicians placed involuntary childlessness within the domain of fertility specialists or regarded it as patients’ private matter. Fourteen family physicians (27%) considered fertility counseling more important at the follow-up interview than at the time of the baseline interview. Judgmental views of infertile couples could be detected in both interviews. More than one third of the family physicians assumed a connection between the patients’ childlessness and their personal behavior or way of living. Although the majority (73%) of the family physicians regarded involuntary childlessness as a disease and considered assisted conception techniques as legitimate, a recommendation for fee reimbursement for fertility services was rejected by more than half of the physicians. Conclusions: Most German family physicians do not consider that care of involuntarily childless couples is within or appropriate to their scope of practice.

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Couples who have difficulty conceiving a child at some point during their reproductive lives may present to their family physician with fertility concerns. The family physician, in turn, must decide whether or not to refer these patients to specialists. Even for patients referred to specialists, the family physician is sometimes asked to provide counseling and information about the psychosocial and physical implications and the success rates of assisted conception techniques, such as in-vitro fertilization, intracytoplasmatic sperm injection, and gamete intrafallopian transfer.

Infertility is mainly caused by ovulation failure, infection-related tubal damage, and sperm defects or dysfunction. Approximately 25% of couples are diagnosed with unexplained infertility because no specific cause is identified. Family physicians, however, will find a broader variety of reasons for involuntary childlessness in their practice population than in specialty clinic populations. Problems identified in family practice also include nonmedical reasons for childlessness (such as problems in partnerships, sexual dysfunctions, or anxieties because of pregnancy complications) that are not amenable to medical treatments. In all these cases, but also if treatment for medical causes fails or if the infertile couple does not want to seek specialist care, the family physician is likely to be an important source of advice and support for childless couples.

Care of involuntarily childless patients is, therefore, a complex task that requires clinicians to consider the whole person in the context of the family. This approach is most central in family practice. In a previous study in the area of Göttingen, Germany, however, many family physicians regarded infertility as the patients’ private matter and placed it within the domain of specialists. Analyzing data from that study, we became aware of three issues that needed further investigation: 1) family physicians’ feelings toward infertile patients, 2) the role of social and economic issues (i.e., reimbursement) in the care of involuntarily childless
couples, and 3) the influence of participation in the first interview on the physicians’ attitudes and performance.

We conducted follow-up interviews with physicians from the first study that focused on three main objectives: 1) to gain better insight into family physicians’ value systems by confronting them with negative statements about involuntarily childless patients from the baseline interviews, 2) to determine the consequences of social and economic factors by asking the physicians a) whether involuntary childlessness is a social rather than a medical condition and b) whether health insurance should cover the costs of fertility investigation and treatment, and 3) to reveal whether the participating physicians had become more sensitive toward fertility issues—as a result of the Hawthorne effect, which is generally defined as the modification of subjects’ behavior due to their knowledge that they are taking part in a field experiment.14

Methods

Until May 1999, vocational training of family physicians in Germany took 3 years and included mandatory rotations in family practice, internal medicine, and surgical fields. The doctors also had to complete 240 hours of theoretical seminars, including 40 hours of basic psychosomatic care (e.g., psychosomatic-oriented diagnosis/therapy and training in interviewing skills). Starting in May 1999, vocational training for family physicians in Germany was expanded to 5 years, covering family practice, internal medicine, surgery, and pediatrics as mandatory fields. Theoretical seminars now take 80 hours (including 40 hours of basic psychosomatic care). OB-GYN, as many other subjects, may be chosen on a voluntary basis. No data are available regarding how much infertility care is provided by family physicians in Germany.

Physicians’ Recruitment

In the first study, all 68 accredited family physicians in the area of Göttingen, a university town of 130,000 inhabitants in northern Germany, and its rural catchment area were invited—by letter and additional telephone calls—to participate in a survey about fertility counseling.13 Over the next 2 years, we interviewed patients in each practice about their expectations about family and sexual counseling and their experiences, if any, of involuntary childlessness.7 At the end of these 2 years, all physicians who took part in the first survey were asked for a follow-up interview.

The Interview Schedules

In both surveys, we used semi-structured interview schedules, which focused on the physicians’ perspectives of fertility issues in family practice and personal experiences with involuntarily childless patients. In the follow-up interview, we confronted the physicians with some of their own or their colleagues’ moral judgments about involuntarily childless patients that had been collected in the previous interviews (Table 1) and asked them to comment on these statements. Since the interview data from the first survey revealed that the care of involuntarily childless couples touches on the problem of responsibility for infertility and reimbursement for infertility services, we included questions about whether the physicians view infertility as a medical or a social condition. In addition, we asked the physicians whether fee reimbursement by the health insurance companies should include the costs of fertility investigation and treatment. (In Germany, infertility evaluations, as well as eight cycles of insemination and up to four cycles of in-vitro fertilization, are covered by health insurance. To date, intracytoplasmatic sperm injection is usually not covered.)

