Physician Satisfaction With Capitation Patients in an Academic Family Medicine Clinic

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Physician work satisfaction may play an important role in the management and quality of health care, yet cost-containment measures may compromise levels of physician satisfaction. This article reports an evaluation of physician attitudes toward aspects of capitation plans that may place the physician in conflict with the physician's traditional role. The literature was reviewed in an effort to generate a list of constructs that would be relevant to physician work satisfaction. By using constructs that focus on both physician work satisfaction and capitation, a survey instrument was developed and serially administered to physicians involved directly in a capitation program. Among the five dimensions studied, providers rated capitation patients more favorably in only one area: interpersonal relationships. Providers indicated a preference for noncapitation patients in the dimensions of autonomy, intellectual stimulation, time restraints, and structural variables. Furthermore, physicians' satisfaction levels with capitation patients tended to decrease the longer they cared for them. These findings are consistent with expectations, and lend support to the hypothesis that organizational constraints may have an adverse effect on physician attitudes toward selected aspects of caring for capitation patients.

Previous studies suggest an association between levels of job satisfaction and levels of organization in medicine.[1–5] Historically physicians have worked in more traditional settings, such as solo practice or partnerships. In recent years greater numbers of physicians have entered organized work settings. Since professional values and job expectations may be in conflict with such settings, the greater involvement of physicians in organized systems (such as a prepayment program) may have a negative impact on their work satisfaction. The literature on this topic has been reviewed extensively elsewhere.[6]

One common form of cost containment, capitation, uses risk-sharing as a method to reduce costs. Risk-sharing imposes specific organizational constraints on physicians when they care for capitation patients. It is, therefore, reasonable to speculate that the care of capitation patients will adversely affect a physician's satisfaction with the practice of medicine.

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For several reasons health care managers and planners need to understand the importance of physician satisfaction to the success of any cost-containment program. Dissatisfied physicians are less likely to perform at optimal levels,[7] and several studies suggest that dissatisfied physicians will not remain within their present system of reimbursement.[8–11] Also, an increasing portion of the population is participating in these cost-containment programs. Because recent work supports a relationship between patient and physician satisfaction,[12,13] the lower levels of satisfaction among physicians affiliated with capitated health care plans could raise major concerns about possible patient disenrollment. Furthermore, several reports describe a relationship between provider satisfaction and quality of care.[12,14,15]

Physician satisfaction instruments have been developed previously,[16–18] but none specifically measures physician work satisfaction in a group of providers who care for both capitation and noncapitation patients. This article reports the results of an evaluation of physician attitudes toward characteristics of a capitation program that may place the physician in conflict with the physician's traditional role. To measure these attitudes, this study examined physicians who cared for a mixture of capitation and noncapitation patients. The study reported here tested

the hypothesis that lower levels of physician satisfaction are associated with a risk-sharing cost-containment program.

METHODS

The Study Setting

The UCLA Family Health Center is an outpatient setting in the UCLA Medical Center, where approximately 18 family practice residents and nine full-time family practice faculty practice acute and ongoing care. At the time of this study, the faculty included six board-certified family physicians, one board-certified internist, one board-certified psychologist, and one licensed clinical social worker. Over 75 percent of both resident and faculty providers were male. The mean age for the faculty was 35 years, and for residents it was 26 years.

The physical structure, appointment scheduling, length of appointment, and provider type were similar for capitation and noncapitation patients. Diagnostic case mix and demographic data on patients were not measured in this particular study, but previously published data comparing the same capitation patients with fee-for-service patients in 1987 demonstrated that capitation patients were younger than noncapitation patients, and tended to see the physician more frequently for health maintenance and family planning.[19]

Each provider saw between four and 12 patients per session, one to four times each week. Ten to 30 percent of each individual provider's practice consisted of capitation patients, and the remaining noncapitation patients were self-paying or covered by Medicare, Medicaid, or indemnity plans. This mix of capitation and noncapitation patients enabled providers to serve as their own controls. Providers distinguished capitation patients and noncapitation patients by their charge documents, which are completed by the provider at each visit. At the time of sampling the providers, 42 percent of the providers acknowledged seeing more than 21 different capitation patients at least once since the program had begun. Faculty tended to see the largest numbers of capitation patients. As anticipated, providers tended to have increasing numbers of capitation patients in their practices during the course of the study.

