Practice and Career Satisfaction Among Residency Trained Family Physicians: A National Survey

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This paper reports the results of a national survey of perceptions of practice and career satisfaction among the first cohorts of residency-trained family physicians. The findings indicate that a large majority of the respondents (n = 876), most of whom had been in practice for only three years or less at the time of the survey in 1979, were well satisfied with their careers and work in general as well as with their residency training, practice arrangements and facilities, colleague relationships, and hospital privileges. Several sources of relative dissatisfaction and difficulty were reported by the physicians, however, including practice time pressures, the necessity of treating emotional problems beyond their training, financial costs associated with operating their practice, paperwork, and perceived interference of external regulations and/or agencies in the physician-patient relationship.

With a sizable number of family practice residency graduates now in practice, it becomes both timely and essential to conduct follow-up studies evaluating their practice patterns and career development.[1] A number of questions need to be addressed by such studies: Are these graduates locating in areas of need? Are they providing comprehensive primary care services to an identified population on a continuing basis as emphasized in their residency training? Do they view their residency training as having adequately prepared them for providing such services? Have they been able to establish a viable organizational and financial basis for their practice? How satisfied or dissatisfied are they with various aspects of their careers and practice? Will they stay in family practice?

Several recently completed follow-up studies have begun to address some of these issues, obtaining information on a number of demographic, practice, and attitudinal characteristics of large samples of the first cohorts of residency graduates. One of these included 3,021 office-based respondents in a national survey conducted by the American Academy of Family Physicians (AAFP) of 4,295 diplomates of the American Board of Family Practice who had graduated from a family practice residency program between 1970 and 1978.[2] Four other studies were conducted among all graduates of statewide residency networks in Minnesota,[3] Virginia,[4] Washington,[5] and New York,[6] with response rates ranging from 61 to 93

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percent. Included among some of the major findings of these studies are the following. In regard to practice location, these graduates, although distributed in communities of all sizes, have been more likely than newly trained physicians in other specialties to settle in smaller, nonmetropolitan communities, a pattern consistent with one of the major original goals of family practice to increase the availability of primary care in rural areas. In terms of practice arrangements, only about one in five graduates has entered solo practice, with over one half choosing to practice in either a partnership or family practice group. Attitudinally, a large majority of graduates from the Minnesota, Virginia, and Washington networks indicated that they felt adequately prepared by their training to perform a wide variety of primary care tasks and functions and also reported high levels of overall professional and practice satisfaction.

This paper reports the results of a national survey of family practice residency graduates conducted in 1979 which complement and extend the findings of the earlier reports. The survey was designed to gather information on how satisfied residency-trained family physicians are with their careers in general, as well as with specific aspects of their practice, and to identify significant problems or difficulties they may be encountering in their work.

Methods

To assess career and practice perceptions, a 76-item questionnaire was constructed. The first section contained items asking the physicians to indicate on a 7-point scale how satisfied or dissatisfied they were (1, very dissatisfied; 4, neutral; 7, very satisfied) with different aspects of their practice (eg, hospital privileges) as well as with their careers and work in general. The specific items included had been constructed by the authors or adapted from a survey of American general practitioners conducted by Mechanic[7] in the early 1970s. A second set of items asked the physicians to indicate how much of a problem was being caused by various aspects of their work (eg, too many patients), using a 4-point scale (1, not a problem; 2, a problem but not serious; 3, a fairly serious problem; 4, a very serious problem) reported by Mechanic and Faich[8] in a study of British general practitioners. Additional items requested information on other work- and career-related perceptions and attitudes, training and practice characteristics, and general demographic data. A pretest of the questionnaire administered to 40 family physicians in Georgia resulted in minor revisions of several items.