Data Analysis

As previously described,13 the follow-up interviews were conducted by one of the authors. We decided not to tape-record the interviews because some physicians would have refused to participate under these circumstances. The interviewer, a psychologist, has been trained and has many years of experience in recording interviews by hand. The information obtained was recorded as literally as possible (six pages of written comments during the average interview), transcribed, and processed the same day.

We structured the written material according to the main themes. We analyzed the physicians’ statements in accordance with the guidelines of Miles and Huberman15 and Kuzel16 to identify the physicians’

<table>
<thead>
<tr>
<th>Statements From Interview I</th>
<th>Agreement in Interview II</th>
</tr>
</thead>
<tbody>
<tr>
<td>・ There is an inferiority complex among those women who are not able to have a child.............................................. 75%</td>
<td></td>
</tr>
<tr>
<td>・ The couples are to blame/have only themselves to blame for missing the point (of time) .............................. 14%</td>
<td></td>
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<tr>
<td>・ First a car, then a house, and then children ....................... 57%</td>
<td></td>
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<tr>
<td>・ I have the theory that there are nearly always relationship conflicts in which no children can be begotten ......................................................... 29%</td>
<td></td>
</tr>
<tr>
<td>・ Mostly, these are couples where you are happy that they didn’t have a child ...................................................... 14%</td>
<td></td>
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</tbody>
</table>
### Table 2
Communication About Involuntary Childlessness — Statements From Physicians Who Did Not Change Their Attitude From Interview I

<table>
<thead>
<tr>
<th>Physician (gender, age)</th>
<th>Statements From Interview I</th>
<th>Statements From Interview II</th>
</tr>
</thead>
<tbody>
<tr>
<td>M, 41 years</td>
<td>It is not my concern. The desire to have children belongs in the field of gynecologists, urologists, and psychologists.</td>
<td>I have no idea what my patients think about this. I didn’t try to find out.</td>
</tr>
<tr>
<td>F, 56 years</td>
<td>This topic was not discussed. I know couples who have remained childless. I did not ask them why. I would have found that tactless.</td>
<td>The situation has not changed. I ask about their family situation in the case history discussion. It is only information to me. I am not a gynecologist who can perform the further consultation.</td>
</tr>
<tr>
<td>M, 47 years</td>
<td>I have no idea how my patients plan their lives. Whether or not they don’t want to or cannot. I wait for the patients to address the subject.</td>
<td>I listen to everything that the patients say. But I don’t ask such things without a reason. I don’t find the topic that interesting.</td>
</tr>
<tr>
<td>M, 53 years</td>
<td>I don’t ask [about childlessness]. It is frequently a taboo topic. There are so few patients. The desire to have children—I cannot do that. When a “ninny” consults me once a year or even more seldom. I cannot master this topic.</td>
<td>I would never address anyone on this topic on my own. Many react sensitively to it. One can only achieve something in this area when the patients are suffering. Is this meddling, or do they expect me to ask—it is difficult.</td>
</tr>
<tr>
<td>F, 42 years</td>
<td>I do ask, ‘Would you like to have children?’ But that is not an offer to discuss whether there are problems in this area. I want to wait and see whether the patients address this topic of their own accord.</td>
<td>It is talent to be able to bring up the subject as a physician. One wants to address it, but my patients often don’t react to the attempt. One has used the wrong approach.</td>
</tr>
<tr>
<td>M, 46 years</td>
<td>I don’t know whether my patient desires to have children. The patients do not come as couples. The gynecologist is the primary contact for women. Men keep to themselves anyway.</td>
<td>Nothing has changed. I am not included in the treatment. That’s the way things are in urban areas: family medical treatment doesn’t exist. It’s up to the patients.</td>
</tr>
</tbody>
</table>

### Table 3
Communication About Involuntary Childlessness — Statements From Physicians Who Changed Their Attitude From Interview I

