

FAMILY MEDICINE

FACTBOOK



American Board
of Family Medicine



THE CENTER FOR
PROFESSIONALISM & VALUE
IN HEALTH CARE



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of Family Medicine**

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FAMILY MEDICINE FACTBOOK

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Preface

With a focus on longitudinal physician-patient relationships caring for a range of conditions across multiple settings, family medicine is a medical specialty uniquely positioned to impact the core functions of primary care: First Contact, Comprehensiveness, Continuity and Coordination.¹ As a patient's primary point of contact in the medical system, family physicians are trained to build patient trust, monitor population health, and provide both preventive and acute treatments in inpatient, outpatient and other settings. The scope of a family physician's practice knowledge base runs both broad and deep, and their training incorporates care of children, adults, and the elderly, as well as women throughout pregnancy, birth, and the postpartum periods.

The American Board of Family Medicine (ABFM) conducts regular surveys of family physicians across multiple points in their training and practice careers, not only during and shortly after residency training completion, but when they complete continuous certification cycles. These surveys are unique for many reasons, including their exceptional response rates. Furthermore, their analyses are used to inform not only the ABFM and Diplomates, but also policymakers, planners, and the public, about the remarkable work of family physicians and their teams. Survey data have been pivotal in advancing funding for family physicians and primary care, a better understanding of the discipline and its needs, and improving patient and population health.

Findings from these surveys tell us what family physicians are doing in practice, how it is changing over time, and who they are serving and working with. The findings also tell us how they are adapting to changes in the external environment, such as payment reform, team-based care, digital health adoption, consolidation of delivery systems, and even the pandemic. A range of stories have emerged from the ABFM research team's use of these data over the past decade. For example, after documenting the rapidly declining scope of family medicine, survey responses revealed that a broader scope of practice, and particularly provision of obstetrical care, may be protective against physician burnout.^{2,3} Family physicians are among the leaders in value-based care transformation efforts, advocating for metrics that improve population health and promote health equity.

Using the most up to date data available, we present the first edition of the Family Medicine Factbook, a curated series of basic analyses intended to provide a broad perspective on family medicine and family physicians themselves. We hope that patients, physicians, payors, policymakers, and advocates will benefit from learning more about this keystone specialty of U.S. primary care, gaining a better understanding of the physicians' geographic distribution, the populations served and services provided, their team-based care leadership and the challenges faced in the course of their work. We welcome your feedback, as we hope this is but the first in a series of data-driven insights into the contributions of the family medicine workforce.



1. Background & Context

In 2020, the emergence of the Sars-CoV-2 virus (COVID-19) placed the country's health care system under a new microscope. Failures in coordinating the health care response, along with the parallel crises of access to care and inequities of treatment have since highlighted inherent weaknesses in the current state of health care. This also shone light on the longstanding inattention to primary care. Family medicine was both called upon and impacted in many ways, including requests to cover additional care in hospitals, emergency departments, and other settings, pivot rapidly to telehealth without additional resources, and continue providing care in their offices without basic personal protective equipment (PPE). The financial challenges of smaller size and dependence on fee-for-service payment were revealed as family physicians were tasked first to survive office shutdowns and then to take on sometimes overwhelming numbers of COVID-19 patients. The risk associated with these visits was high—ultimately resulting in family physicians comprising approximately one-third of all physician COVID-19-related deaths.⁴

Family medicine has also been essential to advances in health equity and addressing social determinants of health. As the nation's most widely distributed physician discipline, family physicians also provide the majority of care for underserved urban and rural populations, and often act as a first-contact for health-related issues.⁵

This Factbook describes the current state of family medicine in the United States through the presentation of data from sources including surveys and research executed by the American Board of Family Medicine (ABFM). The intention of the Factbook is to characterize family medicine through lenses of physicians, patients, and graduate medical students. Providing a compendium of this data is critical to help guide researchers, decision makers, and other stakeholders at a time when health care delivery systems continue to evolve after the COVID-19 pandemic.

Family Medicine: A Brief History

In 1969, the American Board of Family Practice (ABFP) was approved by the American Board of Medical Specialties (ABMS) to be the 19th medical specialty board in the United States.⁶ The ABFM was the first board to issue time limited certifications, requiring physicians to demonstrate ongoing medical knowledge via examination every seven years. In 2003, ABFM became the first specialty board to issue certification which required maintenance of certification (continuous certification), doing so every 7-10 years.⁷

Family medicine is a primary care specialty, that stems from early generalist physicians, and provides first point-of-contact care to patients without the need for a referral like many other specialties.⁸ Family physicians provide the majority of care for underserved rural and urban populations in the United States, and have one of the largest scopes of practice in health care.⁵ They are the only specialists qualified to treat most health-related issues and ages ranging from newborns to seniors.⁵ This breadth of practice requires an understanding of social determinants of health and community health, the building of trust between the patient and physician, and the responsibility of being a patient's first form of contact for health care needs.⁵ Underinvestment in primary care, and subsequently family medicine, creates issues regarding patient access to necessary preventive health services and leads to declining numbers of primary care physicians in the workforce and creates reduced access to a broad range of services to patients who need them the most.⁹

Family Medicine Factbook: Data Sources and Approach

This snapshot of the family medicine workforce represents ABFM Diplomates as of January 1, 2022, following a uniquely challenging and transformative period during the COVID-19 pandemic. In January 2022, there were more than 100,000 family medicine Diplomates, representing all physicians who held current ABFM certification status. This status is initially earned by completing residency training, obtaining a full medical license, and by passing the Family Medicine Certification Examination, and is maintained by continuous family medicine Certification. To create the Factbook, we used data from responses to ABFM questionnaires received from January 1, 2016, to January 1, 2022, to describe the trends and current state of family physician demographics (see **Methods Appendix**).

The importance that this Factbook holds is two-fold. It offers insight and commentary on the current state of family medicine amidst a crucial time for health care system reflection and reform, and following the COVID-19 pandemic. Using real time data and analysis, topics of interest regarding overall patient and physician well-being are touched upon. In addition, this Factbook is strategically organized to optimize information recall and comprehension, allowing the Factbook to act as a one-stop-shop reference for discussions of the family medicine workforce, with the goal of simplifying the compendium of family medicine data to impact further research, policy reform, advocacy, and education. 🌟

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2. Who Practices Family Medicine?

As of January 1, 2022, there were a total of 102,349 family physicians certified by the American Board of Family Medicine (Diplomates). These Diplomates are distributed relatively evenly across 10-year age groupings, with a small plurality in the 40-49 age group but roughly one quarter also falling in the 30-39, 50-59, and 60+ ranges. While more than half are male (54.4%), the majority of residents in family medicine are female¹⁰, and women represent a larger share of the Diplomate pool each year. Nearly three-quarters (72.7%) of current Diplomates identify as White, with 16.6% identifying as Asian, 5.7% as Black or African American, 0.9% American Indian or Alaska Native, 0.5% as Native Hawaiian or Pacific Islander, and almost 3.5% as another race. The proportion of family physicians who identify as Hispanic or Latinx was 6.8% in 2022. In terms of medical degree and training, most family physicians (86.7%) graduated from an MD program, and nearly 77% completed residency training in the United States or Canada. [10](#)