Utilizing the American Medical Association's Physician Masterfile,[9] a simple random sample of 2,000 individuals was drawn in January 1979 from all physicians listed as having received residency training in family practice and currently as being in nonfederal, office-based practice in the continental United States. The questionnaire was mailed in February 1979, accompanied by a cover letter describing the nature and purpose of the study. Of the 2,000 questionnaires initially mailed out, 35 were returned because of a wrong address, reducing the number of potential respondents to 1,965. After three follow-up mailings ending in April 1979, 1,036 questionnaires had been returned of which 22 were blank, resulting in a completed survey response rate of 52 percent. Initial examination of the completed questionnaires also revealed that some of the physicians did not conform to the originally specified sampling criteria, including 64 physicians reporting that they had been enrolled in a family practice residency program for only one year or less, and 58 reporting that they were currently in some type of non-office-based practice (ie, military assignment, academic medicine, emergency medicine, and public or student health). In addition, 24 physicians reported they had been in practice for eight years or more, raising the possibility that they had entered one of the new residency programs with previous practice experience. Physicians falling into any of these three categories were consequently eliminated from further analysis, reducing the size of the study sample to 876.

Results

Sample Characteristics

Although adequate, the relatively low response rate raises questions concerning sample representativeness. To assess this, the demographic, train-

ing, and practice characteristics of respondents in the study sample were compared with corresponding data reported in the AAFP and regional surveys described above. The distributions of characteristics in these comparisons were quite similar, indicating that individuals in the study sample were fairly representative of the total population of family physicians trained in the United States during the 1970s. An overwhelming majority of the respondents were male, native-born United States citizens, and less than 35 years old. Slightly over one third and one half were located in the Midwest and in communities of less than 25,000 population, respectively. Ninety percent reported having received three years of family practice residency training, and 95 percent indicated that they were board certified. Only one respondent reported having received his undergraduate medical education in a foreign medical school. Seventy-three percent reported having been in practice for three years or less, with 60 percent indicating that they were currently practicing in either a partnership or family practice group. Approximately two of every three respondents reported practicing between 50 to 69 hours per week, seeing between 16 to 30 patients per day in their office, and earning an annual net income of less than $50,000.

Practice and Career Satisfaction

Table 1 presents descriptive statistics (means, standard deivations, and frequency distributions of scale responses broken into three categories) for the family physicians' ratings of satisfaction with various aspects of their careers and practice. As the table indicates, most of the items received mean ratings above the midpoint of the 7-point scale, reflecting moderate to high levels of satisfaction among the majority of respondents. The highest satisfaction ratings were associated with items referring to hospital privileges, respect received from patients, adequacy of residency training, relationships with consultants, work in general, adequacy of office and support staff, and office and hospital facilities. Moderate satisfaction ratings were associated with several items referring to the extent with which the physician's overall professional goals had been presently achieved, opportunity for professional contact with other family physicians and specialists, and practice organization and management. The lowest satisfaction ratings were associated with items referring to practice time requirements, time available for family, leisure, and continuing medical education, and the financial costs involved in operating the physician's practice.

Problems and Difficulties

Table 2 presents corresponding statistics for the physicians' ratings of the degree to which various aspects of their work was causing a problem or difficulty. Of these, two items referring to taking care of medical or surgical problems "beyond my training" were judged as causing the least difficulty, with three fourths of the respondents reporting that these were not a problem. Having to take care of emotional problems beyond the physician's training, on the other hand, was much less likely to be rated as nonproblematic. Two items referring to having too many patients to see and boredom from having to deal with routine and unchallenging medical problems were rated as mildly problematic by over one third of the physicians. Fewer than 10 percent, however, rated either as involving a fairly or very serious problem. Two items referring to interference of external regulations and/or agencies in the physician-patient relationship and paperwork associated with patient care were rated as causing the greatest difficulty, with over one half the respondents reporting each to involve a fairly or very serious problem.

Correlates of Satisfaction and Difficulty

To assess possible relationships between selected demographic and practice characteristics of the respondents and ratings of satisfaction and difficulty, a number of exploratory bivariate contingency table analyses were also conducted. Responses to the individual satisfaction and problem items were dichotomized (1 to 3 *v* 4 to 7 for the satisfaction scale, and 1 and 2 *v* 3 and 4 for the problem scale) and cross-tabulated with each of the following variables: sex, years in practice, community size, and type of practice arrange-

Table 1. Family Physicians' Ratings of Satisfaction with Various Aspects of Their Careers and Practice