<table>
<thead>
<tr>
<th>Physician (gender, age)</th>
<th>Statements From Interview I</th>
<th>Statements From Interview II</th>
</tr>
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<tbody>
<tr>
<td>F, 38 years</td>
<td>I ask when the couple does not have a child. But when I notice that this is a problem area, I don’t. If I see that the couple is open for it, I do.</td>
<td>. . . Since our first discussion, my awareness of the problem has changed. I have become aware that there is a problem.</td>
</tr>
<tr>
<td>M, 38 years</td>
<td>I think that when it is causing someone problems, he or she should address it on his or her own initiative. It is not my responsibility. That is a couple’s most intimate area.</td>
<td>Normally the patients don’t come to us. It cannot be a focus of our work. The only thing is: your activities have made me a bit more sensitive so that I reconsider whether or not I can give any advice.</td>
</tr>
<tr>
<td>M, 33 years</td>
<td>Of course, I don’t ask every couple, ‘Why don’t you have any children?’ One is aware of it. So that one says, ‘Let’s take a look and see whether everything is OK.’ That is a reason to address it.</td>
<td>I have developed the ambition to be concerned about it. I have found out where I can send my patients.</td>
</tr>
<tr>
<td>F, 54 years</td>
<td>I know of patients who have this problem and I am informed of it in passing. . . . It is more likely to be mentioned by the patients.</td>
<td>I have somehow become more conscious of the fact that this topic should be something that concerns the so-called family physician.</td>
</tr>
<tr>
<td>M, 50 years</td>
<td>Things have changed. I have advised two or three married couples. . . . Up to that time I had not considered it to be an important, relevant topic. I now keep it more in mind.</td>
<td></td>
</tr>
<tr>
<td>M, 44 years</td>
<td>It [childlessness] is very seldom mentioned. If it is mentioned at all, then primarily by women.</td>
<td>My perception has been heightened. . . . So that I mention it. So that I offer . . . diagnostic help somewhat more selectively and more rapidly. Also to find out whether it is involuntary childlessness or periodically desired childlessness.</td>
</tr>
</tbody>
</table>
basic ideas and personal attitudes toward involuntarily childless patients and fertility counseling in family practice. Two of the authors independently analyzed all the interviews and compared their assessments. Complete agreement was reached between the two authors as to whether or not physicians changed their attitudes concerning communication about involuntary childlessness (see examples in Tables 2 and 3). However, the researchers disagreed in 3 of the 51 interviews as to whether physicians regarded involuntary childlessness as patients’ individual responsibility (Table 4). The matter was discussed until a consensus was reached.

Results

Subjects

In the first interview study, the analysis was based on 57 physicians. (Eighty-four percent of all accredited family physicians in the wider area of Göttingen participated in this study.) Two years later, three physicians had given up their practices and were excluded; another three declined the follow-up interview because of lack of time and/or interest. Thus, 51 physicians (94%) from the original sample agreed to be interviewed once again. The follow-up interviews lasted about 15 minutes. Twelve (24%) of the physicians were female. Their ages ranged from 33 to 79 years (median=51 years, SD=10.4).

All the physicians surveyed had completed at least 3 years of vocational training. On average, they had worked as family physicians for 16 years (SD=11.3). Thirty-nine percent of the practices were located in the city of Göttingen and the remainder in its rural catchment area.

Communication About Involuntary Childlessness in Family Practice

In the first survey, nearly all the physicians (95%) had regarded their work as family oriented. The majority (65%), however, had placed the topic of involuntary childlessness within the domain of specialists.

Table 4

| Individual Responsibility in Cases of Involuntary Childlessness—Pros and Cons From Interview II |
|-------------------------------------------------|-------------------------------------------------|
| **INVOLUNTARY CHILDLESSNESS AS DISEASE**         | **HEALTH INSURANCE COVERAGE FOR FERTILITY MANAGEMENT** |
| *(Code of interviewed physician)*               |                                                   |

**PRO**

- It is a right to be able to reproduce oneself. This is an elementary right. (50)
- Everyone should be able to have a child or to procreate. (03)
- Nature forgot something in this case. Something doesn’t function. (38)
- It is a social standard to have children. (56)
- Yes, because it causes psychic problems. Many women feel inferior to other people, especially their husbands. And this is also seen in this way by their husbands. (11)

**CON**

- I think it only has validity as a disease in the minds of those concerned. It is not a disease. (20)
- Childlessness is fate like a ‘handicap;’ something that one does not have... How can one cope with it? How can one integrate into one’s concept of life? (49)
- It’s bad luck; the opportunity has been wasted. (07)