The Capitation Program

The capitation program for university employees and their families was free of charge to enrollees, and provided complete medical coverage within the university, including all diagnostic tests (laboratory tests and x-ray examinations), consultations, office visits, and prescribed therapy. The university paid the entire premium, so patients did not participate in cost-sharing. Consequently, the number of visits to the physician and the demand for diagnostic tests were not limited. In contrast, faculty providers were at risk as a group for part of their capitation patients' medical care costs, thereby providing a cost-containing incentive for the provider. Cost containment was encouraged through (1) extensive provider education about risk-sharing consequences, (2) utilization review, and (3) financial reward for lower medical expenditures (a fixed percentage of the profits from capitated patients was distributed evenly among the physicians).

The capitation program imposed two important changes in the previous system of providing health care. First, physicians experienced reduced control over medical care delivery (ie, reduced autonomy). For example, restrictions are imposed by a utilization review committee on the use of consultants for capitation patients. Thus, a physician may make a referral to a consultant, but only if authorized by the utilization review committee. Second, with the addition of the capitation program, providers experienced busier schedules and encountered more paperwork. While the busier schedules might have resulted from more patients entering the practice, the increased paperwork (special referral forms) resulted from the capitation system.

Measuring Job Satisfaction

To determine whether there was a difference in physician satisfaction with capitation patients as compared with noncapitation patients, previously identified empirically and theoretically distinct constructs were reviewed from studies published between 1965 and 1986. The literature review uncovered 11 different constructs used in 23 separate studies that were directly related to provider satisfaction.[4,12–14,16–18,20–36] Five of these constructs are defined in the way they were used in the previous studies (Table 1). Several previously published reviews discuss the usefulness of these studies.[18,20] The most commonly used constructs in the previous studies included intellectual stimulation, structural variables, interpersonal relationships with patients, autonomy, and financial compensation. Less frequently used constructs were good outcome, job variety, collegial relationships, status, and time constraints. The diversity in constructs results from the variation in study settings and objectives.

Full-time general internal medicine and family practice faculty, part-time family practice clinical faculty, and family practice residents at UCLA were consulted to create a more complete provider-satisfaction construct list. Interviewers asked open-ended questions about physicians' feelings toward the new capitation system. Physician interviews were useful in determining the relative impor-

TABLE 1. CONSTRUCTS AND DESCRIPTIONS OF CONSTRUCTS

Constructs	Descriptions of Constructs
Difficult relationships with patients	Patient personality traits (eg, difficult, unreasonable, annoying, demanding, noncompliant, threatening, ungrateful, discourteous, disrespectful, dishonest, blaming, harrassing)
Intellectual stimulation and problem solving	Quality and quantity of intellectually interesting patients, task completion, continuing medical education, proper use of the physician
Autonomy	Degree of control, restraints on the system of health care delivery, peer review
Time	Time to deal with individual patients, case load, personal time
Structure	Structural variables regarding ancillary personnel, system of health care delivery, availability and accessibility of resources

TABLE 2. SAMPLES OF SURVEY ITEMS

Compared with all other patients in my practice . . .
- . . . capitation patients are more/less challenging
- . . . capitation patients comply better/worse with a follow-up appointment
- . . . capitation patients provide a better/worse educational experience
- . . . ordering diagnostic tests for capitation patients is easier/more difficult
- . . . capitation patients are more/less demanding
- . . . I would choose more/fewer capitation patients for my practice
- . . . capitation patients are more/less easily satisfied with their care
- . . . capitation patients are more/less compliant with medications
- . . . capitation patients have needs that are easier/more difficult to meet

Since the capitation program began . . .
- . . . the staff seems more/less stressed
- . . . my workload has increased/decreased
- . . . I feel more/less rushed
- . . . there is more paperwork

tance of the constructs to these providers. Ninety percent of the providers believed that autonomy and intellectual stimulation were among the two most important constructs in determining their personal satisfaction with the practice of medicine. Autonomy and good outcome were considered particularly important by the part-time clinical faculty, and intellectual stimulation was most important for the full-time teaching faculty.

From among the final list of constructs, five were chosen for this study: autonomy, intellectual stimulation, interpersonal relationships with patients, time constraints, and structural variables (Table 1). These constructs were chosen for specific reasons: autonomy, as a capitation program would seem likely to affect this area; intellectual stimulation, as it is generally considered a major determinant of provider satisfaction for most physicians; interpersonal relationships with patients, because this construct evaluates providers' attitudes toward personal aspects of their capitation patients; and time constraints and structural variables, because they help validate providers' perceptions about the new cost-containment program.

