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ABSTRACT

This document reports on a study of influences on the choice of family practice as a medical speciality in a setting in which primary care is not stressed. The study surveyed 392 alumni of the University of Michigan Medical School who graduated between 1950 and 1984 and were members of the American Academy of Family Physicians and/or were certified by the American Board of Family Practice; of these, 243 returned completed questionnaires for a response rate of 63%. Each eligible graduate received a questionnaire consisting of five sections and 40 questions. The questionnaire items included such topics as: year of graduation from medical school; post-graduate training; parents' occupations; practice profiles; time period during which decision to be a family physician was made; and institutional influences on career choice. Results include the following: 16% of the family physicians surveyed had at least one physician parent; about 52% came from middle class families; most came from large and small hometowns with 36.9% growing up in major metropolitan areas or suburbs of a city larger than 50,000; and private physicians practicing in either solo or group practices comprised 73% of the respondents. The largest influences on specialty choice were found to be the opportunity to treat a variety of illnesses, know patients personally, and work with people as opposed to things. The medical school setting provided little support for the choice of family practice but offered an environment of high quality education and an opportunity to see a variety of illnesses. Contains 13 tables and 24 references. (SM)

The Tertiary Care Medical Center as a Training Ground For Family Physicians

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INTRODUCTION

Since the turn of the century, a dramatic shift in orientation away from primary patient care has been evidenced in the popularity and universality of specialization. In 1900, at least 80% of all practicing physicians were general practitioners; by 1970 that figure had dropped to 20%. Although the popularity of general practice waned in the medical community, the patient community's desire for generalists did not. The specialty of family practice was established in 1969 to address the needs of the patient population and to give academic credibility to family medicine (Geyman, 1985). To better understand and focus the growth of the specialty of family practice, researchers need to study the demographic features of individuals who choose family practice, the motivating factors behind their decision to become a family physician, and the educational setting in which the decision was made.

The literature on specialty choice has come primarily from institutions that focus on primary care either through mandatory primary care clerkships or by basing all clinical experiences in community-based hospitals. These institutions differ significantly from the University of Michigan where the focus is on tertiary care, there are no required primary care clerkships, and the choice of family practice is often disparaged by faculty and residents from other specialties.

General conclusions about personal and practice demographics and influences on specialty choice can be derived from the literature. Wilson and Hallett (1985) found significant influences on specialty choice of family practice included preference for a continual physician-patient relationship and knowing a patient personally over a period of time, desire to live in a rural area, desire to coordinate a patient's total care and involve the patient in treatment decisions, and desire to be close to the patient and his/her family. The challenge of difficult diagnoses and the ability to work with well-established treatment procedures were also influential as were the need for few manual skills and the opportunity to treat a variety of illnesses. Wilson and Hallett also explored personal demographics that correlated with the choice of family practice and found children of small town, rural, middle-class families and/or children of general physicians tended to be family physicians and tended to return to a town of the same size to practice. The commitment of the medical school to family practice was also strongly influential. Personal factors such as beliefs, past experiences, and present situation and career factors such as pay, prestige, and promotional opportunities were examined as well. Many of these factors were previously reported by Monk and Terris in 1956.

Taylor (1986) reported factors influencing the decision to be a family physician can be separated according to when the decision was made. Role models, family, and community influences are strongest before medical school, clerkships are the strongest influence during medical school, and experience in another specialty and realizing the nature of family practice work are the strongest influences after medical school. The influence of a preceptorship on career choice was explored by Chaulk, Bass, and Paulman (1987) who found that not only was the preceptorship experience a good one, but that it had a significant influence on career choice. Black, Schmittling, and Stern (1980) found a direct relationship between the year a student took a preceptorship and the year the specialty choice was made by the student.Other studies explored practice profiles and practice type and delineated the differences between an area of specialization and personality type, the relationship between the medical school orientation and the career choices of the graduates (Corley, 1983 and

Erdman, Jones, and Tonesk, 1978).