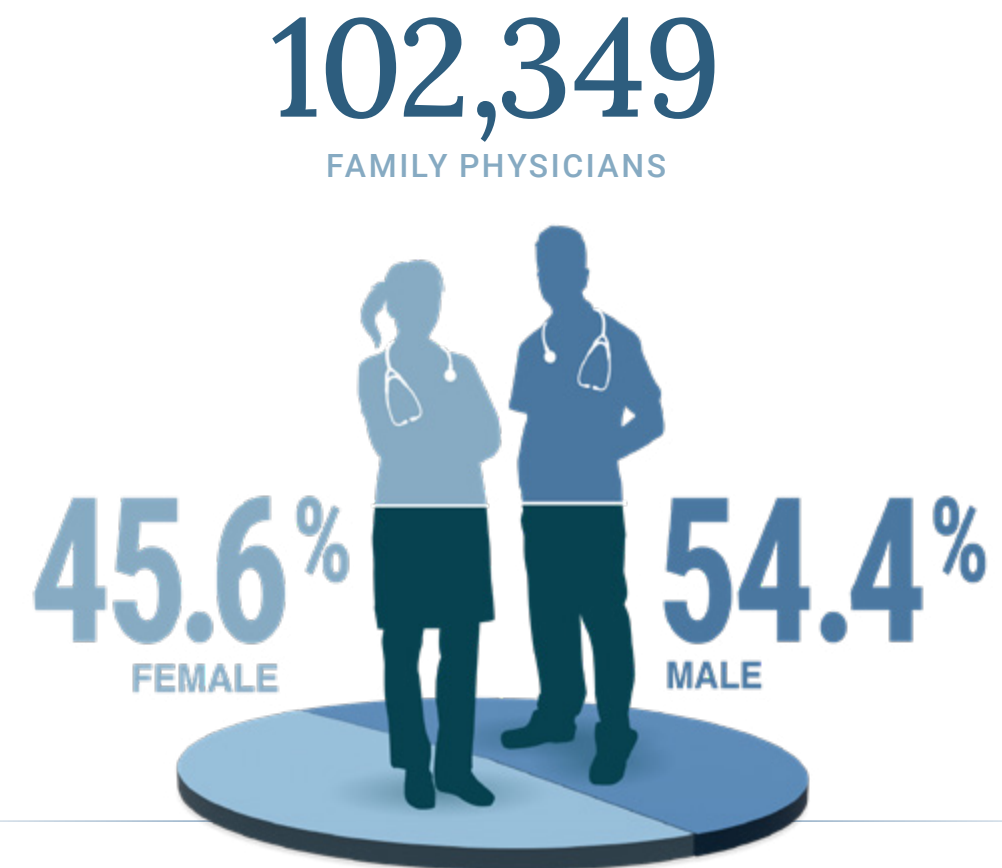


FIGURE 1:
**Family Physicians
by Gender**

FIGURE 2. Family Physicians by Age



FIGURE 3: Family Physicians by Race

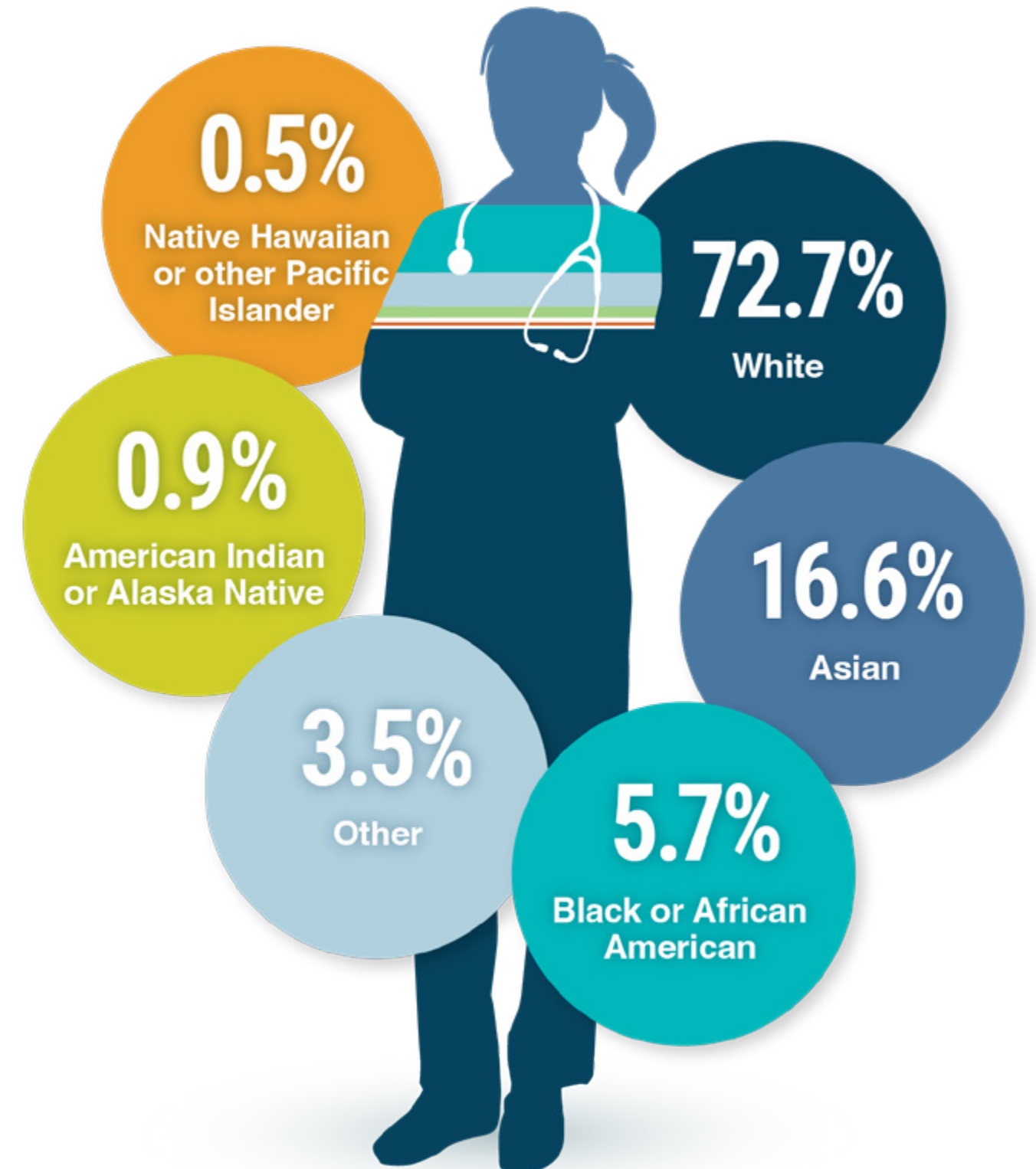
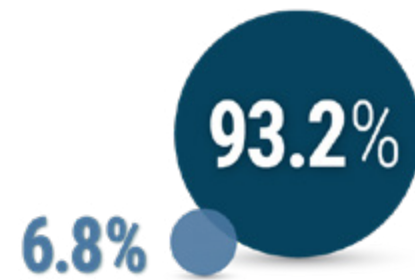
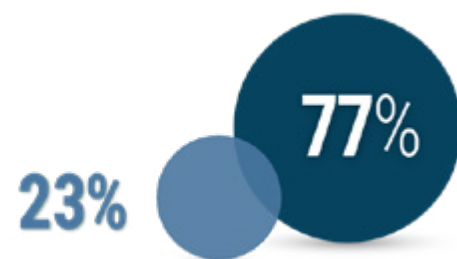


FIGURE 4:
Family Physicians by Ethnicity



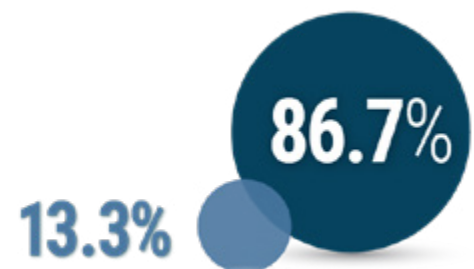
- Hispanic or Latino
- Not Hispanic or Latino

FIGURE 5:
Family Physicians by Medical School



- International
- US/Canada

FIGURE 6:
Family Physicians by Medical Degree



- DO
- MD



3. Where Do Family Physicians Practice?

Geographic Distribution of Family Physicians

American Board of Family Medicine (ABFM) Diplomates are found in all 50 states, multiple U.S. territories, and abroad in other countries. Using 2021 state-level population estimates from the U.S. Census Bureau¹¹, there are approximately 30 family physicians for every 100,000 persons in the United States. The most common state in which these physicians practice is California (12.0%) followed by Texas (7.6%), Florida (5.1%), Pennsylvania (4.1%), and New York and Illinois (3.9%). The map (Figure 7) demonstrates the ratio of family physicians per state population. Alaska has the highest number of ABFM Diplomates per 100,000 population at 65.9 while Connecticut and New Jersey have the lowest at 17.1 each.

TABLE 1. Family Physicians by Location

Location	Number of ABFM Diplomates (% of Total)	Per 100,000 population by state, 2021
UNITED STATES TOTAL	102,349	30.4
Alabama	1,250 (1.2%)	24.8
Alaska	483 (0.5%)	65.9
Arizona	1,816 (1.8%)	25.0
Arkansas	994 (1.0%)	32.8
California	12,264 (12.0%)	31.3
Colorado	2,542 (2.5%)	43.7
Connecticut	616 (0.6%)	17.1
Delaware	308 (0.3%)	30.7
District of Columbia	246 (0.2%)	36.7
Florida	5,222 (5.1%)	24.0

Continued on page 14

TABLE 1. Family Physicians by Location (Continued)

Location	Number of ABFM Diplomates (% of Total)	Per 100,000 population by state, 2021
Georgia	2,659 (2.6%)	24.6
Hawaii	529 (0.5%)	36.7
Idaho	810 (0.8%)	42.6
Illinois	3,985 (3.9%)	31.4
Indiana	2,432 (2.4%)	35.7
Iowa	1,515 (1.5%)	47.4
Kansas	1,301 (1.3%)	44.3
Kentucky	1,209 (1.2%)	26.8
Louisiana	1,147 (1.1%)	24.8
Maine	776 (0.8%)	56.5
Maryland	1,425 (1.4%)	23.1
Massachusetts	1,654 (1.6%)	23.7
Michigan	3,105 (3.0%)	30.9
Minnesota	3,073 (3.0%)	53.8
Mississippi	640 (0.6%)	21.7
Missouri	1,708 (1.7%)	27.7
Montana	545 (0.5%)	49.4
Nebraska	867 (0.8%)	44.2
Nevada	728 (0.7%)	23.2
New Hampshire	563 (0.6%)	40.5
New Jersey	1,590 (1.6%)	17.1
New Mexico	826 (0.8%)	39.0
New York	3,990 (3.9%)	20.1

TABLE 1. Family Physicians by Location (Continued)