Thirteen items were designed to test some aspect of each construct, and one item was designed to test overall global satisfaction. Individual questions consisted of a short statement about health care delivery followed by five possible answers. The wording of the answers required providers to compare their perceptions of patients enrolled in a capitation program with those of all other patients for whom they provide care. For example, one statement asked the provider about time limitations with health care delivery: "Since the capitation program began, I feel (1) much more rushed, (2) somewhat more rushed, (3) about as rushed as I was before, (4) somewhat less rushed, (5) much less rushed." The content of each item is described briefly in Table 2. Scoring rules were such that a final score of 5 always indicated greatest satisfaction with the capitation group. A score of 1 indicated greatest satisfaction with noncapitation patients. A score of 3 indicated similar levels of providers' feelings toward both groups.

Several measures were used to estimate the reliability and validity of the questionnaire. First, tests were administered to 20 physicians at the beginning of the study, and again to the same group several days later. On each of the final 14 items, at least 70 percent of the physicians indicated an identical level of satisfaction on both occasions. Second, the distribution of answers to each individual question was examined, and questions were excluded when responses did not fall into a Gaussian (normal) distribution. Third, the responses to two questions with similar face value were compared as a measure of internal validity. The correlation coefficient for these two questions was 0.63, compared with less than 0.20 for items with unrelated face value.

Study Design

The survey was administered three times during a one-year period. The longitudinal design was created to eval-

TABLE 3. SCORES FOR PHYSICIAN PREFERENCE CONSTRUCTS BASED ON COMBINED RESULTS OF SURVEYS IN A ONE-YEAR PERIOD*

Construct	Number of Questions	Mean Score**	Preference Score		
			Percent <3.00***	Percent =3.00	Percent >3.00****
Autonomy	2	2.60 ± .60	59.7	30.6	9.7
Intellectual stimulation	2	2.77 ± .52	43.5	43.5	12.9
Interpersonal relationships	5	3.40 ± .43	11.3	8.1	80.6
Time constraints	1	2.50 ± .62	50.0	46.8	3.2
Structural	3	2.48 ± .48	71.0	19.4	9.7
Global	1	2.85 ± .65	25.8	61.3	12.9
Average satisfaction	13	2.75 ± .30	80.6	3.2	16.2

Score Code: 1 = strong preference for noncapitation patients; 2 = moderate preference for noncapitation patients; 3 = point of indifference; 4 = moderate preference for capitation patients; and 5 = strong preference for capitation patients

*** ± = Standard deviation*

**** Percent < 3.00: percent of providers who favored other patients over the capitation patients in terms of this construct*

***** Percent > 3.00: percent of providers who favored the capitation patients over all other patients in terms of this construct*

uate whether physician attitudes changed over a period of one year, since they would have more exposure to the new capitation system. Research assistants administered the questionnaire to first-, second-, and third-year resident cohorts and to a faculty cohort shortly after the initiation of the capitation program (January 1984) (n = 21). The survey was administered again to the same cohorts six months later (June 1984) (n = 23), and 12 months later (January 1985) (n = 18).

STATISTICAL ANALYSIS

Seven summary scores were computed for all four cohorts. For each survey conducted, a mean score was calculated for each of the five constructs, a global satisfaction score, and an average satisfaction score. The mean score for an individual construct was calculated by weighting equally the mean scores of all the questions pertaining to that construct (arithmetic mean). The global satisfaction score was based on the single global satisfaction item. The arithmetic mean for the five construct scores was calculated to determine the average satisfaction score. Zero order correlation coefficients were determined, using the BMDP 1R statistical software,[37] describing the relationships among the five constructs, the global satisfaction score, and the average satisfaction score. Multiple regression was used to analyze the correlation between the dependent variable, average satisfaction, and the independent variables: length of time of physician involvement in the capitation program, level of training of the provider (ie, residents compared with faculty), and the number of capitation patients seen by a provider at the time of the survey.

RESULTS

The descriptive statistics of each construct are summarized in Table 3. The mean score was less than 3.00 in all cases except for interpersonal relationships with patients. The mean construct scores during each of the three survey periods are shown in Table 4. The general trend in all categories was downward, indicating an increasing preference for the noncapitation patients. Among the three independent variables considered in this study, only the length of time providers were involved in the program could significantly explain any of the variance in the average satisfaction score ($r = -.29$, $P < .05$).