Other studies and reports that were reviewed in preparing and analyzing this study included Allen et al. (1987), Bass and Paulman (1983), Brearley, Simpson, and Baker (1982), Burkett and Gelula (1982), Ciriacy et al. (1980), Czinkota and Johnston (1983), Edwards, Euans, and Kissling (1988), Gaede et al. (1983), Geyman (1980), Hafferty and Boulger (1986), Henry and Zivick (1986), McCranie, Hornsby, and Calvert, (1982), Paiva, Vu, and Verhulst (1982), and Rabinowitz (1988).

This study explored influences on the specialty choice of family practice in a setting in which primary care is not stressed. Factors explored included the timeframe in which the decision to become a family physician was made, personal demographics, practice profiles, institutional influences on the decision, and satisfaction with the choice to become a family physician.

METHODS

During the summer of 1987, the authors surveyed 392 alumni of the University of Michigan Medical School who graduated from medical school between 1950 and 1984 and were members of the American Academy of Family Physicians (AAFP) and/or were certified by the American Board of Family Practice (ABFP). The alumni were selected from a list of all graduates provided by the University of Michigan Medical Center Alumni Society.

Each eligible graduate received a questionnaire with a cover letter outlining the purpose of the study and the means by which confidentiality would be maintained, a coded cover sheet, and a stamped, addressed, return envelope. The questionnaire consisted of five sections and 40 questions. Respondents were also informed how they could get a copy of the results. Each questionnaire had a unique code on the cover sheet and upon return, the cover sheet was removed and placed separately from the response data. The questionnaire responses were then coded for analysis. The cover sheets served to acknowledge receipt of the questionnaire and to avoid further mailings to the respondent. Two follow-up letters were sent two and four weeks after the initial mailing. The second follow-up mailing included a stamped, addressed postcard to return if an additional questionnaire was needed.

The questionnaire items were developed according to the factors reported in the literature. These included year of graduation from medical school, post-graduate training, parents' occupations, size of home town, practice profiles, size of the town in which respondent practiced, current type of practice, time period during which decision to be a family physician was made, person's age at the time of the decision, relative strength and valence of personal, environmental, and institutional influences on career choice, reservations about the decision to become a family physician, positive and negative influences of the university's tertiary care setting, positive and negative experiences that reinforced the decision, curriculum related to preparedness for practice, faculty contacts that positively affected the decision, questions regarding whether the person would choose or recommend the University of Michigan again for family practice, other specialties the respondent would have chosen, and overall satisfaction with specialty choice. A variety of checklist, Likert-type, and open-ended items were utilized.

RESULTS

Three of the 392 questionnaires were returned by the postal service marked as undeliverable and no alternate address could be found. Responses to the initial and follow-up mailings were received from 246 individuals, including three who chose not to participate, for a response rate of 63%. Among the 243 individuals who returned completed questionnaires, 85% were males and 15% were females while 89% were currently married. This sample compared favorably to the percentage of the total number of male (87%) and female (13%) graduates from the medical school from 1954-1984. In response to a question regarding overall satisfaction with the choice to become a family physician, 91% of the alumni who answered this question indicated great or moderate satisfaction with their choice.

Forty (16%) of the family physicians surveyed had at least one physician parent and of those forty, only eight had at least one parent who was a general or family physician. About 52% of the respondents came from middle class families and 47% of the respondents came from rural areas or

small cities (population < 50,000).

Private physicians practicing in either solo or group practices comprised 73% of the respondents with another 12% working in an HMO or as a hospital staff member. Of all the physicians surveyed, 22% were involved in teaching in either a part-time or full-time faculty position. The practice profiles included a surprising 74% of the family physicians still practicing obstetrics while 63% of the respondents were board-certified family physicians. Slightly over half of the respondents, 53%, reported that the medical school curriculum met their needs as a family physician.

Most of the respondents came from large and small hometowns with 36.9% growing up in major metropolitan areas or suburbs of a large city larger than 50,000 in population and 29.6% coming from towns of less than 10,000. For size of town of practice, 32.6% of the respondents reported they practiced in towns of less than 10,000 and 28.3% practiced in major metropolitan areas or suburbs.