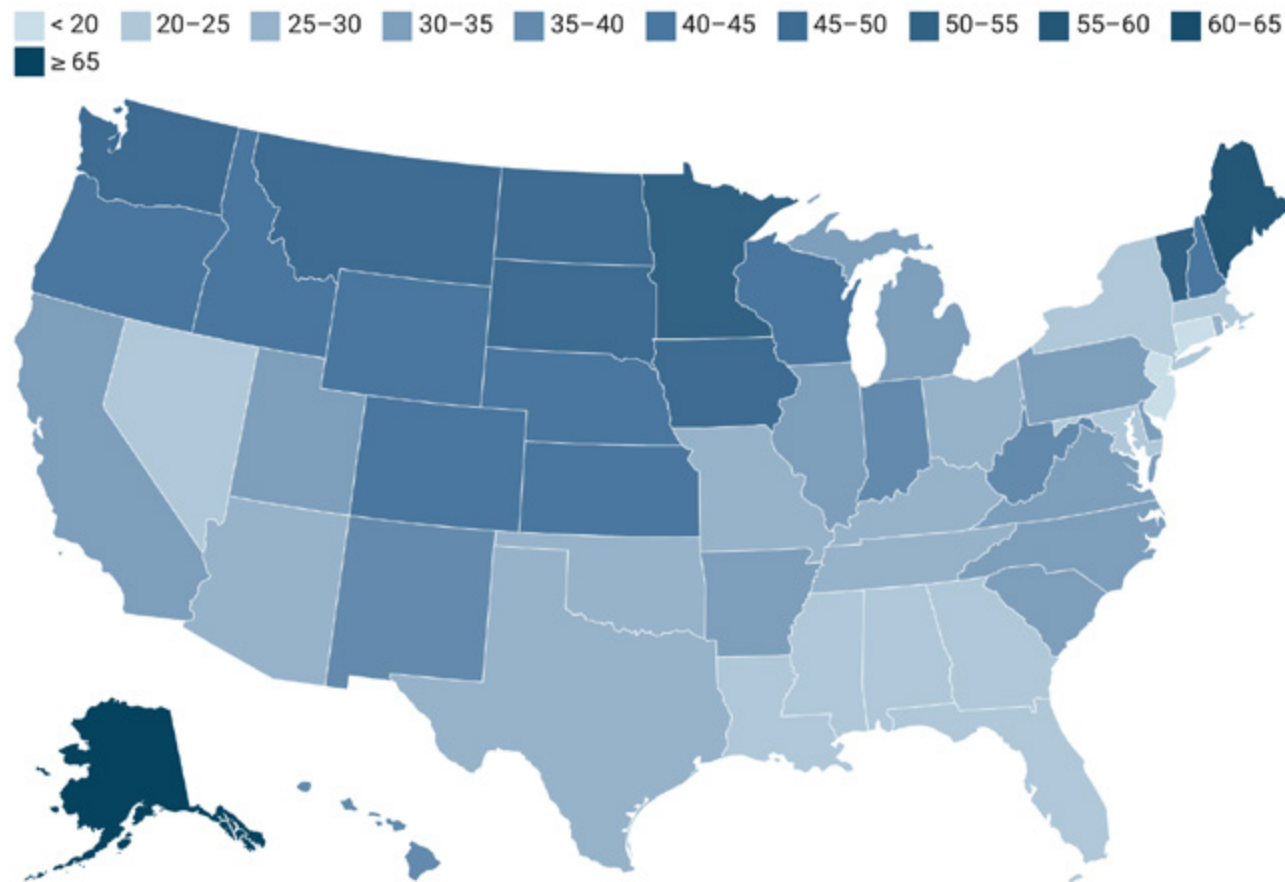
Location	Number of ABFM Diplomates (% of Total)	Per 100,000 population by state, 2021
North Carolina	3,547 (3.5%)	33.6
North Dakota	370 (0.4%)	47.7
Ohio	3,410 (3.3%)	28.9
Oklahoma	1,006 (1.0%)	25.2
Oregon	1,872 (1.8%)	44.1
Pennsylvania	4,205 (4.1%)	32.5
Rhode Island	278 (0.3%)	25.4
South Carolina	1,718 (1.7%)	33.1
South Dakota	437 (0.4%)	48.8
Tennessee	1,858 (1.8%)	26.6
Texas	7,756 (7.6%)	26.3
Utah	1,063 (1.0%)	31.8
Vermont	354 (0.3%)	54.8
Virginia	2,868 (2.8%)	33.2
Washington	3,736 (3.7%)	48.3
West Virginia	671 (0.7%)	37.6
Wisconsin	2,621 (2.6%)	44.4
Wyoming	254 (0.2%)	43.9
Federated States of Micronesia	2 (0.0%)	-
Guam	32 (0.0%)	-
Northern Mariana Islands	4 (0.0%)	-
Puerto Rico	172 (0.2%)	-
Trust Territory of the Pacific Islands	2 (0.0%)	-

Continued on page 16

TABLE 1. Family Physicians by Location (Continued)

Location	Number of ABFM Diplomates (% of Total)	Per 100,000 population by state, 2021
Virgin Islands	15 (0.0%)	-
Armed Forces Americas	2 (0.0%)	-
Armed Forces Europe	120 (0.1%)	-
Armed Forces Pacific	84 (0.1%)	-
Non-U.S.	1,074 (1.0%)	-

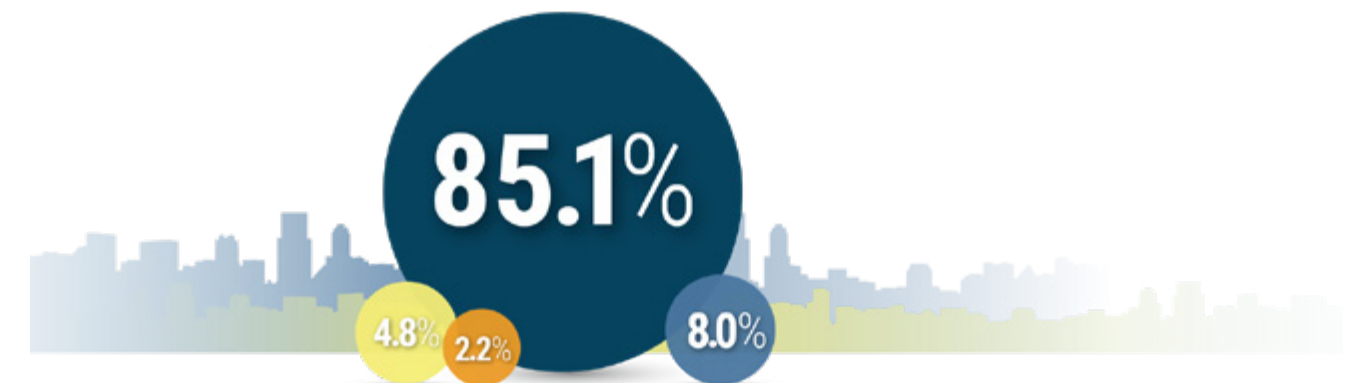
FIGURE 7. Geographic Distribution of Family Physicians per 100,000 State Population



Rural Health

Family medicine serves an important role in improving health care access for rural populations due to its breadth in scope of practice. Previous research has found that family physicians are disproportionately represented in rural areas compared to primary care physicians in other specialties.¹² ABFM defines rural practice as existing in a county with a Rural-Urban Continuum Code (RUCC) of greater than 4 on the U.S. Department of Agriculture (USDA) 9-point scale.¹³ Using practice location data for family medicine Diplomates in U.S. states, 8.0% practice in a large rural city or town, 6.9% practice in a small isolated city or town, and 85.2% do not practice in a rural area.

FIGURE 8. Family Physicians by Practice Rural-Urban Continuum Code (RUCC) Designation



Practice Location

The majority of family physicians provide direct outpatient care (93.6%). Outpatient medicine is defined as clinical work outside of a hospital setting, including ambulatory clinics, community practices, and home-based care. See Chapter 5 for more details on Diplomate practice sites.

Most family physicians reported providing continuity care (78.7%). Continuity care involves an ongoing relationship between the clinical care team and patient, forming a sustained partnership to address health care needs and whole-person health.¹⁴ By seeing the same physician over time, the patient and provider benefit from greater trust, improved communication, and partnered responsibility.¹⁵ Studies indicate a strong relationship between physician-level continuity and improved patient outcomes including reduction in ED visits, hospital admissions and readmissions, and per member per month cost.^{16, 17}

For those not in outpatient continuity care, the most popular alternative principal practice activities were urgent care (28.6%), emergency medicine (21.4%), and hospital medicine (20.2%). To further characterize physician practice types, we obtained questionnaire respondent data from early career family physicians who were practicing for three years since residency graduation (cohort from the ABFM Graduate Survey

Report – see **Methods Appendix**). Compared to ABFM Diplomates who are later in their careers and maintain continuous certification, more early career Diplomates reported practicing direct patient care (98.5% vs. 93.6%). Furthermore, if they were not practicing outpatient continuity care, early career Diplomates reported a higher percentage practicing hospitalist medicine (46.9% vs. 20.2%). Interestingly, there was a lower percentage of early career Diplomates reporting emergency medicine, geriatrics, and urgent care practice compared to mid-or late career ABFM Diplomates. 🧠

TABLE 2. Reported Practice Type by Family Physicians

	Early Career Family Physicians (N=12,106)	Mid-or Late Career Family Physicians (N=32,801)
Direct patient care N (Percent)		
Yes	11,825 (98.5%)	30,701 (93.6%)
No	281 (2.3%)	2,100 (6.4%)
Outpatient continuity care N (Percent)		
Yes	9,555 (80.8%)	24,162 (78.7%)
No (Column Percent)		
Emergency Medicine	349 (15.4%)	1,401 (21.4%)
Geriatrics	41 (1.8%)	180 (2.8%)
Hospitalist	1,063 (46.9%)	1,322 (20.2%)
Pain Management	1 (0.0%)	31 (0.5%)
Palliative Care	83 (3.7%)	256 (3.9%)
Sleep Medicine	2 (0.1%)	23 (0.4%)
Sports Medicine	78 (3.4%)	263 (4.0%)
Urgent Care	516 (22.8%)	1,872 (28.6%)
Other	135 (6.0%)	1,190 (18.2%)