DISCUSSION

The average satisfaction scores at each of the three survey times indicate that resident and faculty providers in the UCLA Family Health Center were less satisfied with caring for capitation patients than for their other patients. Further, levels of satisfaction tended to decrease over time. These findings were predicted by medical care delivery models, suggesting that physicians become more dissatisfied with higher levels of organization in medicine.[1–4]

The calculation of an average satisfaction score assumed that each construct carried some importance for the provider. This assumption may result in falsely low predictions of overall satisfaction if, for example, a construct

TABLE 4. MEAN CONSTRUCT, GLOBAL, AND OVERALL AVERAGE SATISFACTION SCORES OF THE FOUR COHORTS COMBINED AT EACH OF THE THREE SURVEY PERIODS*

	January 1984 Mean	June 1984 Mean	January 1985 Mean
Autonomy	2.88	2.39	2.53
Intellectual stimulation	2.69	2.96	2.64
Interpersonal relationships	3.54	3.38	3.24
Time constraints	2.57	2.57	2.33
Structural	2.52	2.49	2.42
Global	2.86	2.87	2.83
Average satisfaction	2.84	2.78	2.67

** Score code: 1 = strong preference for noncapitation patients; 2 = moderate preference for noncapitation patients; 3 = point of indifference; 4 = moderate preference for capitation patients; and 5 = strong preference for capitation patients*

with high scores, such as interpersonal relationships with patients, was much more important to each provider than other constructs. Information from provider interviews suggested, however, that providers considered constructs with lower mean scores, such as autonomy and intellectual stimulation, to be more important than constructs with higher mean scores.

The similar mean scores for global satisfaction and average satisfaction lend some support to the method of weighting constructs in this study. The global satisfaction item is also important because it asks providers about their preference for capitation patients and measures one of the final outcomes of provider satisfaction—participation in the cost-containment program.

Individual construct scores were consistent with expectations. During interviews, most providers said they enjoyed relating to capitation patients, as these patients were generally younger and healthier. For the interpersonal relationships construct, more than 80 percent reported a more favorable attitude toward the capitation patients. The responses to the other four constructs, however, indicated a less favorable attitude toward capitation patients as compared with noncapitation patients.

Providers stated during interviews that they consider autonomy and intellectual stimulation to be major causes of personal satisfaction with the practice of medicine. If cost-containment programs do reduce provider satisfaction, they probably do so by affecting these two constructs. In the capitation system, physicians perceived reduced control over the medical care (diagnostic workup and treatment) of their patients. Primary care physicians have little control over the number of patient visits because the capitation program eliminates the usual cost barrier to these patients. Thus, with the capitation population, physicians may see a greater number of visits as "unnecessary." This perception affects the physicians' control (autonomy) over their practice, and possibly the amount of intellectual stimulation they derive from patient care because they find the generally younger and healthier capitation population less intellectually stimulating. Yet providers find interpersonal relationships with this same group very satisfying.

Providers may favor particular patients because of any number of independent variables besides the insurance plan. For example, large differences between the demographic characteristics of capitation and noncapitation groups may influence physicians' attitudes toward their patients. This study, however, was not designed to evaluate the importance of other possible independent variables.

Average satisfaction levels diminished at the time of each successive sampling. Among the three independent variables considered, only the duration of the program had a statistically significant negative correlation with the average satisfaction score. Perhaps other independent variables external to this study could explain this decrease in the average satisfaction score. Possibly, the increasing loss of physician autonomy, now found in other reimbursement programs such as Medicare, added to physician dissatisfaction. This survey instrument asked providers to compare their feelings toward capitation patients with their feelings toward the rest of their patients, however. Phrasing the question this way reduces the potential effects of other cost-containment programs.

It is difficult to generalize these data because the sample sizes are small, providers in this study may not be typical of the average primary care provider, and capitation programs vary. Nevertheless, these data support the speculation that physicians, who are accustomed traditionally to high levels of autonomy in managing their patients, will find the management of capitation patients less satisfying.

Studies of provider satisfaction have broad management and quality-of-care implications. One provider commonly interacts with thousands of patients. Consequently, improving one provider's satisfaction level may affect favorably the quality of care and satisfaction levels of many patients. Finding ways to increase provider satisfaction may also enhance the success of cost-containment programs. Future studies should address the effects of capitation and risk-sharing on a larger and broader-based sample of physicians.

References

1. Ben-David J: The professional role of the physician in bureaucratized medicine: A study in role-conflict. Hum Relations 1958; 2: 255–274
2. McElrath DC: Perspectives and participation of physicians in prepaid group practice. Am Sociol Rev 1961; 26:596–607