Wilson and Hallet's finding that the size of hometown accurately predicts the size of the town in which the person practices was also found in this study. Respondents from small hometowns (population <10,000) were significantly more likely to choose a small town for a practice site. The same association existed for people from large metropolitan areas (population > 50,000) as they were more likely to choose metropolitan areas as their practice sites (X^2=53.107, df=16, p<.001).

Twenty-three potential influences on specialty choice were offered and the strength of each of the influences was assessed by the respondent using a 0 to 7 scale. Mean responses and standard deviations for each influence are summarized in Table 7. "Ability to treat a variety of illnesses" was the strongest influence on specialty choice in this population with a mean of 5.76 (sd=1.29) indicating a moderate to strong influence on specialty choice. "The opportunity to know patients personally" was also a moderately strong influence (mean=5.60, sd=1.49), as were "Ability to work better with people as opposed to things" (mean=5.27, sd=1.79) and "Opportunity to coordinate a patient's care" (mean=5.11, sd=1.66). Not surprisingly, "Commitment of the medical school to family practice" (mean=0.71, sd=1 06), "Respondent's sense of belonging in family practice due to affiliations with groups in medical school" (mean=1.42, sd=1.78), "Attendance at family practice seminars, career nights, informal gatherings, etc.," (mean=1.45, sd=1.61) and "Expected salary" (mean=1.61, sd=1.53) were weak influences at the University of Michigan.

A correlational analysis was used to assess the relationship between the 23 sources of influence on respondents' specialty choice and the development of family practice as a specialty. Pearson correlation coefficients were calculated for each of the 23 items paired with the year of the respondent's graduation. Positive, significant correlations were observed on "Contact with role models" (r=.30, df=43, p<.05) and "Other subspecialty training" (r=.29, df=43, p<.05). The influence of these two items is strongest among more recent graduates and weakest among the earliest graduates. The first finding is understandable due to the increasing visibility of family practice faculty within educational and clinical activities within the medical school during the more recent years. The second finding can be attributed to the increasingly subspecialty nature of the training at the medical school with each successive year. Significant but negative correlations were observed on "Contact with difficult diagnoses" (r=-.36, df=43, p<.05) and "Expected salary" (r=-.32, df=43, p<.05). The influence of these two items on specialty choice is greatest among the earliest graduates and weakest among more recent graduates. An explanation of the negative correlation between year of graduation and "Contact with difficulty diagnoses" could be attributed to the increasingly tertiary nature of the medical school experience over the past years that has made contact with difficult diagnoses more common than in the 1950s and 1960s. The greater influence of "Expected salary" for those who graduated in the earlier years studied could be attributed to the large numbers of older students, especially veterans of World War II and the Korean War who were within that cluster as well as the greater sense of service and social commitment often found among those who went to college and medical school during the 1970s and early 1980s. Examination of the scatter plots confirm that the relationship between these items and year of graduation is linear.

Univariate analysis of variance (ANOVA) was used to investigate the influence of each of the 23 items on specialty choice. Respondents were clustered according to important dates in the history of family practice as a specialty and in the history of family practice and primary care at the University of

Michigan and compared on each of the 23 items. The cluster for the graduates between 1954-69 was chosen to attempt to include graduates likely to be less than 65 years old and still in active practice as well as those who graduated from medical school prior to the establishment of family practice as a specialty in 1969. The cluster from 1970-73 encompasses the time of the initial development of family practice residencies in the state of Michigan. The years from 1974-78 covered a period of major involvement by the Michigan Academy of Family Physicians to develop programs in family practice at all three medical schools in Michigan and the establishment of the University of Michigan Department of Family Practice on March 1, 1978. The period from 1979-1982 was marked by the initial presence of family practice faculty at the university while 1983-84 represented alumni who had entered medical school in 1979 and 1980 and were in the first classes to go through all four years of medical school with family practice faculty at the University of Michigan. Those in the 1983-84 cluster had also just completed residency training at the time of the survey.