FIGURE 9. Family Physicians by Practice Type

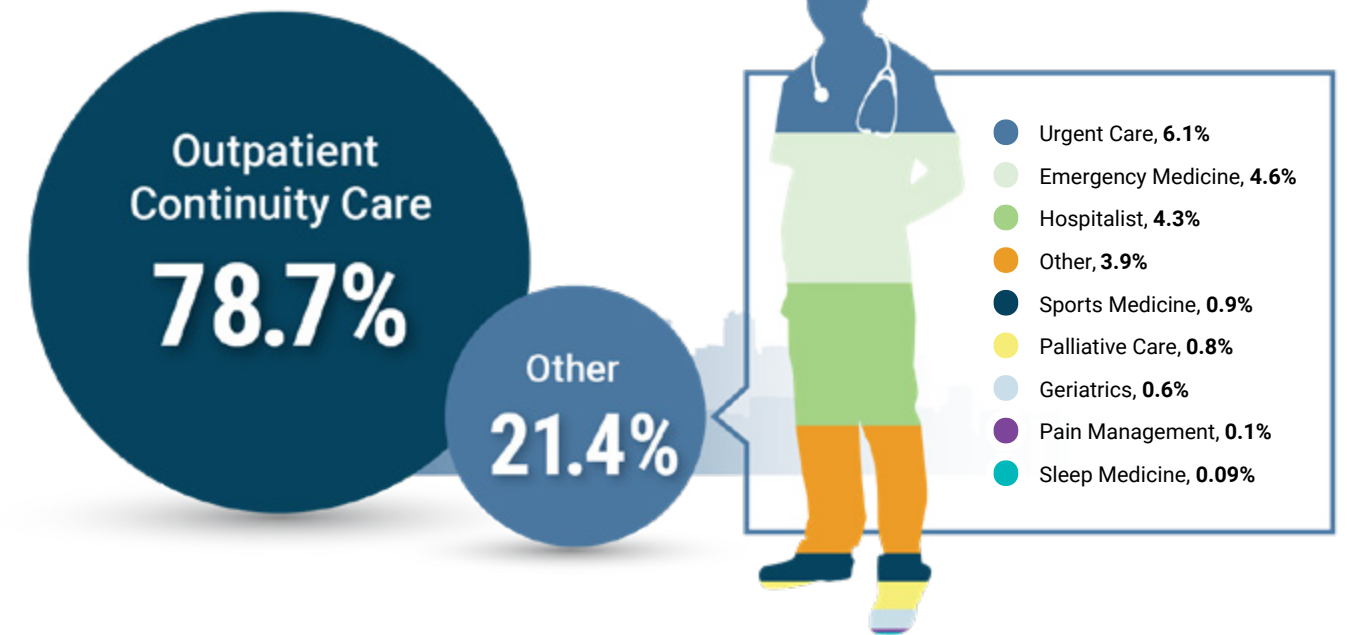
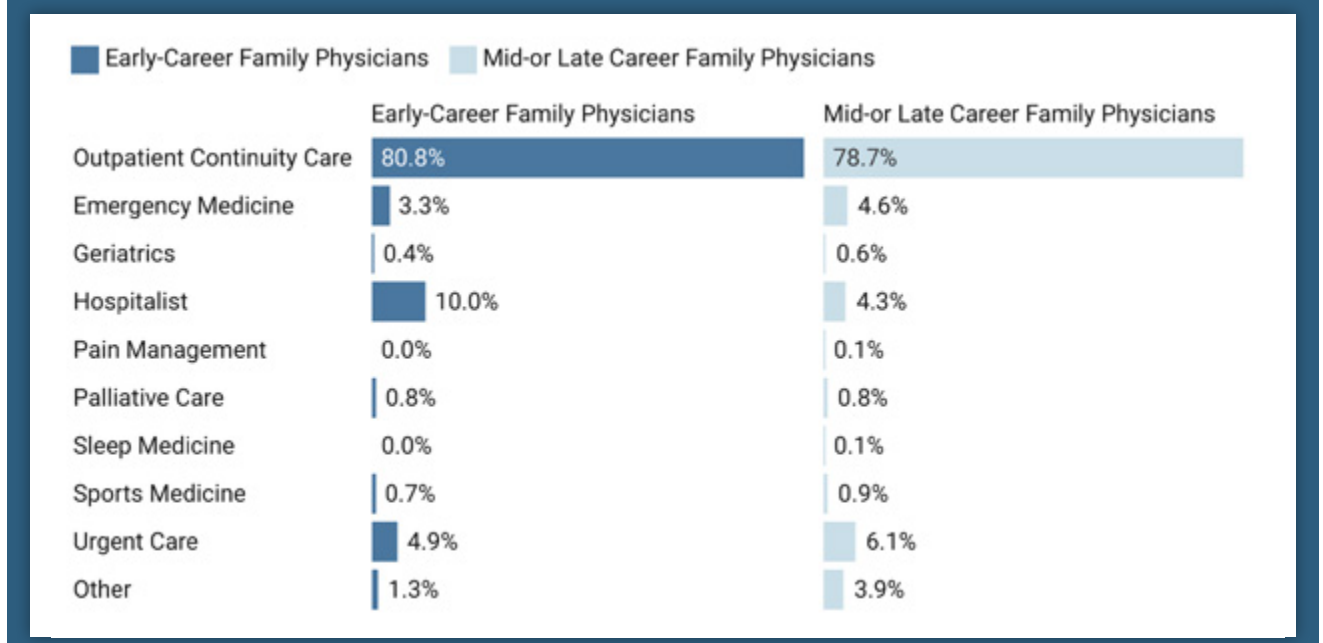


FIGURE 10. Comparison of Early and Mid-or Late Career Family Physicians by Practice Type





4. How are Family Medicine Practices Organized & Structured?

Family physicians who reported practicing outpatient continuity care were surveyed on further questions pertaining to their practice organization and structure.

Practice Sites

The plurality of American Board of Family Medicine (ABFM) Diplomates report a principal practice site at a hospital- or health-system owned medical practice (35.3%) or at an independently-owned practice (30.7%). A greater percentage of mid- or late career Diplomates reported working in independently-owned practices compared to early career physicians (30.7% vs. 14.0%). On the other hand, a higher proportion of early career Diplomates reported working in Federally-Qualified Health Centers (12.3% vs. 6.7%) and academic health centers (11.8% vs. 7.6%) compared to the majority of Diplomates.

Less than half of family physicians (43.5%) report practicing in multiple sites. The most common setting for a secondary site was at a hospital (20.9%). When comparing early career Diplomates with mid- or late career Diplomates, a greater percentage reported secondary practice sites in another outpatient clinic (11.6% v. 5.7%), urgent care clinic (12.4% vs. 7.9%), or emergency department (6.3% v. 4.4%). Interestingly, a lower percentage of early career respondents reported a secondary site of a nursing home or assisted living facility (11.9% vs. 13.4%). See Chapter 7 for more detailed facts on scope of practice.

TABLE 3. Reported Practice Sites by Family Physicians

	Early Career Family Physicians	Mid-or Late Career Family Physicians
Principle practice site N (Column Percent)	N = 9,537	N = 24,169
Hospital-/health-system owned medical practice	3,669 (38.5%)	8,525 (35.3%)
Independently-owned	1,335 (14.0%)	7,409 (30.7%)
Managed care/HMO practice	685 (7.2%)	1,501 (6.2%)
Academic health center/faculty practice (residency or university teaching environment)	1,127 (11.8%)	1,844 (7.6%)
Federally Qualified Health Center or Look-Alike	1,176 (12.3%)	1,622 (6.7%)
Rural Health Clinic (federally qualified)	442 (4.6%)	575 (2.4%)
Indian Health Service	99 (1.0%)	150 (0.6%)
Federal (Military, Veterans Administration/ Department of Defense)	519 (5.4%)	959 (4.0%)
Government clinic (state, county, city, maternal and child health, public health center, etc.)	136 (1.4%)	355 (1.5%)
Workplace clinic	139 (1.5%)	430 (1.8%)
Other	210 (2.2%)	799 (3.3%)
Other practice sites N (Column Percent)	N = 9,548	N = 24,169
None	4,397 (46.2%)	13,652 (56.5%)
Another outpatient clinic	1,100 (11.6%)	1,375 (5.7%)
Urgent care clinic	1,182 (12.4%)	1,902 (7.9%)
Emergency department	604 (6.3%)	1,062 (4.4%)
Hospital (not emergency department)	3,003 (31.5%)	5,063 (20.9%)
Nursing home or assisted living facility	1,132 (11.9%)	3,238 (13.4%)
Hospice facility	175 (1.8%)	455 (1.9%)
Other institutional setting (school-based clinic, correctional facility, etc.)	264 (2.8%)	423 (1.8%)
Patient homes	728 (7.6%)	1,753 (7.3%)
Other	342 (3.6%)	1,043 (4.3%)

FIGURE 11. Family Physicians by Practice Site

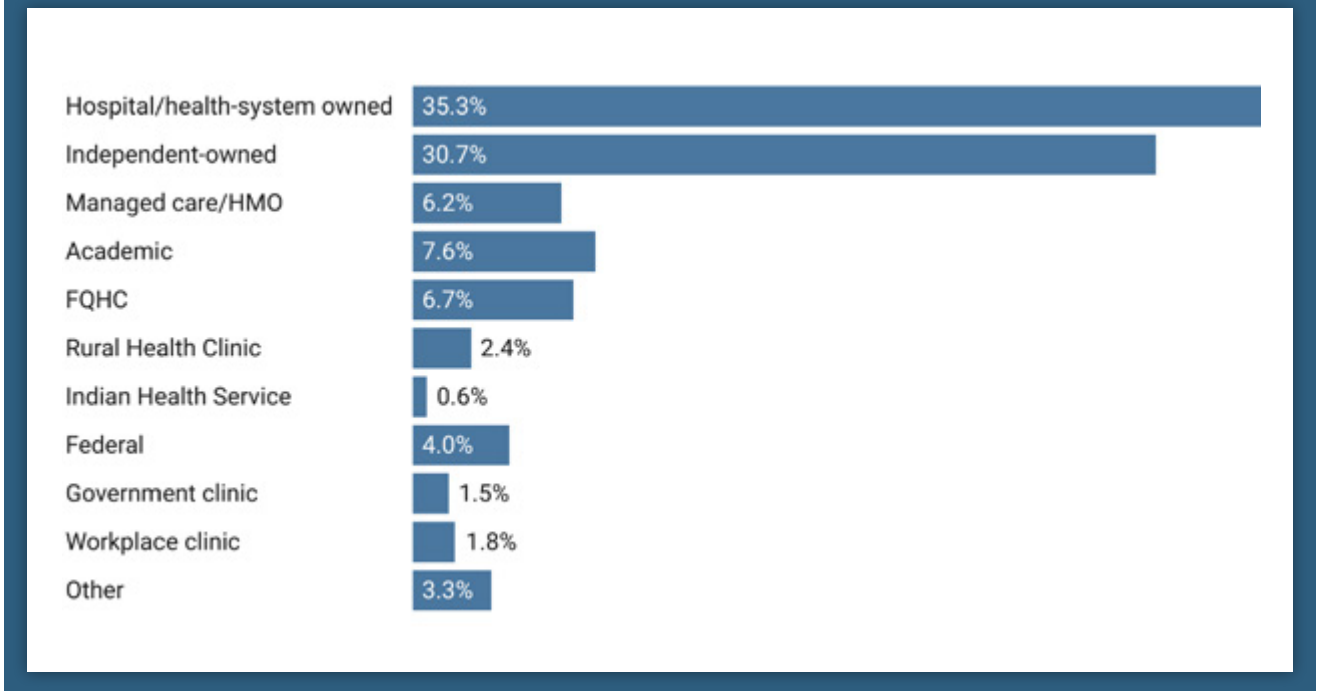
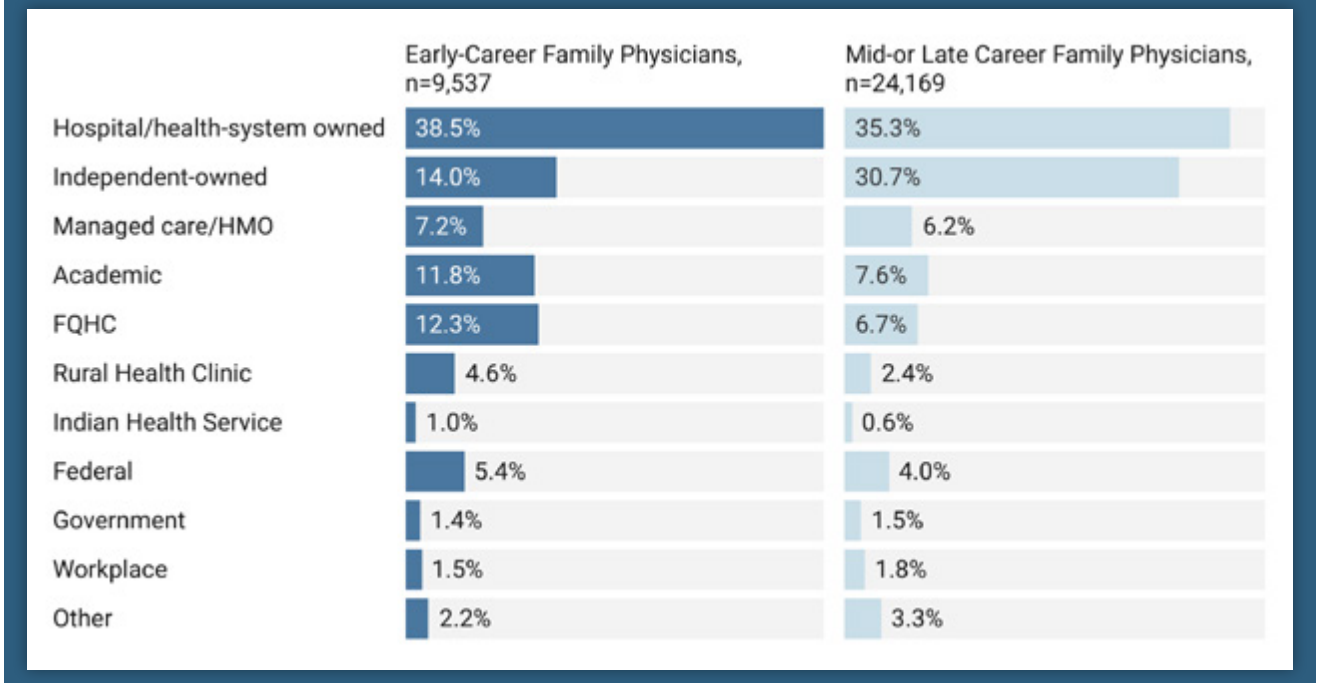