	Mean ± SD	Very Satisfied (6-7)* No. (%)	Moderately Satisfied or Neutral (4-5)* No. (%)	Dissatisfied (1-3)* No. (%)
The hospital privileges I have	6.1 ± 1.2	679 (78)	150 (17)	41 (5)
The respect I receive from my patients	5.9 ± 1.0	653 (75)	192 (22)	27 (3)
The adequacy of the residency training I received	5.8 ± 1.2	631 (72)	191 (22)	50 (6)
The consultant relationships I have with specialists	5.6 ± 1.2	548 (63)	275 (31)	49 (6)
My work in general	5.5 ± 1.0	525 (60)	307 (35)	40 (5)
The adequacy of my office and support staff	5.5 ± 1.3	521 (60)	277 (32)	71 (8)
The hospital facilities in my community	5.5 ± 1.4	536 (61)	243 (28)	92 (11)
The physical resources and facilities in my office	5.4 ± 1.3	479 (55)	296 (34)	97 (11)
The extent to which I have presently achieved my overall professional goals	5.2 ± 1.2	416 (48)	378 (43)	77 (9)
The opportunity I have for professional contact with physicians in other specialties	5.2 ± 1.5	460 (53)	287 (33)	124 (14)
The opportunity I have for professional contact with other family physicians	5.1 ± 1.4	407 (47)	328 (38)	135 (15)
The organization and management of my practice	5.0 ± 1.4	374 (43)	363 (42)	134 (15)
The amount of time my practice requires	4.8 ± 1.5	315 (36)	352 (41)	203 (23)
The time I have for continuing medical education	4.7 ± 1.5	295 (34)	358 (41)	219 (25)
The time I have for leisure and relaxation	4.2 ± 1.6	220 (25)	338 (39)	314 (36)
The time I have for my family	4.2 ± 1.6	231 (27)	316 (36)	320 (37)
The financial costs involved in operating my practice	3.8 ± 1.6	136 (16)	340 (39)	390 (45)

*Responses on a scale from 1 (very dissatisfied) to 7 (very satisfied) were grouped into three main categories of satisfaction

Table 2. Family Physicians' Ratings of the Difficulty Being Caused by Various Aspects of Their Work

	Mean ± SD	Not a Problem (1)* No. (%)	Problem, but Not Serious (2)* No. (%)	Fairly or Very Serious Problem (3-4)* No. (%)
Having to take care of medical problems beyond my training	1.3 ± .5	636 (73)	221 (25)	16 (2)
Having to take care of surgical problems beyond my training	1.3 ± .5	670 (77)	175 (20)	9 (1)
Having too many patients to see	1.6 ± .7	460 (53)	345 (39)	68 (8)
Boredom from having to deal with routine and unchallenging medical problems	1.5 ± .6	462 (53)	380 (44)	32 (4)
Having to take care of emotional problems beyond my training	1.7 ± .7	351 (40)	428 (49)	95 (11)
Interference of external regulations and/or agencies in the physician-patient relationship	2.6 ± .9	94 (11)	298 (35)	467 (54)
Paperwork associated with patient care	2.7 ± .8	57 (7)	316 (36)	500 (57)

*Responses on a scale from 1 (not a problem) to 4 (very serious problem) were grouped into three categories of difficulty

ment. In terms of satisfaction, sex was not significantly associated with any item (chi-square at the .05 level of significance). Community size was significantly associated with one item, with family physicians in communities of 9,999 population or less being more likely than those in communities of 10,000 or greater to report dissatisfaction with their opportunity for professional contact with physicians in other specialties (30 *v* 7 percent). With regard to practice experience, those physicians in practice for four to seven years were less likely than those in practice for less than two years to be dissatisfied with the organization and management of their practice (9 *v* 18 percent). At the same time, however, they were more likely to be dissatisfied with the time their practice required (28 *v* 18 percent) and the time available for their families (43 *v* 29 percent).

Type of practice arrangement exhibited significant associations with seven satisfaction items (Table 3). Physicians in family practice and multispecialty groups were less likely than those in solo and partnership practice to report dissatisfaction with their practice time requirements, time available for family, leisure, and continuing medical education, and opportunity for professional contact with other family physicians. Respondents in large family practice (five or more physicians) and multispecialty groups were also less likely to report dissatisfaction with their practice financial costs and opportunity for professional contact with physicians in other specialties.