Six items were found to have significant overall F statistics. Post-hoc contrasts were then performed between each of the clusters for these items. Table 8 displays the 23 items and their overall and cluster means. The cluster means in bold print indicate that significant contrasts were found for these six items.

When asked if they would return to the University of Michigan provided their choice of family practice remained the same, 74% indicated they would return citing the excellent education as the main reason. Of those that would not return, the lack of exposure to primary care medicine (25%), the lack of support for the decision to enter family practice (25%), and bad personal experiences with faculty at the University of Michigan (23%) were the main reasons given for the decision not to return. Likewise, 72% of the respondents indicated they would recommend the University of Michigan Medical School to a young person thinking of becoming a family physician, citing similar reasons to those just discussed. For these and other open-ended items on the questionnaire, multiple responses were allowed and coded for analysis.

Respondents were asked a series of questions concerning their decision to become family physicians. The mean age at which the decision was made to become a family physician was 22.5 years (sd=5.4, range=5-47). When asked which time period best represented the time during which they made the decision to become a family physician, 50% indicated during medical school, 22% before or during high school, 19% after high school and/or during undergraduate college, 5% after residency training or internship, and 4% after medical school while in residency training in another specialty. Fifty-two percent of the respondents indicated there was one positive or negative experience that strongly reinforced the decision to become a family physician. Examples of experiences that served to strongly reinforce the respondents' decisions to become family physicians included the following statements. One respondent wrote, "The resident on my first rotation (3rd year) had just returned from the PHS in a remote area. He had done 'general practice' and impressed on me the need for generalists." Another alumnus responded, "1) Seeing patients come in on wrong medications or wrong diagnoses made me want to treat them better and 2) The faculty who told me he wouldn't give me a recommendation letter for FP, he made me mad and swayed me toward FP!" A third respondent answered, "I could not believe that the LMD was incompetent and was willing to risk becoming that LMD to prove that the family physician was indeed competent and necessary to the health care of the L.P. (local patient)."

Overall, 60% of the respondents had no serious reservations at any time about their decision to become a family physician. If the respondents could not have become family physicians, their choices of specialty would have been internal medicine (21%), obstetrics/gynecology (17%), pediatrics (15%), surgery (8%), dermatology (7%), orthopaedic surgery (6%), and emergency medicine (5%).

There was a strong association between the time of decision and the cluster of graduation years (X^2=44.81, df=16, p<.0001). The most striking results were for those who graduated during the years 1950-1969 as more of these respondents than expected made their decisions after medical school and after internship or residency training. Since there were no family practice departments or residency programs during the time these respondents were in medical school, these findings are not surprising. Respondents in the clusters of graduation years of 1974-78 and 1979-82 made their decisions to become family physicians in greater numbers than expected during medical school, perhaps as a result of the activities leading up to and after the establishment of the Department of

Family Practice at the University of Michigan in March 1978.

Respondents also described aspects of the tertiary care setting that positively and negatively affected their decision to become family physicians. In response to the question of positive influence, 35% of the respondents left the item blank or wrote none. Of the 158 who responded to this item, 47 detailed how negative behaviors exhibited toward patients by the specialists in the tertiary care setting convinced them of the importance of the primary care providers' role in the community. One respondent wrote, "The dehumanization of splitting and fragmenting patients into disease processes of specialization. People treated as disease rather than a total person who has a specific disease." Another responded, "I realized I actually wanted to know my families and the University demonstrated that was impossible in a tertiary setting." A third wrote, "The recognition that I felt most challenged by diversity rather than subspecialty. Exposure to extremely talented people in subspecialties made multiple areas interesting." Another graduate commented, "For many people in my class, family practice was a reaction against what we saw at the university. The depersonalization of the patient, lack of importance of psychosocial issues, attendings that knew a lot about organs and nothing about people."

Of the 208 who responded to the item on negative influences of the medical center, 21% used "L.M.D." or "local medical doctor" in citing examples of derogatory comments made about family/general physicians. Representative comments include, "It was expected that we all would be specialists not generalists and we were talked to accordingly. The 'poorly trained L.M.D.' was referred to in a condescending fashion. We've had to overcome that stigma!!!" Another respondent commented, "When I attended U of M med school, the 'LMD' was a low-life, unsophisticated ignoramus and the U was the 'mecca' of enlightenment. I heard nothing good about family practice."