FIGURE 12. Comparison of Early and Mid-or Late Career Family Physicians by Practice Site



Practice Site Characteristics

Family physicians were asked to provide further information about their primary practice sites to characterize ownership status, practice size, and specialty mix. The majority did not have an official ownership stake in their practice sites. Family medicine practices also tend to have more than one provider (89.5%), and the plurality of Diplomates work in practices that only have family medicine providers (50.3%). ABFM Diplomates early in their careers were much less likely to have an ownership stake or work in solo practice compared to the greater majority of Diplomates.

TABLE 4. Reported Practice Characteristics by Family Physicians

	Early Career Family Physicians	Mid-or Late Career Family Physicians
Principle practice ownership N (Column Percent)	N = 6,837	N = 24,169
No official ownership stake (100% employed)	5,723 (83.7%)	15,943 (66.0%)
Sole owner	170 (2.5%)	2,852 (11.8%)
Partial owner or shareholder	734 (10.7%)	4,336 (17.9%)
Self-employed as a contractor (including locums)	162 (2.4%)	704 (2.9%)
Other	48 (0.7%)	334 (1.4%)
Practice size N (Column Percent)	N = 9,526	N = 24,169
Solo	297 (3.1%)	2,528 (10.5%)
2-5 providers	3,341 (35.1%)	8,016 (33.2%)
6-20 providers	3,657 (38.4%)	7,697 (31.8%)
>20 providers	2,231 (23.4%)	5,928 (24.5%)
Practice specialty mix N (Column Percent)	N = 9,527	N = 24,169
Family medicine only	4,193 (44.0%)	12,160 (50.3%)
Primary care mix (family medicine, internal medicine, and/or pediatrics)	3,171 (33.3%)	6,598 (27.3%)
Multiple specialties (not only primary care)	2,163 (22.7%)	5,411 (22.4%)

FIGURE 13. Comparison of Early and Mid-or Late Career Family Physicians by Practice Ownership

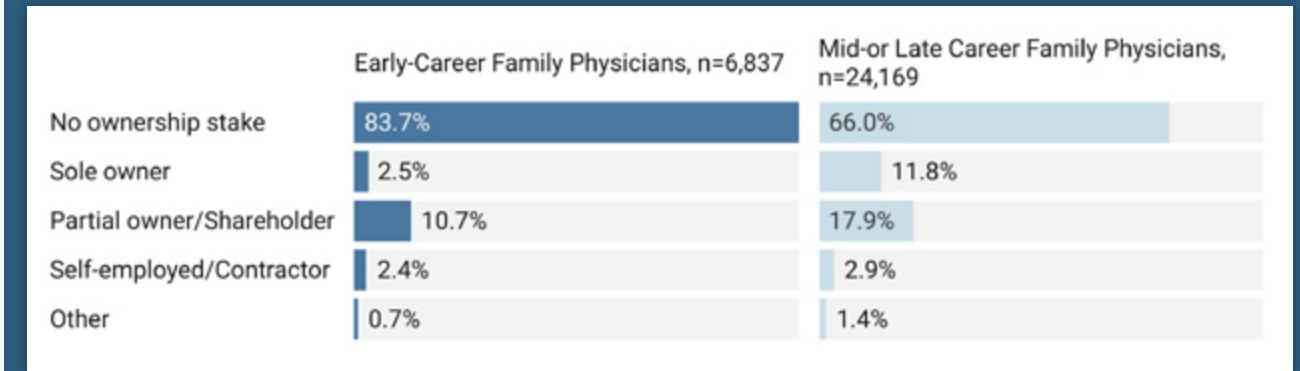
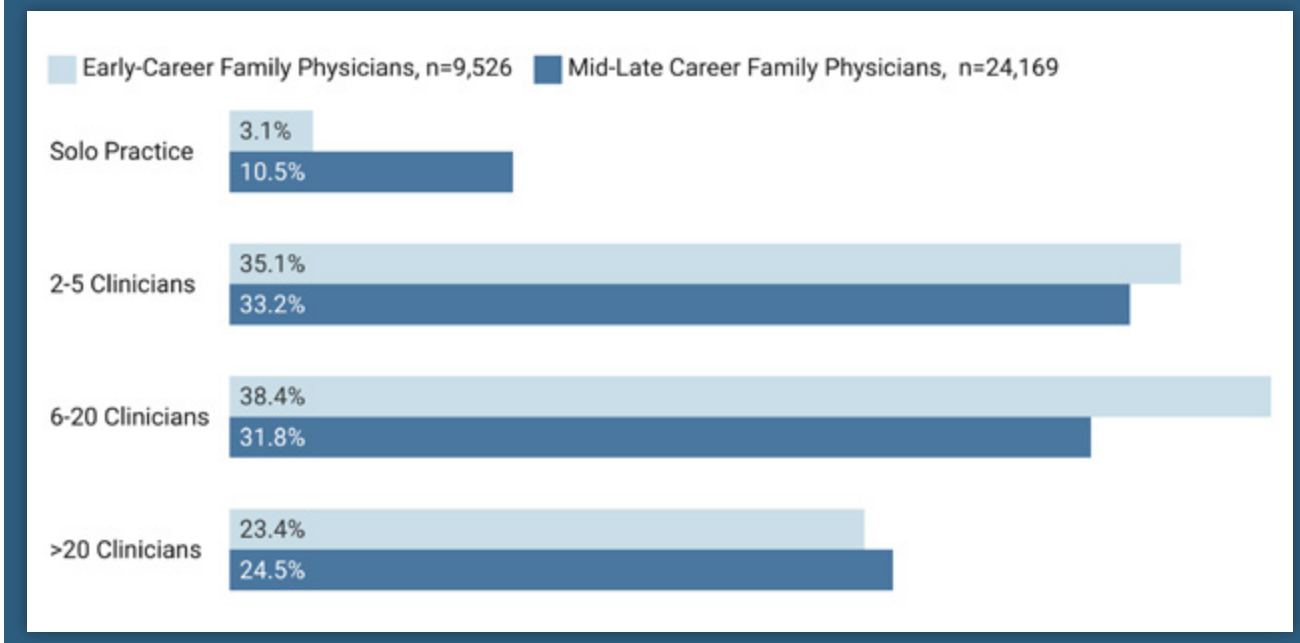


FIGURE 14. Comparison of Early and Mid-or Late Career Family Physicians by Practice Size and Specialty Mix



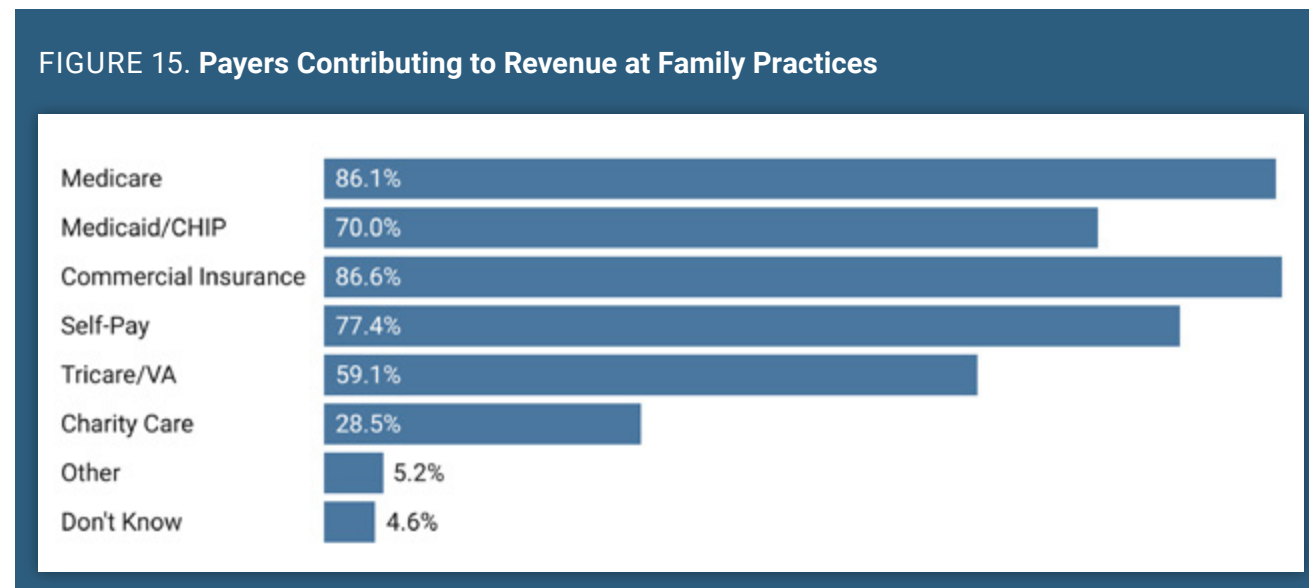
Practice Payment

Family medicine physicians are predominantly reimbursed by payers through a fee-for-service (FFS) model, through which practices bill for delivering specific services, collect copays from patients, and are reimbursed by payers based on services provided. This model not only incentivizes increased service volume, but also limits flexibility in care planning and makes health care feel transactional.¹⁸ Alternative payment models, redefining quality measures, and increasing investments in primary care are ongoing initiatives supported by ABFM to address issues in health care payment models.¹⁹⁻²¹ As decision makers

