

Family Physicians' Satisfaction With Practice

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Background: During the past decade, dramatic changes have occurred in the way family physicians deliver health care.

Objective: To examine how satisfied family physicians are with their practice and compensation and what factors are associated with higher or lower satisfaction.

Methods: As part of a larger study examining decision making for specific medical problems, a random sample of board-certified family physicians were asked to rate on a 5-point Likert scale their satisfaction with practice, satisfaction with compensation, and likelihood that they would again select their current specialty. Responses were collapsed into those satisfied or highly satisfied vs those who were neutral or dissatisfied. The likelihood of again selecting family practice as a specialty was dichotomized similarly into those very likely or likely vs all others. Bivariate and multiple regression comparisons were made with demographic and practice characteristic variables.

Results: The overall response rate was 58.1% (N = 537). Most family physicians (82.4%) are satisfied

with their careers, most (65.5%) are satisfied with the compensation they receive, and, if given the opportunity, most (74.9%) would again select family practice as their specialty. Factors that appeared to be associated with lower levels on more than 1 satisfaction measure included working in a group of physicians with 3 or fewer members and not including maternity care in one's practice. In addition, older physicians stated they were less likely to enter family practice again, and those who worked more hours were less satisfied with their compensation.

Conclusions: Overall, family physicians are satisfied with their careers and compensation. The observation that those in smaller group practices were less satisfied suggests that practices with smaller numbers of members will continue to decline while the number of family physicians employed in larger group practices grows. This may have implications for health care delivery, especially in rural areas where smaller practices are more common.

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THE DELIVERY of health care has changed dramatically in the past decade. Managed care has placed family physicians in a pivotal role in how health care is managed and delivered. The growth of managed care has given family physicians and other generalists a larger role in the health care system, but at a price. Physicians often cite the loss of control over medical decisions and referrals¹ and decreased autonomy in practice decisions² as sources of discontent with practice. There has been little evaluation of whether family physicians think that any advantages conferred by the increase in managed care outweigh the drawbacks.

In general, managed care places high value on satisfaction, but the focus is on patient satisfaction. Less attention has been

paid to physician satisfaction and little research has been performed that evaluated physician satisfaction, especially as it relates to practice organization.³ Based on evidence that increasing organizational size is associated with declining worker satisfaction,⁴ Barr³ has argued that as professionals assemble into larger groups and organizational management becomes increasingly complex, physician satisfaction will fall. Other research suggests that patient satisfaction and provider satisfaction are associated.⁵ In groups where systems produce more efficient care and provide greater continuity, both patients and physicians report being more satisfied.⁵ The link between physician and patient satisfaction implies that physician satisfaction should be an important component in assessing the health of a managed care delivery system.

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PARTICIPANTS AND METHODS

In May 1996, a questionnaire was mailed to a sample of family physicians practicing in 10 states (Alabama, Arizona, California, Connecticut, Colorado, Minnesota, Missouri, North Carolina, Ohio, and Washington) selected from the published list of physicians certified by the American Board of Family Practice. The individual states were chosen to include representation from all 9 census districts in the United States plus California.⁶ Because local state health care environments may vary widely, the sample was limited to 10 states to minimize variation. The initial mailing of the satisfaction questionnaire was sent to 1100 family physicians selected by use of a computer-generated random number sequence. After this initial mailing, which included a letter explaining the purpose of the study, the survey, and a return business reply envelope, all physicians were sent a postcard reminding them to complete the survey. To ensure anonymity, no respondent identification was included on the actual questionnaire; return envelopes, however, were coded to track nonresponders. Those who had not responded within 3 weeks were sent a second copy of the survey materials.

The satisfaction survey was part of a larger study examining maternity health care decision making by obstetricians and family physicians. To encourage family physicians who did not include maternity care in their practice to return the questionnaire, the questionnaire was titled "Satisfaction With Practice," and all maternity care questions were included at the end of the survey. The survey was pilot tested on a panel of physicians from a state not included in the sample and was approved by the Human Subjects Committee at the University of Wisconsin–Madison Medical School. The survey contained questions in the following categories: demographics and practice experience; practice variables, including practice arrangement (solo, group, multispecialty vs single specialty, etc), how most of their patients paid for their care, the number of hours worked per week, whether maternity care was included in the physician's practice, and the size and location (rural, suburban, or urban) of the community where the practice was located; and satisfaction variables, including satisfaction with one's career, the likelihood of choosing the

specialty again, and satisfaction with compensation given the amount of work performed. A final section queried physicians about maternity care decisions, but these results are not included in this report.