Another 81 alumni reported influential faculty or residents made condescending remarks about the specialty and those in it. One alumnus stated, "Too many to list, one was biochem professor characterizing family doctors as 'Hick-boob doctors' in lecture, much negative input was slightly more subtle, the dean's comments 'no one could do reasonable GP with less than 6 years residency." Another wrote, "Senior year, seven who indicated they were interested in FP (GP in those days), I was one of the seven, were required to meet with a member of the department of psychiatry as a group to discuss values, goals, decision making and GP as a dying specialty. We also were informed of the North Carolina study indicating the poor quality of care given by GP's." A third wrote, "Meeting for my dean's letter and having him tell me I shouldn't go into FP shook me up a bit."

Other respondents mentioned instances of being told by faculty that family practice was not a "real" specialty or that the individual was too smart to "waste his/her mind" on family practice. Other alumni noted there were no family physician role models with whom to interact.

DISCUSSION

Many of the findings of the survey were encouraging and similar to those reported by other researchers. Other findings were not as supportive of previous research. The finding of an association between the size of the hometown and the size of the town of practice that was strong and supportive of other research in the field was encouraging. Due to the steep competition for admission to the University of Michigan, the heavy proportion of students from major metropolitan areas that attend the University of Michigan, and the tertiary care nature of the medical school, the researchers expected that many more students would choose to practice in a larger city and/or metropolitan area regardless of home town size. The finding that respondents from larger home towns returned to metropolitan areas to practice as family physicians was as expected.

The family background of the respondents was similar to other research but only about half of all respondents fit the mold of the previous studies (middle-class child) suggesting that influences other than role models and middle class family values are drawing people to family practice at the University of Michigan. The overwhelming number of physicians in private practice supports the idea that the physician wants greater professional independence than seen at the university. However many of those in private practice are among the older respondents who will soon be leaving active practice. The number of respondents who would return to the University of Michigan even with the negative

attitudes toward primary care coupled with the 60% of all respondents who had no reservations about their decision to become family physicians reinforced the notion that a strong academic, tertiary care setting like the University of Michigan may be an acceptable environment for the training of family physicians.

The results of analysis of the respondent ratings of the 23 influences on specialty choice result in important findings for this sample. As expected, those factors directly related to characteristics of family practice such as factors related to continuous and comprehensive care and interpersonal relationships with patients were of greater influence while factors related to the relatively low prestige of family practice within the medical school and hospital received the lowest overall ratings. However, participation in a preceptorship and contact with role models did not have as significant impact at the University of Michigan as has been demonstrated in similar studies. The hostile attitude often exhibited toward those students considering the specialty of family practice at the University of Michigan, coupled with the lack of continuous, coordinated care shown to be valued by the respondents, may serve as a paradoxically positive influence that reinforces the choice of an interactive person- and family-oriented specialty.

Many of the findings can be attributed to the increasing visibility of family practice as a specialty nationally and at the University of Michigan with each successive year. While the presence and influence of family practice at the University of Michigan are not as impressive as at other medical schools, this study does offer findings that the most recent graduates have benefited by local and national changes.

SUMMARY AND CONCLUSIONS

The tertiary care setting and other influences on specialty choice were explored in this study of graduates of the University of Michigan Medical School. The largest influences on specialty choice were found to be the opportunity to treat a variety of illnesses, know patients personally, and work with people as opposed to things. The medical school setting although providing little support for the choice of family practice, offered an environment of high-quality education, an opportunity to see a variety of illnesses, and a model of tertiary, uncoordinated, discontinuous care which the graduates were determined not to replicate in their own medical careers. This environment was desirable to most of the respondents as seen by their decision to return to the University of Michigan if they were to do it all again, due primarily to the quality of the education they received despite some of the negative experiences they had to endure while receiving that education. A large proportion of the respondents had no reservations about their decision to become a family physician and are greatly or moderately satisfied with their specialty choice. Support for previous research was found in the significant correlation of hometown size and the size of the town in which the respondent practiced. This survey does not answer the question of whether or not a tertiary care setting is best suited for the training of primary care physicians, but it does provide data indicating that family physicians trained in such an environment can be satisfied with their career choice and medical school.