**PRO**

- I think that funds should be made available for this... It is an elementary need. And psychic problems are created... It is an elementary right. (37)
- I don’t think that one should differentiate between those who can afford it and those who can’t. It is not social if only those who have the necessary money can have children. (11)
- There are technical opportunities. Yes, I am for fee reimbursement by the health insurance companies. In the past, people adopted children because these technical options were not available. (14)
- Infertility can lead to general health impairment. It would be more economical for the health insurance companies to pay now, because the consequential costs could be greater. (53)

**CON**

- There will have to be percentage excess... The person who orders the music must pay. We don’t live in ‘the Land of Plenty.’ (19)
- Fertilization medication is an expensive field... It is bad to fulfill the desire to have children at all costs... One must be limited to what is appropriate in the field of medicine, since the resources in the field of medicine are limited. (49)
- When I see that someone has been active in his or her profession until he or she is 35 and then with 40 says, ‘I want to have a child.’ Although he or she had previously rejected the idea. Why should the general public have to pay for it? (55)
- If someone desires children, he or she should make the decision and
The physicians presumed that the patients themselves would like to segregate fertility problems from their family practice and would prefer to seek specialist help. At the time of the follow-up interview, 22 family physicians (43%) did not know of any patient in their practice who had had fertility problems. These physicians were not accustomed to initially discussing fertility concerns in everyday practice. Table 2 shows the statements of those family physicians persisting in their point of view and attitudes in the repeated personal interviews.

Fourteen physicians (27%) reported that they had become more “sensitive” to fertility problems among their patients. In most cases, these physicians had already been open-minded about patients’ needs but were, at the time of the first survey, reluctant to address the topic of childlessness with their patients. These physicians now considered fertility counseling, performance of first-line investigations, and referral of involuntarily childless patients to specialist services more important than they had 2 years before (Table 3).

**Family Physicians’ Views on Infertile Patients**

In the follow-up interviews, the family physicians commented on some of their own or their colleagues’ characterizations of childless patients, which had been collected in the previous interviews. The physicians were confronted with five statements in which involuntary childlessness was, more or less, seen as a result of the patients’ personal behavior or lifestyle (Table 1).

About 75% of the physicians agreed to the characterization of childless women as feeling inferior (see Table 1, example 1), and more than 50% assented that these patients first preferred acquiring possessions to raising children (Table 1, example 3). Subsequently, the family physicians described their own impressions of and experiences with involuntarily childless patients. They emphasized the influence of fertility problems on personality, sexuality, social acceptance, and partnership. However, they also pointed to psychosomatic complaints (especially depression) and psychic disorders (eg, feelings of selfishness, guilt, and inferiority) as a consequence of involuntary childlessness. More than 33% alluded to the patients’ “excessive” desire to have a child or their tendency to postpone childbearing, respectively.

I believe that women often have an excessive desire for a child. And the more they pursue their aim the worse the result will be. (Interview II, age 39, male)

If you make money for 15 years and then, age 40 years, you desire to have children? Why haven’t you had the wish for children in the past 15 years? Is it (ie, the “advanced” age) good for the child—that’s the question, too. (Interview II, age 55, male)

**Involuntary Childlessness as a Medical Condition**

The majority of the family physicians (73%) agreed to the connotation of involuntary childlessness as a disease and, accordingly, did not support the assumption of individual responsibility for this condition. These physicians characterized reproduction as an instinct and childlessness as a “deviation from nature” or as a “physical defect” and emphasized that the assisted conception techniques now available should be used. These methods were seen as legitimate for medical causes of childlessness (Table 4).

In some contrast to these statements, only about half of the physicians (47%) recommended health insurance coverage for fertility diagnosis and treatment, especially to avoid involuntary childlessness being turned into a “question of finances.” These physicians did not regard reproductive medicine as “first-class health service;” money should be saved for elsewhere in the health care system. On the other hand, 39% of the physicians said that the patients should share the cost of fertility diagnosis and treatment, and 15% said that patients should have to bear the full cost (Table 4).

**Discussion**

Fertility counseling does not seem to be a common and routine task for family physicians in Germany, although nearly all the doctors interviewed regarded their work as family oriented. Most of the physicians considered fertility concerns to be infrequent and an insufficient reason for an encounter in family practice. They were, therefore, uncertain of their own usefulness and/or proficiency in cases of involuntary childlessness.

In both surveys, the majority of the family physicians had reservations about addressing fertility issues during consultations. The follow-up data also revealed these attitudes as being stable. After analyzing and comparing the two interviews, we now better understand why many family physicians do not necessarily act in accordance with the principles of family medicine put forward by, for example, Smilkstein and McWhinney.