Satisfaction variables were assessed using a 5-point Likert scale. For analyses, satisfaction or likelihood of choosing the specialty was treated as a dichotomous variable formed by collapsing the 2 positive responses into a positive response and treating neutral and negative responses as a negative response.

To evaluate practice characteristics, several questions were asked. First, physicians were asked to characterize their practice arrangement as solo or a small practice of 3 physicians or fewer, a large practice of more than 3 physicians, a teaching practice, or a military or public health practice. Practice arrangement was further categorized based on whether the highest proportion of patients in the physician's practice was capitated or managed as opposed to other types of payment (fee-for-service, discounted fee-for-service, Medicare or Medicaid, and self-payment). Physicians were also asked to describe the community in which they practiced, the type of hospital to which they admitted patients, and whether they included maternity care in their practice.

Of the 1100 family physicians in the initial sample, 180 surveys were returned uncompleted because the recipient had died or retired from practice (n=56) or had moved to a state not included in the survey (n=124). Subtracting these 180 physicians who could not be contacted from the original 1100 left an effective sample of 924 physicians. Of this potential sample, 537 (58.1%) returned completed surveys.

Categorical variables were compared using the χ^2 or Fisher exact test, and continuous variables were compared using the Student *t* test or the Wilcoxon rank sum test when variances were unequal. Those variables that were associated with 1 of the satisfaction variables on bivariate analysis were then entered into a logistic regression model using either overall satisfaction, satisfaction with compensation, or likelihood of choosing family practice again as the dependent variable. Regression models were analyzed using a commercially available software program (True Epistat, Epistat Services, Richardson, Tex, 1992). Statistical significance was defined as $P < .05$.

Physician satisfaction is also important when health workforce issues are considered. Various predictions have been made of health workforce needs during the next decades, and all suggest that a greater supply of generalist physicians, including family physicians, will be needed to meet the demands of the expanding managed health care system. These predictions, however, make assumptions about physician attrition from practice and productivity that are based on historical references and may not be relevant under new delivery systems. If new delivery systems produce dissatisfied generalist physicians, physicians may be more likely to reduce their workload or retire from the workforce prematurely. Thus, the assumptions of the models that predict workforce needs may depend on how satisfied physicians are with working conditions and benefits.

In this study, I examined family physician satisfaction in practice, satisfaction with compensation, and the likelihood that a physician would choose family practice again as a specialty. I envisioned this as an exploratory study to determine if there are independent predictors of satisfaction that can be used to help guide projections of future health care workforce needs.

RESULTS

The demographic and practice characteristics of respondents are shown in **Table 1**. These results are comparable to the mean age (44.8 years), gender composition (21% female), hours worked per week (52.8 h/wk), and percentage of family physicians who include maternity care in their practice (30.5%) found in a national survey of family physicians performed by the American Acad-

Table 1. Respondent Characteristics (N = 537)*

Characteristic	Family Physicians
Mean (SD) age, y	44.1 (8.8)
Sex, female	139 (25.9)
Mean (SD) weekly hours worked	52.9 (13.6)
Mean (SD) years of experience since residency	13.5 (9.1)
Include maternity care in practice	147 (27.4)
Type of practice	
Single specialty	160 (29.8)
Multispecialty	250 (46.6)
Academic	41 (7.6)
Other	86 (16.0)
Majority of patient population	
Capitated or managed	168 (31.3)
Medicaid or no insurance	369 (68.7)
Location of practice	
Urban or suburban	273 (50.8)
Small city or town	123 (22.9)
Rural	140 (26.1)

*Values are number (percentage) unless otherwise indicated. All respondents did not reply to every question.

Table 2. Overall Satisfaction Based on Demographic or Work Factors*

Characteristic	Family Physicians		P
	Satisfied (n = 443)	Not Satisfied (n = 94)	
Mean (SD) age, y	44.1 (9.4)	44.2 (7.2)	.87
Mean (SD) weekly hours worked	52.9 (13.8)	53.3 (13.0)	.78
Mean (SD) experience, y	13.6 (9.4)	13.2 (7.7)	.58
Sex			
Male	332 (83.4)	66 (16.6)	.34
Female	111 (79.9)	28 (20.1)	
Maternity care in practice?			
Yes	130 (88.4)	17 (11.6)	.03
No	311 (80.4)	76 (19.6)	
Type of practice			
Small group	123 (76.9)	37 (23.1)	.03
Large group	207 (82.8)	43 (17.2)	
Academic	39 (95.1)	2 (4.9)	
Other	74 (86.0)	12 (14.0)	
Majority of patient population			
Capitated or managed	139 (82.7)	29 (17.3)	.92
Nonmanaged care	304 (82.4)	65 (17.6)	
Location of practice			
Urban or suburban	221 (81.0)	52 (19.0)	.56
Small city or town	105 (85.4)	18 (14.6)	
Rural	116 (82.8)	24 (17.1)	