With regard to problems and difficulties, no item was found to be significantly associated with either sex or community size. Two items were correlated with years in practice, with family physicians in practice for four to seven years being more likely than those in practice for less than two years to view paperwork (62 *v* 49 percent) and external interference (61 *v* 50 percent) as involving

Table 3. Satisfaction Items with Significant Differences (P <.05) in Proportion Dissatisfied by Type of Practice Arrangement

	Solo (n = 221) No. (%)	Partnership (n = 197) No. (%)	Family Practice Group, 3-4 (n = 240) No. (%)	Family Practice Group, 5+ (n = 80) No. (%)	Multispecialty Group (n = 130) No. (%)
Practice time requirements	65 (30)	53 (27)	44 (18)	12 (15)	26 (20)
Time for leisure	108 (49)	76 (39)	69 (29)	22 (28)	36 (28)
Time for family	101 (47)	77 (40)	75 (31)	22 (28)	42 (32)
Time for continuing education	83 (38)	52 (27)	50 (21)	10 (13)	20 (15)
Family physician contact	47 (21)	38 (20)	31 (13)	2 (3)	16 (12)
Practice financial costs	117 (53)	94 (48)	105 (45)	28 (35)	42 (33)
Speciality contact	38 (17)	29 (15)	41 (17)	4 (5)	11 (9)

a fairly or very serious problem. These same two items were also associated with type of practice arrangement, mainly as a result of differences between solo practitioners and those in multispecialty groups, with the former being more likely to rate each as involving a fairly or very serious problem (66 *v* 46 percent for paperwork, and 59 *v* 45 percent for interference). One additional item exhibited a trend toward association with practice arrangement (P = .08), with physicians in family practice and multispecialty groups being less likely than those in solo and partnership practice to view taking care of patients' emotional problems beyond their medical training as a fairly or very serious problem (7 *v* 14 percent).

Discussion

Consistent with findings reported in the recent regional graduate surveys described earlier, these results indicate that a large majority of the respondents were generally well satisfied with their careers in family practice. Few of the physicians, for example, reported any degree of dissatisfaction with the extent to which they had presently achieved their overall professional goals or their work in general. As an additional measure of overall career satisfaction, the physicians had also been asked whether, if given the opportunity, they would change from family practice to some other medical specialty or field. Only 10 percent (n = 86) responded that they would, further indicating a generally high level of satisfaction with having chosen family practice as a specialty and career.

In terms of clinical preparation, three fourths of the respondents reported being well satisfied with the adequacy of their residency training and indicated that they were experiencing no difficulties in handling medical or surgical problems. Most of the respondents also reported being moderately to well satisfied with their practice arrangements and colleague relationships, including practice organization and management, office and hospital facilities, office support staff, consultant relationships with specialists, and opportunity for professional contact with other family physicians and specialists. In addition, fewer than one in ten respondents reported any degree of dissatisfaction with their hospital privileges, a finding of particular importance given the concern frequently expressed among medical students and family practice residents as to how likely they would be to encounter arbitrary restrictions or limitations in their use of hospital facilities.[10] Taken together

with data reported in the regional and AAFP surveys, this finding suggests that most residency-trained family physicians have not encountered significant difficulties in this area. Almost all respondents in the four regional surveys indicated having hospital admission privileges, with 90 and 97 percent of the Washington and Minnesota graduates, respectively, also reporting that they were satisfied with their privilieges. In the AAFP national survey, approximately nine in ten respondents reported having hospital admitting privileges in pediatrics, family practice, medicine, and intensive/coronary care units, with less than 2 percent reporting that such privileges had been denied. A more recent national survey conducted by the AAFP in 1980 also found 95 percent of the 4,366 respondents reporting that they were satisfied with their hospital admission privileges.[11]