evaluate and debate payment reform, it is important to understand the payor groups that contribute to family medicine practices. ABFM Diplomates were asked to identify payers that make up the majority of their primary practice site revenue. The most common payers identified were Medicare (86.1%) and commercial insurance (85.6%), followed by direct payment (self-pay, 77.4%) and Medicaid / the Children’s Health Insurance Program (CHIP) (70.0%).

TABLE 5. Reported Payers Contributing to Revenue at Family Practices

Payer contributing to revenue	Family Medicine Physicians
Total	4,762
Medicare	4,100 (86.1%)
Medicaid/CHIP	3,335 (70.0%)
Commercial Insurance	4,075 (85.6%)
Self-Pay	3,684 (77.4%)
Tricare/VA	2,808 (59.1%)
Charity Care	1,354 (28.5%)
Other	248 (5.2%)
Don't Know	217 (4.6%)



Practice Population Characteristics

Family physicians were asked to estimate the percentage of patients they saw across specific age ranges with total sum to 100%: age <5, age 5-18, age 19-64, and age 65+. While this data is limited by self-reporting, average values revealed that approximately 85% of patients in Diplomate patient panels are in the adult range (19+).

TABLE 6. Population Ages Reported at Family Practices

	Family Physicians
Total	24,266
Percent of Patients: Under 5 Mean [IQR]	6.79 [2, 10]
Percent of Patients: 5-18 Mean [IQR]	11.54 [5, 15]
Percent of Patients: 19-64 Mean [IQR]	51.52 [40, 65]
Percent of Patients: 65+ Mean [IQR]	33.63 [20, 45]

Compared to other primary care physicians, family physicians care for a greater proportion of historically underserved patient groups.²² Physicians surveyed were asked to estimate the proportion of their patients that were part of a historically marginalized group, defined as “uninsured, covered by Medicaid insurance, homeless, low income, non-English speaking, racial/ethnic minority, or otherwise traditionally underserved”. Approximately one in five Diplomates reported that over half of their patients were a part of such a group.

TABLE 7. Proportion of Vulnerable Patients Reported at Family Practices

		Family Physicians
Total		24,266
Vulnerable Patients N (Column Percent)	<10%	9,399 (38.7%)
	10-49%	9,872 (40.7%)
	>50%	4,995 (20.6%)

Patient-Centered Medical Home

The patient-centered medical home (PCMH) model was launched in 2007 to promote comprehensive primary care. To be formally designated as a PCMH, primary care practices undergo an accreditation process through a state or national organization that has specific requirements determined by the organization. The National Committee for Quality Assurance (NCQA) is the most widely adopted PCMH model for practices in the U.S.²⁶ Among ABFM Diplomates who work in outpatient continuity care, 42.2% report working at a recognized PCMH. 🌐

TABLE 8. Patient-Centered Medical Home Status of Family Practices

		Family Physicians
Total N (Percent)		3,526
Principal practice certified as a PCMH by the NCQA or other state or national accrediting organization	Yes	1,488 (42.2%)
	No	1,182 (33.5%)
	Don't Know	856 (24.3%)

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5. Who Do Family Physicians Work With?

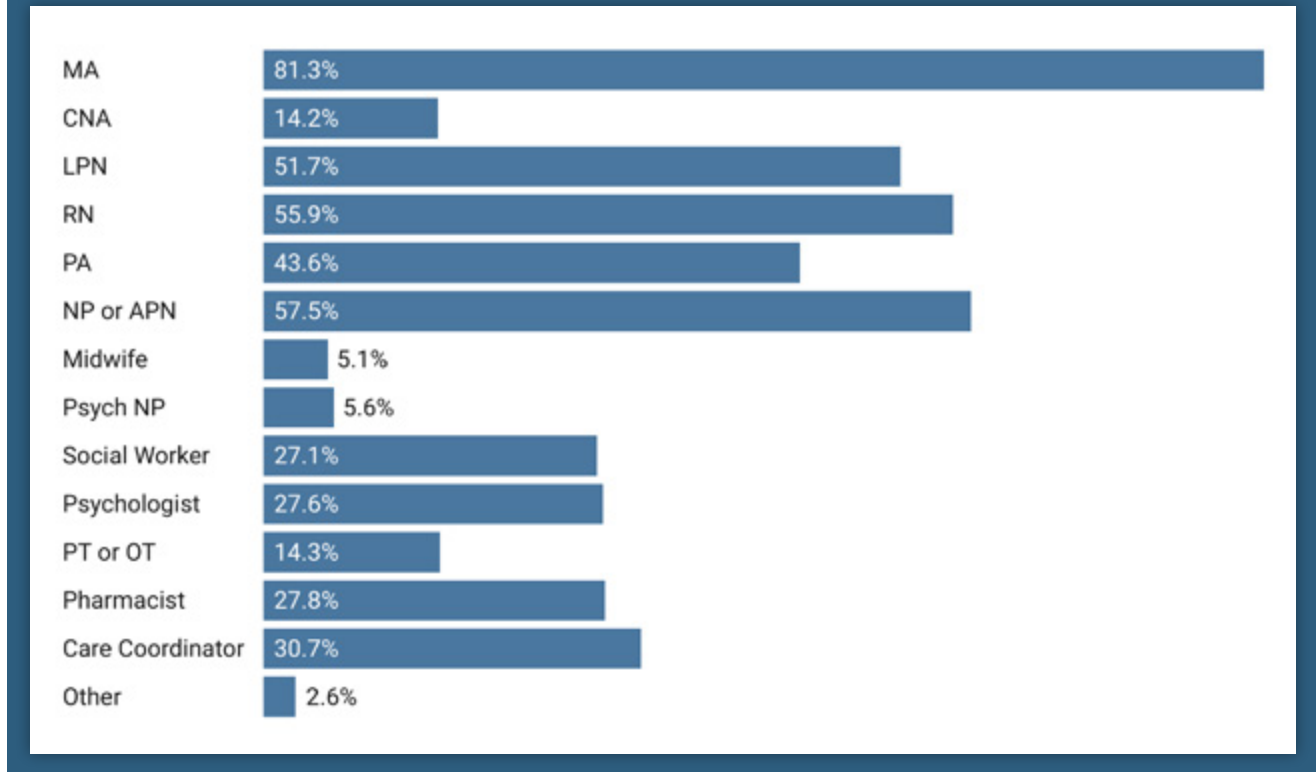
Due to the breadth and scope of family medicine training, family physicians may elect to practice in a number of different settings, from inpatient to outpatient or both. They may collaborate in those settings with any number of different types of medical professionals. The nature of these collaborations may include clinical support with patient care (as with a medical assistant, a scribe, or possibly a licensed professional nurse or registered nurse). They may include a supervisory component, such as when a nurse practitioner or physician assistant is supervised by a physician, although these roles vary by state legislation. Other collaborators include embedded pharmacists to assist with medication optimization, social workers or clinical psychologists for mental health care, and care coordinators or social workers to assist with wraparound services including discharge planning and connection to outpatient resources.

When American Board of Family Medicine (ABFM) Diplomates were asked about team collaboration, approximately 4 in 5 respondents reported working with a medical assistant (MA; 81.3%). The majority of respondents also said they worked with a nurse practitioner (NP) or advanced practice nurse (APN) regularly (57.5%), and more than half also collaborated with a registered nurse (RN) (55.9%) and a licensed professional nurse (LPN) (51.7%). More than one quarter of the sampled physicians collaborated with other professionals, including physician assistants (PA) (43.6%), care coordinators (30.7%), pharmacists (27.8%), psychologists (27.6%), and social workers (27.1%). Additionally, 3,284 family physicians (13.5% of those surveyed) report working with psychiatrists. 🌐

TABLE 9. Non-Physician Health Care Providers Working with Family Physicians

	Family Physicians
Total	24,266
Medical Assistant N (Percent)	19,738 (81.3%)
Certified Nursing Assistant N (Percent)	3,437 (14.2%)
Licensed Practical Nurse N (Percent)	12,556 (51.7%)
Registered Nurse N (Percent)	13,568 (55.9%)
Physician Assistant N (Percent)	10,577 (43.6%)
Nurse Practitioner or Advanced Practice Nurse N (Percent)	13,946 (57.5%)
Midwife N (Percent)	1,246 (5.1%)
Psychiatric Nurse Practitioner N (Percent)	1,364 (5.6%)
Social Worker N (Percent)	6,583 (27.1%)
Psychologist N (Percent)	6,705 (27.6%)
Physical or Occupational Therapist N (Percent)	3,467 (14.3%)
Pharmacist N (Percent)	6,752 (27.8%)
Care Coordinator N (Percent)	7,439 (30.7%)
Other N (Percent)	621 (2.6%)
None N (Percent)	782 (3.2%)