*Values are number (percentage) unless otherwise indicated. All respondents did not reply to every question.

emy of Family Physicians.⁷ The sample for this study, however, may be skewed toward physicians who work in a managed care setting because 31.3% of physicians in this survey described managed care as the largest component of their patient population, whereas, nationally, only 18% of patients in the practice of family physicians are described as in a capitated system.⁴

In general, most respondents were satisfied with their careers. Of the 537 respondents, 443 (82.4%) reported that

Table 3. Satisfaction With Compensation Based on Demographic or Work Factors*

Characteristic	Family Physicians		P
	Satisfied	Not Satisfied	
Mean (SD) age, y	44.1 (9.1)	44.2 (7.2)	.24
Mean (SD) weekly hours worked	51.6 (13.3)	55.6 (13.9)	.001
Mean (SD) experience, y	13.5 (9.2)	13.5 (8.9)	.94
Sex			
Male	262 (65.8)	136 (34.2)	.82
Female	90 (64.7)	49 (35.2)	
Maternity care in practice?			
Yes	103 (70.1)	44 (29.9)	.16
No	246 (63.6)	141 (36.4)	
Type of practice			
Small group	86 (53.8)	74 (46.2)	<.001
Large group	174 (69.6)	76 (30.4)	
Academic	26 (63.4)	15 (36.6)	
Other	66 (76.7)	20 (23.2)	
Majority of patient population			
Capitated or managed	113 (67.3)	55 (32.7)	.58
Nonmanaged care	239 (64.8)	130 (35.2)	
Location of practice			
Urban or suburban	173 (63.4)	100 (36.6)	.08
Small city or town	91 (74.0)	32 (26.0)	
Rural	87 (62.1)	53 (37.8)	

*Values are number (percentage) unless otherwise indicated. All respondents did not reply to every question.

they were satisfied or highly satisfied with their career, and 402 (74.9%) stated that they would select family practice as a specialty. When asked about satisfaction with overall compensation, 352 (65.5%) said that they were satisfied or highly satisfied. The percentage of respondents satisfied with compensation was significantly less than the number who were satisfied in general ($P < .001$).

When overall satisfaction was compared based on demographic and practice characteristics of the respondents, 2 factors were associated with increased satisfaction (**Table 2**). First, those who included maternity care in their practice were more likely to be satisfied than those who did not. The second factor associated with satisfaction was the type of practice arrangement. Compared with the other practice arrangements, family physicians who were in smaller groups were less likely to be satisfied. On the contrary, academic family physicians reported the highest level of overall career satisfaction.

When satisfaction with compensation was considered, 2 variables were associated with differences in physicians' satisfaction (**Table 3**). Those who were less satisfied reported working more hours than those who were satisfied. Second, the practice arrangement was associated with differences in satisfaction with compensation. Similar to the observations about reports on overall satisfaction, those who were members of small groups were the least likely to be satisfied with their compensation.

When the likelihood of selecting family practice as one's specialty was evaluated, several statistically significant associations were noted between physicians' age and years of experience, maternity care, and practice arrangement and the likelihood of entering family practice again (**Table 4**). Both increasing physician age and years of

Table 4. Likelihood of Selecting Family Practice Again as Specialty Based on Demographic or Work Factors*

Characteristic	Family Physicians		P
	Satisfied	Not Satisfied	
Mean (SD) age, y	43.3 (8.5)	46.5 (8.5)	<.001
Mean (SD) weekly hours worked	53.1 (13.3)	52.4 (14.5)	.61
Mean (SD) experience, y	12.7 (9.0)	15.9 (9.1)	<.001
Sex			
Male	332 (83.4)	66 (16.6)	.34
Female	111 (79.9)	28 (20.1)	
Maternity care in practice?			
Yes	123 (83.7)	24 (16.3)	.006
No	279 (72.1)	108 (27.9)	
Type of practice			
Small group	109 (68.1)	51 (31.9)	.005
Large group	185 (74.0)	65 (26.0)	
Academic	38 (92.7)	3 (7.3)	
Other	70 (81.4)	16 (18.6)	
Majority of patient population			
Capitated or managed	132 (78.6)	36 (21.4)	.18
Nonmanaged care	270 (73.2)	99 (26.8)	
Location of practice			
Urban or suburban	208 (76.2)	65 (23.8)	.43
Small city or town	94 (76.4)	29 (23.6)	
Rural	99 (70.7)	41 (29.3)	

*Values are number (percentage) unless otherwise indicated. All respondents did not reply to every question.

experience were associated with a decreased likelihood of selecting family practice again. Including maternity care in one's practice was associated with an increase in the likelihood that the respondent would enter family practice again. Finally, those practicing in smaller groups were least likely to report that they would enter family practice again. Academic family physicians were most likely to report that they would enter family practice again.