3. Mechanic D: General medical practice: Some comparisons between the work of primary care physicians in the United States and England and Wales. Med Care 1972; 10:402–420
4. Mechanic D: The organization of medical practice and practice orientations among physicians in prepaid and nonprepaid primary care settings. Med Care 1975; 189–204
5. Scott WR, Shortell SM: Organizational performance: Managing for efficiency and effectiveness. In Shortell SM, Kaluzny AD (eds): Health Care Management: A Text in Organization Theory and Behavior. New York, John Wiley & Sons, 1983
6. Lichtenstein RL: The job satisfaction and retention of physicians in organized settings; a literature review. Med Care Rev 1984; 41:139–179
7. Likert R: New Patterns of Management. New York, McGraw-Hill, 1961
8. Porter LW, Steers RM: Organizational, work, and personal factors in employee turnover and absenteeism. Psychol Bull 1973; 80: 151–176
9. Prybil LD: Characteristics, career patterns and opinions of physicians who practice in large multi-specialty groups. Med Group Manage 1974; 21:22–26
10. Ross A Jr: A report on physician termination in group practice. Med Group Manage 1969; 16:15–21
11. Nicholas GA: Job satisfaction and nurses' intention to remain with or to leave an organization. Nurs Res 1971; 20:218–228
12. Linn LS, Brook RH, Clark VA, et al: Physician and patient satisfaction as factors related to the organization of internal medicine group practices. Med Care 1985; 23:1171–1178
13. Weisman CS, Nathanson CA: Professional satisfaction and client outcomes, a comparative organizational analysis. Med Care 1985; 23:1179–1192
14. Melville A: Job satisfaction in general practice: Implications for prescribing. Soc Sci Med 1980; 14A:495–499
15. Mechanic D: Politics, Medicine and Social Science. New York, Wiley-Interscience, 1974
16. Shore BE, Franks P: Physician satisfaction with patient encounters: Reliability and validity of an encounter-specific questionnaire. Med Care 1986; 24:580–589
17. Linn LS, Yager J, Cope D, et al: Health status, job satisfaction, job stress, and life satisfaction among academic and clinical faculty. JAMA 1985; 254:2775–2782
18. Stamps PL, Piedmont EB, Slavitt DB, et al: Measurement of work satisfaction among health professionals. Med Care 1978; 16:337–353
19. Murray JP: A comparison of patient satisfaction among prepayment and fee-for-service patients. J Fam Pract 1987; 24:203–207
20. Lichtenstein R: Measuring the job satisfaction of physicians in organized settings. Med Care 1984; 22:56–89
21. Mawardi BH: A career study of physicians. J Med Educ 1965; 40:658–666
22. Mechanic D: Correlates of frustration among British general practitioners. J Health Soc Behav 1970; 11:87–104
23. Friedson E: Prepaid group practice and the new "demanding patient." Milbank Mem Fund Q 1973; 51:473–488
24. Hopkins CE: Cost-sharing and prior authorization effects on medical services in California: Part 2. The providers' reactions. Med Care 1975; 8:643–647
25. Curreri PW, Zimmerman CE, Jaffe BM, et al: Survey of employment satisfaction in academic surgery. J Surg Res 1974; 17:215–218
26. Mangelsdorff AD, Hubbart JA: Army physicians' attitudes toward military medicine. Milit Med 1976; 14:784–789
27. Breslau N, Novack AH, Wolf G: Work settings and job satisfaction: A study of primary care physicians and paramedical personnel. Med Care 1978; 16:850–862
28. Hassinger EW, Gill LS, Hobbs DJ, et al: Perceptions of rural and metropolitan physicians about rural practice and the rural community, Missouri. 1975. Public Health Rep 1980; 95:69–79
29. Weinberger M, Greene JY, Mamlin JJ: The impact of clinical encounter events on patient and physician satisfaction. Soc Sci Med 1981; 15:239–244
30. Linn LS: Career orientations and the quality of working life among medical interns and residents. Soc Sci Med 1981; 15A:259–263
31. McCranie EW, Hornsby JL, Calvert JC: Practice and career satisfaction among residency trained family physicians: A national survey. J Fam Pract 1982; 14:1107–1114
32. Fuller WC, Bhatara VS, Ricci JS, et al: Job satisfaction of central South Dakota physicians. S Dakota J Med 1982; 35:7–11
33. Peters AS, Markello R: Job satisfaction among academic physicians: Attitudes toward job components. J Med Educ 1982; 57: 937–939
34. Barr JK, Steinberg MK: Professional participation in organizational decision making: Physicians in HMOs. J Community Health 1983; 8:160–173
35. Barber FA: Faculty satisfaction, activity, and retention: A study of army academic orthopaedic surgeons. Milit Med 1983; 148: 410–413
36. Rawlins JM, Segree W: Suggestions for increased job satisfaction for doctors and for improved patient care. West Indian Med J 1984; 33:87–91
37. 1R Multiple Linear Regression, 1987 Version. Los Angeles, BMDP Statistical Software, 1987, 2 5.25-inch disks, 1 3.50-inch disk, 4 manuals

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