FIGURE 16. Non-Physician Health Care Providers Working with family physicians



6. What Do Family Physicians Do?

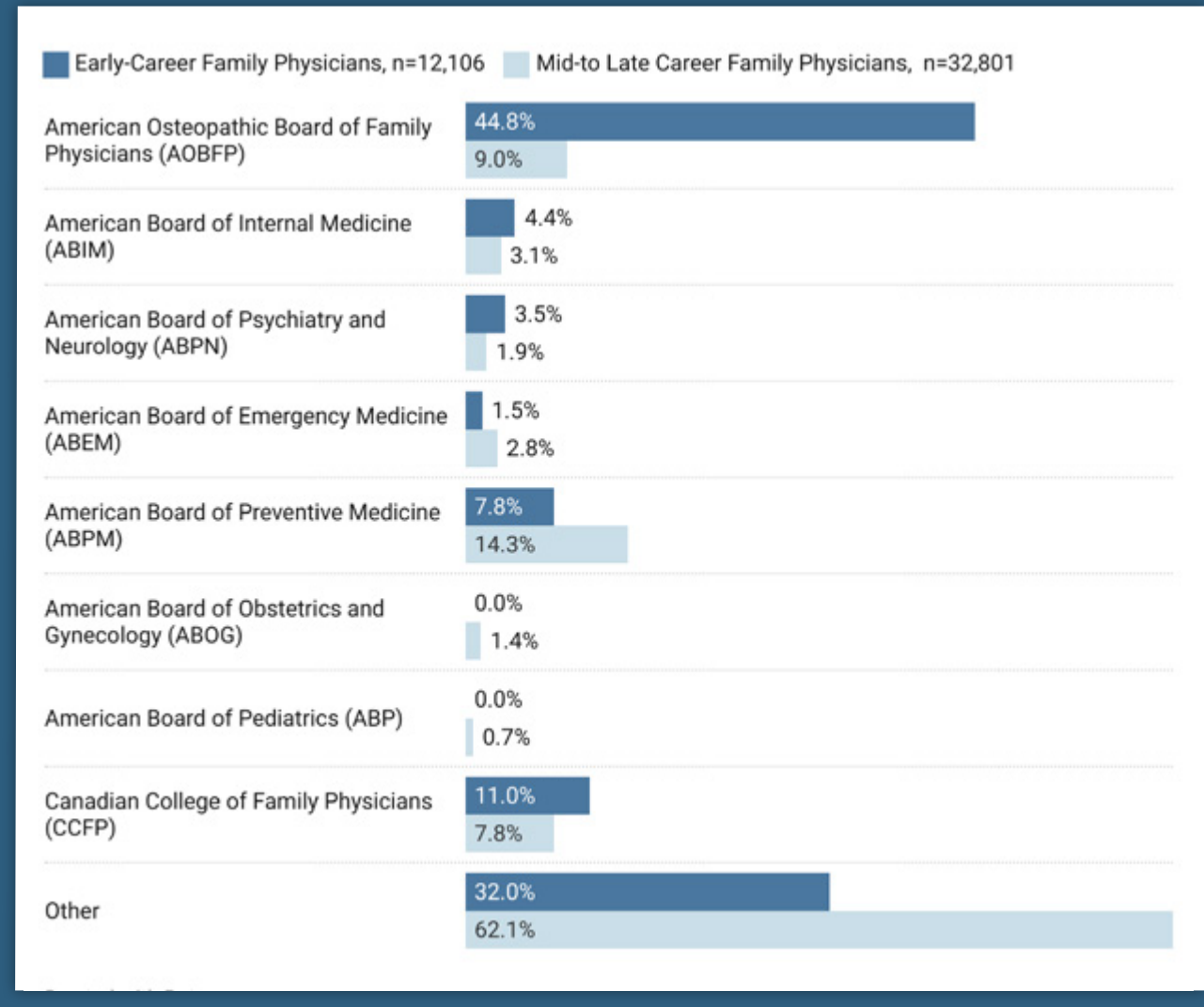
Additional Board Certification

The American Board of Family Medicine (ABFM) is one of 24 medical specialty boards that make up the American Board of Medical Specialties (ABMS), through which specialty boards work to establish standards to maintain physician certification.²⁷ These standards are specific to each specialty and subspecialty to represent individual knowledge and skills in particular areas of medicine.²⁸ Requirements for ABFM certification include participation in ongoing knowledge assessments, continuing medical education requirements, demonstrating improving care in their practices, complying with professional and licensure standards, and passing examinations every ten years.²⁹ The American Osteopathic Association (AOA) is a certification organization for osteopathic physicians and includes the American Osteopathic Board of Family Physicians (AOBFP). AOBFP has its own certification process, which almost 30,000 family physicians have completed.³¹ Board certification is voluntary, and family physicians can elect to certify with either ABFM or AOBFP, both organizations, or neither. Outside of the United States, other countries have their own physician certification boards such as The College of Family Physicians of Canada which represents over 42,000 physicians across Canada.³²

Seven and a half percent (7.5%) of ABFM Diplomates report that they are certified by other board organizations. Of note, the plurality of those earlier in their career who reported additional board certification had certification with AOBFP (44.8%). This was much higher than the mid-or late career Diplomate cohort, where only 9% reported AOBFP certification. This group reported unlisted boards designated as “Other” on the questionnaire the most (62.1%).

7.5%
ARE CERTIFIED IN
ANOTHER SPECIALITY BOARD

FIGURE 17. ABFM Family Physicians with Additional Board Certification



Added Qualification

The ABFM offers Certificates of Added Qualifications and a Designation of Focused Practice to support family physicians who have an area of focused expertise after additional training.³³ These certificates are valid for ten years and can be renewed as part of the Diplomate continuous certification process.³⁴ The most common certificates held by ABFM Diplomates are in Sports Medicine and Geriatric Medicine.

TABLE 10. Family Physicians with Certificates of Added Qualifications (CAQ) or Designation of Focused Practice (DFP)

	Total (N = 102,342)
Certificate of Added Qualification (CAQ) or Designation of Focused Practice (DFP) N (Percent)	
Adolescent Medicine (CAQ)	87 (0.1%)
Geriatric Medicine (CAQ)	2,324 (2.3%)
Hospice and Palliative Medicine (CAQ)	1,789 (1.7%)
Hospital Medicine (DFP)	177 (0.2%)
Pain Medicine (CAQ)	33 (0.0%)
Sleep Medicine (CAQ)	205 (0.2%)
Sports Medicine (CAQ)	2,920 (2.9%)

Practice Scope

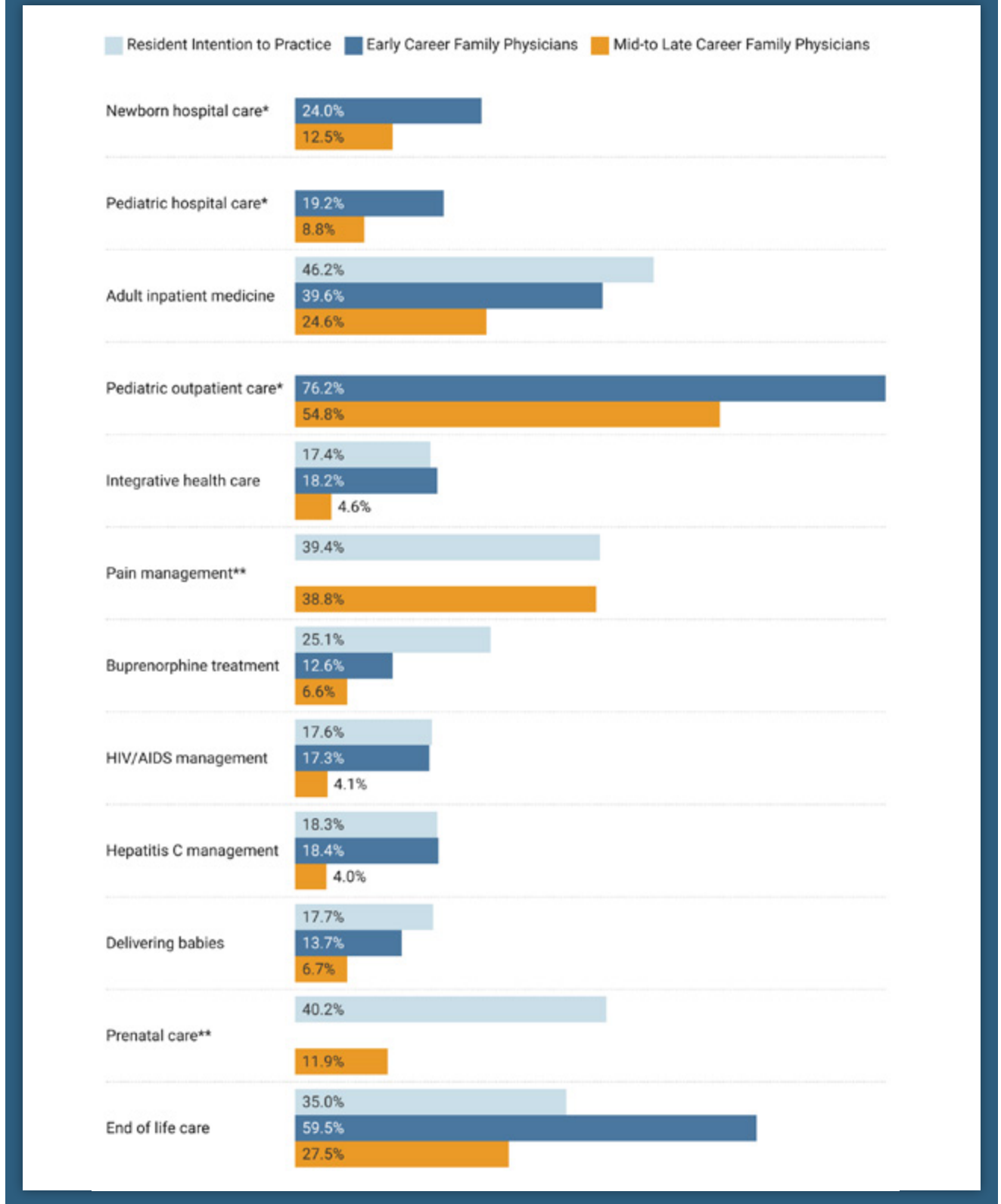
Family physicians’ training incorporates care for children, adults, and the elderly in outpatient and inpatient settings as well as patients throughout pregnancy, birth, and the postpartum period. Family medicine trainees must also receive training in behavioral health issues, chronic disease management, population health, and health system management—while emphasizing wellness and disease prevention.³⁵ This broad training results in variations in actual clinical practice with further heterogeneity across region and physician characteristics such as age cohort and sex.³⁶

Given the large number of family physicians throughout the U.S., trend analysis is difficult but ABFM’s data can serve as a major contributor towards a greater understanding of the actual practice scope of family physicians.³⁶ Family medicine residents and ABFM Diplomates were surveyed about their practice of hospital-based medicine, maternity care, outpatient services such as behavioral health and integrative health, chronic medical conditions including diabetes, hypertension, HIV or hepatitis C infection and substance use disorder, and end of life care. Respondents also provided information about common procedures they perform, including gynecological care, musculoskeletal conditions, inpatient acute management, and office-based procedures. In comparing our surveyed cohorts, while family medicine residents intend to have a wide scope of practice and procedure performance, actual clinical practice decreases with time (see changes from early career Diplomates compared to mid-or late career Diplomates).