The study has limitations that should be addressed in future studies. Only one school and specialty is studied and the survey questionnaire has not been administered with any other samples or specialties. There is no information regarding the academic achievements of the respondents during medical school or residency and there is no way to judge their success or competence in practice. This research sets the stage for a more in-depth look at the tertiary care setting as an influence, both positive and negative, on specialty choice as well as examining other personal and environmental factors that influence the decision to become a family physician. By examining these influences and by scrutinizing medical care in the tertiary care setting, perhaps a more conducive environment for the development of primary care physicians can be achieved.

TABLE 1

Survey Response Rate

Surveys Returned	246	Surveys Mailed	392
Respondents Declined	3	Unable to Deliver	3
N =	243	N =	389
Response Rate	246/389 = 63.2%		

Complete Data Received from 243 Respondents

TABLE 2

Demographic Features of the 243 Respondents

1. Gender:	Males	206	(85%)
	Females	37	(15%)
2. Marital status:		217	(89%) are currently married
3. Parental background:		40	(16%) have at least one physician parent
4. Board-certified family physicians:		152	(63%)

TABLE 3

Overall Satisfaction with Decision to Become a Family Physician

Response	Number	Percentage
Greatly Satisfied	149	61.8
Moderately Satisfied	70	29.0
Somewhat Satisfied	10	4.1
Not Satisfied	12	5.0
Blank	2	

TABLE 4

Did Curriculum in Medical School Meet Respondent's Needs as a Family Physician?

Response	Number	Percentage
Yes	122	53.0
No	108	47.0
Blank	13	

TABLE 5

Size of Hometown

Response	Number	Percentage
<10,000	69	29.6
10,000-24,999	21	9.0
25,000-50,000	24	10.3
>50,000 (NOT including suburbs of major metropolitan areas)	33	14.2
Major Metropolitan area/suburb of a large city >50,000	86	36.9
Blank	10	

TABLE 6

Size of Towns in Which Respondents Practice

Response	Number	Percentage
<10,000	76	32.6
10,000-24,999	29	12.4
25,000-50,000	26	11.2
>50,000 (NOT including suburbs of major metropolitan areas)	36	15.5
Major Metropolitan area/suburb of a large city >50,000	66	28.3
Blank	10	

TABLE 7

Factors that Influence Specialty Choice

FACTORS	MEAN	S.D.
Participation in voluntary preceptorship	3.31	2.47
Contact with role models (before medical school)	3.56	2.39
Contact with role models (during medical school)	2.55	2.12
Perceived prestige of family practice	2.14	1.85
Other subspecialty training	2.20	2.14
Family or lifestyle issues/concerns	3.39	2.12
Ability to coordinate patient's total care	5.11	1.66
Contact with difficult diagnoses	3.03	1.95
Know patients personally	5.60	1.49
Involve patients in treatment decisions	4.14	2.06
Ability to treat a variety of illnesses	5.76	1.29
Ability to work with people as opposed to things	5.27	1.79
Sense of belonging in family practice due to group affiliations	1.42	1.78
Attendance at family practice seminars, career nights, etc.	1.45	1.61
Expected salary	1.61	1.53
Commitment of medical school to family practice	0.71	1.06
Opportunities for career advancement	1.63	1.63
Ability to meet needs of underserved populations	3.27	2.11
Desire to work independently	4.24	2.08
Market/demand for family physicians	3.31	2.02
Desire to live in a rural area	3.06	2.48
Enjoy working with hands	3.20	2.22
Work with well-established treatment procedures	2.24	1.91

Scale: 7=Strong influence, 4=Moderate influence, 1=Weak influence, 0=No influence