Despite their generally positive attitudes, several sources of relative dissatisfaction and difficulty were reported by the family physicians in the present survey. In the clinical sphere, having to take care of patients' emotional problems beyond the physician's training was much more likely to be rated as at least mildly problematic compared with medical and surgical problems, indicating some feelings of relative underpreparation in this area. In comparison, between 17 and 26 percent of respondents in the Minnesota, Virginia, and Washington graduate surveys judged themselves to be "underprepared" in the area of "behavioral/psychiatric disorders," and between 17 and 41 percent considered themselves underprepared in "counseling skills." Another recent survey of 116 graduates of family practice residency programs in Ohio and North Carolina[12] found 34 percent of the respondents reporting that their training in "short-term counseling skills" was "very adequate," with 46 percent rating it "adequate," and approximately one in five (19 percent) considering it "inadequate." In their everyday practice, these graduates reported diagnosing one of every three patients being seen as having psychological problems but providing counseling sessions or mental health referrals in only 2 to 4 percent of all patient visits. Given the strong consensus that family physicians should play a key role in the provision of first-contact mental health services, these findings suggest the need for further efforts to improve residency training and continuing education in this area, with special emphasis placed on developing practical skills in assessing and managing commonly occurring emotional problems in the context of a busy primary care practice.[13]

Practice time pressures and financial costs, paperwork, and perceived interference of outside agencies and regulations in the physician-patient relationship were reported as additional sources of dissatisfaction or serious difficulty by a significant number of family physicians in the present survey. Although few respondents reported that having to take care of too many patients constituted a fairly or very serious problem, from one fourth to one third indicated dissatisfaction with their practice time requirements and the time they had available for their families, leisure, and continuing medical education. Such dissatisfaction was less prevalent among physicians in family practice and multispecialty groups, a pattern consistent with much evidence indicating that group forms of practice provide inherent advantages for managing time demands (eg, more sharing of on-call responsibility).[14] These and other advantages indicate a continuing trend toward group practice among most residency graduates, with the small family practice group of three to four physicians probably remaining the modal arrangement.

Dissatisfaction with financial costs involved in operating the physician's practice, reported by one third to one half the respondents in all practice arrangements, may derive from several sources. Lack of adequate preparation in practice financial management skills, reported by one half to two thirds of respondents in the Minnesota and Washington graduate surveys, may be one source, suggesting the need also to improve residency training and continuing education in this area. An additional source, however, may derive from economic factors associated with the characteristics of family physicians' practices. As recently reported by Glandon and Werner,[15] US office-based physicians' practice expenses increased in relation to their gross income during the 1970s, accompanied by a slight decline in real net income (ie, net income adjusted for price level changes). They suggest that this may reflect fundamental changes in the nature of physicians' practices, including either employment of more ancillary personnel in the practice (eg, nurse practitioners, physician assistants), purchase of more capital equipment (eg, diagnostic equipment, office space), or an increase

in the price of nonphysician inputs (eg, salaries). In family practice all three of these factors may have been operating in various degrees to increase expenses during the 1970s as many of the new graduates attempted to implement models of comprehensive care and team practice emphasized during their residency training.

The serious concern expressed by one in two respondents about paperwork and interference of external regulations in the physician-patient relationship reflects in part other changes influencing all aspects of medicine and health care delivery. Within the past two decades physicians in both institutional and office settings have become increasingly subject to numerous rules and guidelines concerning their modes of practice and clinical work, with such regulation coming from all units of government, third party reimbursement programs, and private professional groups.[16] As a result of these trends, physicians have been presented with new stresses and concerns in their relationships both with patients and colleagues, including issues related to the growing complexity of third party payment procedures and associated paperwork, peer review and quality assurance, cost controls in health care, and confidentiality of patient records. In family practice, where the continuing care of individuals and their families is considered a central task, many family physicians may view these regulatory activities as interfering with the quality of their relationships with patients, resulting in a significant source of career dissatisfaction.

Conclusions

Taken as a whole, the findings of this study indicate that a large majority of the respondents, most of whom had been in practice for only three years or less at the time of the survey in 1979, were generally well satisfied with most aspects of their careers and practice. The reported areas of relative dissatisfaction and difficulty, however, indicate the need for further follow-up studies of these cohorts of graduates as they continue to practice. Does the dissatisfaction with practice expenses, for example, indicate that many family physicians are encountering significant difficulties in establishing a viable financial base for their practice? If so, will they be able to overcome these difficulties, or will many consider changing to some other medical specialty or field? Will these graduates be able to manage their practice time demands in such a way as to establish a satisfying balance between their personal and professional lives, or will many succumb to the intense demands involved in providing comprehensive primary care and "burn out?"[17] Future studies should address these and many other questions in order to obtain a more comprehensive picture of evolving patterns of practice and career satisfaction among these new specialists.

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