To adjust for a possible confounding of variables in the bivariate analyses, logistic regression analysis was performed for all 3 satisfaction measures using the variables found to be associated with differences in the measures with $P < .05$. This low P value was chosen to include only factors most likely to be independently associated with the outcome response being examined. Although it would have been optimal to include other potential confounders, the number of independent variables that could be included was limited by the small number of persons who were not satisfied; to prevent "overfitting" the model, it is recommended that the number of independent variables be limited to one tenth the number of outcome events. Second, because the physician's age and years in practice were highly related, only age was used as an independent variable.

Results of the regression analyses are presented in **Table 5**. After adjustment for other variables, maternity care remained associated with both overall satisfaction ($P = .05$) and the likelihood of again choosing family practice as a specialty ($P = .04$). Compared with those working in smaller groups, academic family physicians seemed to be more satisfied in general and more likely to select family practice as a specialty, but were no more

Table 5. Results of Logistic Regression Between Satisfaction Variables and Demographic or Practice Characteristics

Variable	Adjusted Odds Ratio (95% Confidence Interval)*	P
Overall satisfaction		
Maternity care in practice	1.78 (1.00-3.17)	.05
Work in small group	1.00†	...
Work in large group	1.29 (0.78-2.14)	.31
Work in academics	5.26 (1.21-22.96)	.03
Work in public health or military	1.81 (0.88-3.70)	.11
Satisfaction with compensation		
Hours worked	0.98 (0.97-0.99)	.01
Work in small group	1.00†	...
Work in large group	1.90 (1.25-2.88)	.003
Work in academics	1.35 (0.66-2.76)	.41
Work in public health or military	2.48 (1.34-4.58)	.004
Likelihood of selecting family practice again		
Age	0.97 (0.94-0.99)	.004
Maternity care in practice	1.70 (1.02-2.84)	.04
Work in small group	1.00†	...
Work in large group	1.04 (0.65-1.65)	.88
Work in academics	4.66 (1.36-16.02)	.01
Work in public health or military	1.89 (0.99-3.62)	.06

*Values greater than 1.0 indicate that the factor is associated with increases in satisfaction, etc, whereas values less than 1.0 indicate that the factor is associated with decreased satisfaction.

†The reference variable.

likely to be satisfied with their compensation. Those working in larger groups and those working in public health or military positions were more likely to be satisfied with their compensation than those working in smaller groups. Finally, working longer hours was independently associated with decreased satisfaction with compensation, and increasing age decreased the likelihood that a person would select family practice as a specialty again.

COMMENT

Previous studies have suggested that physicians are not highly satisfied with their careers. For example, an American Medical Association Young Physicians survey performed in 1987 found that 40% of respondents were either unsure or definitely would not go into medicine again.⁸ A second study, although not directly assessing current satisfaction, showed that most academic and private internists were not optimistic about their future.⁹ Two other surveys of physicians in all specialties, however, showed higher levels of job satisfaction both in physicians recently entering practice¹⁰ and in well-established physician groups.¹¹

This study included only family physicians of all ages whereas other studies were limited to American Medical Association members,^{2,12} academic internists in a single state,⁸ recent graduates of a single institution,⁹ or physicians of all specialties in a single county with high managed care penetrance.¹⁰ The study that best approximates the group of physicians in this study is that of Skolnik et al,¹³ who surveyed all board-certified family physicians in Pennsylvania in 1991. They found slightly

lower levels of satisfaction with their practice (70% were satisfied with their general professional life) and incomes (52%) than the respondents in this survey reported. Similar to this study, Skolnik et al reported lower levels of satisfaction in physicians working in solo or small groups and highest satisfaction in academic family physicians.

THIS STUDY SHOWS that most family physicians are satisfied with their careers and, if given the choice, would select family practice again as their specialty. A smaller majority were also satisfied with the compensation they receive. The levels of satisfaction for family physicians found in this study are much higher than those of 3 previous reports of family physicians¹¹ and other specialties.^{8,9} These results could reflect an improvement in physician satisfaction over time or might indicate that family physicians, in general, are more satisfied with their careers than physicians in other specialties.