TABLE 8

Factors that Influence Specialty Choice
Total and by Cluster of Graduation Years

FACTORS	ALL YEARS (n=243)	Graduation Years '54-'69 (n=91)	'70-'73 (n=19)	'74-'78 (n=51)	'79-'82 (n=56)	'83-'84 (n=26)
Participation in voluntary preceptorship	3.31	**2.40**	3.62	**4.23**	3.27	3.13
Contact with role models (before medical school)	3.56	3.99	3.75	**2.93**	**3.08**	**4.21**
Contact with role models (during medical school)	2.55	**1.91**	2.59	2.60	2.96	3.23
Perceived prestige of family practice	2.14	2.56	2.11	2.29	**1.61**	**1.60**
Other subspecialty training	2.20	2.05	1.93	2.41	2.18	2.55
Family or lifestyle issues/concerns	3.39	3.49	3.53	3.32	3.18	3.56
Ability to coordinate patient's total care	5.11	4.89	5.63	5.42	4.93	5.27
Contact with difficult diagnoses	3.03	3.65	3.06	**2.94**	**2.34**	**2.58**
Know patients personally	5.60	5.53	5.32	5.60	5.73	5.77
Involve patients in treatment decisions	4.14	3.97	4.37	4.08	3.96	5.04
Ability to treat a variety of illnesses	5.76	5.59	5.95	5.94	5.66	6.08
Ability to work with people as opposed to things	5.27	5.33	4.63	5.20	5.44	5.28
Sense of belonging in family practice due to group affiliations	1.42	1.07	1.61	1.63	1.43	1.82
Attendance at family practice seminars, career nights, etc.	1.45	1.37	1.37	1.44	1.47	1.70
Expected salary	1.61	1.84	1.63	1.36	1.42	1.62
Commitment of medical school to family practice	0.71	0.51	1.12	0.53	0.85	0.92
Opportunities for career advancement	1.63	1.51	2.06	1.72	1.67	1.54
Ability to meet needs of underserved populations	3.27	2.98	2.95	3.42	3.66	3.35
Desire to work independently	4.24	4.76	4.72	4.07	**3.64**	**3.77**
Market/demand for family physicians	3.31	3.45	3.78	3.29	3.25	2.65
Desire to live in a rural area	3.06	3.22	3.22	2.69	2.94	3.31
Enjoy working with hands	3.20	3.50	3.58	2.85	2.72	3.50
Work with well-established treatment procedures	2.24	2.52	2.76	2.04	1.85	2.12

Scale: 7=Strong influence, 4=Moderate influence, 1=Weak influence, 0=No influence

Six were found to have significant overall F statistics after one way analysis of variance. Post-hoc contrasts were then performed between each of the clusters for these items. The cluster means in bold print indicate that significant contrasts were found for these six items.

TABLE 9

Would Respondent Go to the University of Michigan Again?

Response	Number	Percentage
Yes	173	73.6
No	111	21.3
Other	12	5.1
Blank	8	

TABLE 10

Would Respondent Recommend the University of Michigan to a Young Person Thinking of Becoming a Family Physician?

Response	Number	Percentage
Yes	168	71.5
No	52	22.1
Other	15	6.4
Blank	8	

TABLE 11

Period During Which Decision to Become a Family Physician was Made

Response	Number	Percentage
Before or during high school	52	21.5
After high school and/or during undergraduate college	45	18.7
After undergraduate college and/or during medical school	120	49.8
After medical school while in another residency	11	4.6
After medical school while practicing/teaching	13	5.3
Blank	2	

TABLE 12

Specialty of Choice if Respondents Could Not Have Chosen Family Practice

Specialty	Number	Percentage
Internal Medicine	43	21.2
Obstetrics/Gynecology	34	16.7
Pediatrics	31	15.3
Surgery	17	8.4
Dermatology	14	6.9
Orthopaedic Surgery	12	5.9
Emergency Medicine	10	4.9
Other	32	15.8

TABLE 13

Was There An Experience: Positive or Negative that Strongly Reinforced The Decision To Become a Family Physician

Response	Number	Percentage
Yes	119	51.7
No	111	48.3
Blank	13	

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