By polarizing the interview data, two extreme positions could be identified. One position can be characterized as empathy with infertile patients and the physician’s desire to offer adequate advice and support. The second position is represented by the significant proportion of the physicians who expressed moral and judgmental attitudes toward involuntarily childless patients. This second position may reflect difficulties in the relationship with these patients. The physicians considered the condition of childlessness as a result of personal behavior and way of living, especially because of the patients’ tendency to postpone childbearing. These findings could be confirmed in the follow-up interviews.

Studies have shown that there is an apparent underperformance by family physicians in their ability...
to identify psychological distress in their patients so that they prefer treating patients with clear-cut somatic problems.¹⁹ Many physicians in our sample considered involuntary childlessness to be the patients’ private matter and/or felt uncomfortable initially addressing patients’ intimate conflicts in partnership or sexual life, which are often associated with fertility issues.²⁰ However, avoidance of inquiring about patients’ psychosocial concerns prevents family-oriented medical care.²¹-²⁴

The health care system, too, may be a barrier against realizing a family approach in primary care practices. In Germany, patients are usually required to obtain a referral certificate from their family physician for an appointment to specialist services, but formally they are free to visit any community doctor—generalist or specialist alike.²⁵ Under these conditions, it is not surprising that the majority of the physicians in our study placed involuntary childlessness within the realm of fertility specialists.²¹,²⁶

Whether or not involuntary childlessness will be accepted as an important issue of family practice will also be a matter of priority setting by patients, physicians, and society.²⁷ For example, the “treatment of infertility” was given the second lowest priority in a large, nationally representative survey in the United Kingdom on health care rationing among adults.²⁸ This public opinion is reflected by about half of the physicians in our sample who said—with respect to the use of assisted conception techniques—that the patients should share or pay the costs because the health service funds were finite and had to be spent carefully.¹⁷,²⁹,³⁰ Thus, it might be unfair to blame physicians for being a mirror of social norms.

In summary, our findings confirm the literature relating to the reasons why family physicians may not choose to care for infertile couples: 1) lack of specialized knowledge, training, and experience,²⁹ especially in countries where infertility is viewed as specialist domain.²¹ 2) fear of intrusion and inadequacy when addressing involuntary childlessness and related areas, such as sexuality, which are of an intimate and private nature,²⁰ 3) ambiguities with respect to the views about infertility (disease versus private fate) and the responsibility for this condition (doctor versus patient),²⁷ and 4) economic boundaries to receive reimbursement for family-related counseling.¹⁷,²⁹,³⁰

There is a broad body of literature about how to change physicians’ attitudes and their professional performance but, on the whole, there are no “magic bullets” for improving the quality of the health care they provide.²¹ One in four physicians in our sample confirmed the so-called Hawthorne effect, ie, the modification of subjects’ behavior due to their knowledge that they are taking part in a field experiment,¹⁴ in that they had become more sensitive to fertility problems among their patients. For some doctors, our interviews seem to have had positive effects toward a more sensible understanding of a couple’s emotional state and the physician’s role to help them.

Limitations

The interpretation of our findings is limited because we could not apply a strictly random selection procedure. The area under study, however, may well be representative of family practice in Germany. The study design (baseline and follow-up interviews) and the communication situation (semi-structured interviews and acceptance of negative statements), as well as the high response rates in both surveys, made selection effects unlikely and ensured that a broad variety of family physicians’ attitudes is represented and not only the views of those physicians highly interested in family issues.

Conclusions

There is some concern that the family is not sufficiently regarded in family practice,¹⁷ especially in the care of involuntarily childless patients. According to our findings, an interplay of several factors seems to be responsible for this shortcoming: ambivalent attitudes toward or negative experiences with these patients, as well as the health care system with its focus on specialization. Moreover, care of childless couples and reimbursement for fertility treatment depend on society’s priority setting, which may influence the family physicians’ attitudes. Educators who understand these influences will be better able to change physicians’ attitudes and their restraint in addressing family and fertility issues during consultation.

Nevertheless, all family physicians could be involved in fertility counseling if they gather the reports of specialist services about involuntarily childless patients and take this information into consideration for the consultation. Above all, the physicians should be available for discussion with patients who worry about childlessness, and they should offer, if needed, ongoing support.³²

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Corresponding Author: Address correspondence to Dr Ittner, University of Göttingen, Department of Family Practice, Humboldtallee 38, D-37073 Göttingen, Germany. 49-551-395839. Fax: 49-551-399530. E-mail: eitter@gwdg.de.

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