The findings of high satisfaction among family physicians have important implications for future primary care workforce stability. Compared with previous studies of all specialties, family physicians' satisfaction is at least as high if not higher than that of physicians in other specialties. This implies that physicians' movement out of family practice to other specialties because of dissatisfaction with their career is not likely. Unless other forces intervene that would dramatically change family physicians' practice and lead to sharp changes in satisfaction, this study suggests that outmigration to other specialties should not be a significant factor on projections of family physician workforce.

Another factor suggesting that the family physician workforce is likely to be unaffected by outmigration is the lack of an effect of managed care on overall satisfaction or with satisfaction with compensation. Physicians for whom capitated care constituted most of their patient population were just as likely to be satisfied with their career, their specialty, and their compensation as those whose patient population was the more traditional fee-for-service type. Although the method of this study differs from others, the results reported here are consistent with those of Baker and Cantor,² who reported that among all specialties, practice in a managed care setting appeared to decrease physicians' perceived autonomy, but no consistent relationship could be found between managed care and levels of physician satisfaction. In a qualitative study of physicians, Reames and Dunstone¹ found a high degree of concern about problems in medicine and health care delivery but that physicians who were able to adjust their attitudes to focus on the value of their relationship with patients and their inherent interest in medicine were more satisfied than those who valued being successful at the "business" of medicine. The current finding that most family physicians are satisfied with their practice suggests that family physicians have adjusted well to the changing landscape of medical practice and that future changes in health care delivery or financing are unlikely to disrupt the family physician workforce.

This study also raises 2 other possibly important health delivery issues that warrant further comment. First, one of the consistent findings in this study is that the practice arrangement of family physicians affected their satisfaction with their practice. Physicians who belonged to smaller medical groups consistently were the least satisfied in general, least satisfied with their compensation, and least likely to select family practice again as a specialty. The lower level of satisfaction among family physicians in smaller groups could lead to fewer physicians remaining in this arrangement and discourage others from entering small groups. Data from the American Academy of Family Physicians show that the number of family physicians employed in solo and smaller (2-person) practices has dropped from 59% to 47% during the past 7 years.^{7,14} Furthermore, the percentage of family practice residency graduates who are employed in solo or 2-person groups is even lower than that of the academy's membership in general.⁷ This suggests that younger, residency-trained physicians are opting to join larger medical groups. The reasons for greater dissatisfaction among members of smaller groups cannot be delineated from our results but could be due to several factors, including lifestyle issues involved in covering a practice with a small number of partners and health care delivery issues inherent in accepting greater financial risk for capitated patients in a small group. Whatever the cause, the results of this study suggest that the trend toward fewer family physicians being employed in smaller groups will continue.

The decline in popularity of smaller family practice groups has important implications for practice organization and health care delivery, especially for rural areas where smaller group practices are more common. If family physicians find organization into larger groups desirable, those areas of the country where larger groups of physicians cannot be supported could find it more difficult to recruit physicians. This will increase the access problems for populations in rural areas where smaller groups and solo physicians are the predominant practices.

The other variable that was independently associated with increased satisfaction and increased likelihood of selecting family practice as a specialty was the provision of maternity care. Larimore and Sapolsky¹⁵ reported that family physicians in Florida who include maternity care in their practice appear to have a higher level of practice satisfaction, but their study was based on a small number of physicians in a single state. This study confirms their finding on a larger and more diverse physician population. As noted by Larimore and Sapolsky in their report, the relationship between maternity care and satisfaction may not be causal. Providing maternity care may not increase satisfaction; it could be that dissatisfied physicians are more apt to discontinue providing maternity care.

The conclusions of this study should be interpreted in light of the limitations inherent in the study design. Self-administered questionnaires may be biased by the tendency of respondents to answer questions in a socially desirable fashion. If respondents perceived that it was more desirable to be satisfied than dissatisfied, then

those who were satisfied may have been more likely to complete and return the survey or to err on the side of appearing more satisfied. These tendencies could inflate the proportions of respondents who appeared satisfied.

Second, the classification of health funding mechanisms is a gross oversimplification. Managed care, fee-for-service, and private insurance funding are not singular systems. For example, managed care represents a wide array of plans and delivery models, including capitated systems, group model or employee systems, and others. The lack of an association between health care delivery financing and satisfaction found in this study may mask important differences for certain types of managed care or other insurance models.

Finally, the sample was limited to family physicians certified by the American Board of Family Practice in only 10 states. Although attempts were made to select a sample that was geographically diverse, it is possible that the 10 states represented and the physicians in the sample were not representative of all family physicians. The findings that the physicians in this sample were similar in demographic and practice characteristics to members of the American Academy of Family Physicians suggest that the group of respondents is reflective of all family physicians, but other differences could exist that were not measured in this study.

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