TABLE 11. Reported Practice Intention of Family Medicine Residents and Practice Scope of Family Physicians

	Family Medicine Resident Intention	Early Career Physicians	Mid-or Late Career Family Physicians
Hospital Medicine n (Percent, N)	N = 18,040		N = 30,835
Newborn hospital care	-	2,779 (24% N = 11,602)	3,845 (12.5%)
Pediatric hospital care	-	2,229 (19.2%, N = 11,601)	2,718 (8.8%)
Adult inpatient medicine	8,326 (46.2%)	4,589 (39.6%, N = 11,585)	7,574 (24.6%)
Outpatient Services n (Column Percent)	N = 18,040	N = 11,601	N = 30,835
Pediatric outpatient care	-	8,837 (76.2%)	16,896 (54.8%)
Integrative health care	3,316 (17.4%)	2,117 (18.2%)	1,418 (4.6%)
Medical Condition Management n (Column Percent)	N = 18,040	N = 11,580	N = 6,205
Pain management	7,111 (39.4%)	-	2,406 (38.8%)
Buprenorphine treatment	4,537 (25.1%)	1,454 (12.6%)	407 (6.6%)
HIV/AIDS management	3,176 (17.6%)	1,998 (17.3%)	254 (4.1%)
Hepatitis C management	3,298 (18.3%)	2,129 (18.4%)	251 (4.0%)
Maternity Care n (Percent, N)			
Delivering babies	3,189 (17.7%, N = 18,040)	1,583 (13.7%, N = 11,574)	2,063 (6.7%, N = 30,832)
Prenatal care	7,256 (40.2%, N = 18,040)	-	3,664 (11.9% N = 30,835)
Other	N = 18,040	N = 11,601	N = 30,835
End of life care	6,321 (35%)	6,903 (59.5%)	8,491 (27.5%)

FIGURE 18. Comparing Practice Intention of Family Medicine Residents with Practice Scope of family physicians



*Resident intention to practice data was not collected.
**Early career Diplomates data was not collected.

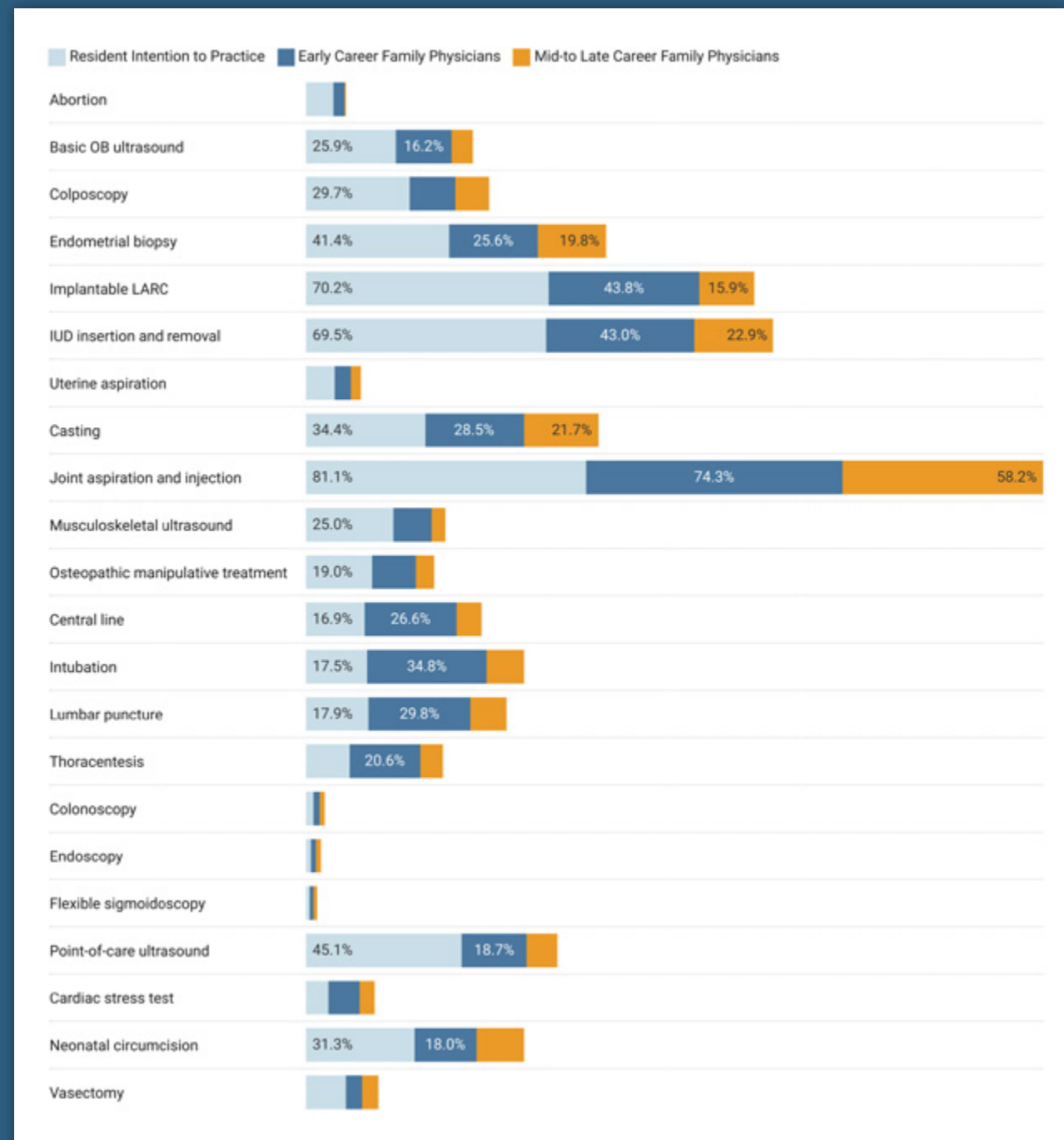
TABLE 12. Reported Procedure Intention of Family Medicine Residents and Procedure Scope of Family Physicians

	Family Medicine Resident Intention	Early Career Family Physicians	Mid-or Late Career Family Physicians
Obstetrics/Gynecology n (Column Percent)	N = 18,040		N = 6,205
Abortion	1,419 (7.9%)	369 (3.2%, N = 11,556)	34 (0.5%)
Basic OB ultrasound	4,675 (25.9%)	1,880 (16.2%, N = 11,590)	380 (6.1%)
Colposcopy	5,365 (29.7%)	1,575 (13.6%, N = 11,590)	610 (9.8%)
Endometrial biopsy	7,462 (41.4%)	2,970 (25.6%, N = 11,591)	1,226 (19.8%)
Implantable long-acting reversible contraception	12,658 (70.2%)	5,082 (43.8%, N = 11,590)	986 (15.9%)
IUD insertion and removal	12,544 (69.5%)	4,982 (43%, N = 11,591)	1,418 (22.9%)
Uterine aspiration	1,493 (8.3%)	528 (4.6%, N = 11,456)	178 (2.9%)
Musculoskeletal n (Column Percent)	N = 18,040	11,585	N = 6,205
Casting	6,200 (34.4%)	3,304 (28.5%)	1,344 (21.7%)
Joint aspiration and injection	14,625 (81.1%)	8,607 (74.3%)	3,614 (58.2%)
Musculoskeletal ultrasound	4,515 (25%)	1,312 (11.3%)	249 (4%)
Osteopathic manipulative treatment	3,427 (19%)	1,480 (12.8%, N = 11,580)	328 (5.3%)

TABLE 12. Reported Procedure Intention of Family Medicine Residents and Procedure Scope of Family Physicians (Continued)

	Family Medicine Resident Intention	Early Career Family Physicians	Mid-or Late Career Family Physicians
Hospital n (Column Percent)	N = 18,040	N = 4,584	N = 6,205
Central line	3,052 (16.9%)	1,219 (26.6%)	445 (7.2%)
Intubation	3,156 (17.5%)	1,596 (34.8%)	658 (10.6%)
Lumbar puncture	3,225 (17.9%)	1,368 (29.8%)	642 (10.3%)
Thoracentesis	2,236 (12.4%)	945 (20.6%)	408 (6.6%)
Gastroenterology n (Column Percent)	N = 11,194	N = 5,296	N = 3,039
Colonoscopy	231 (2.1%)	97 (1.8%)	40 (1.3%)
Endoscopy	161 (1.4%)	81 (1.5%)	35 (1.2%)
Flexible sigmoidoscopy	111 (1.0%)	59 (1.1%)	31 (1.0%)
Other n (Percent, N)			
Point-of-care ultrasound	5,043 (45.1%, N = 11,194)	992 (18.7%, N = 5,296)	277 (9.1%, N = 3,039)
Cardiac stress test	1,181 (6.5%, N = 18,040)	1,034 (8.9%, N = 11,580)	263 (4.2%, N = 6,205)
Neonatal circumcision	5,645 (31.3%, N = 18,040)	2,080 (18%, N = 11,580)	848 (13.7%, N = 6,205)
Vasectomy	2,074 (11.5%, N = 18,040)	542 (4.7%, N = 11,585)	283 (4.6%, N = 6,205)

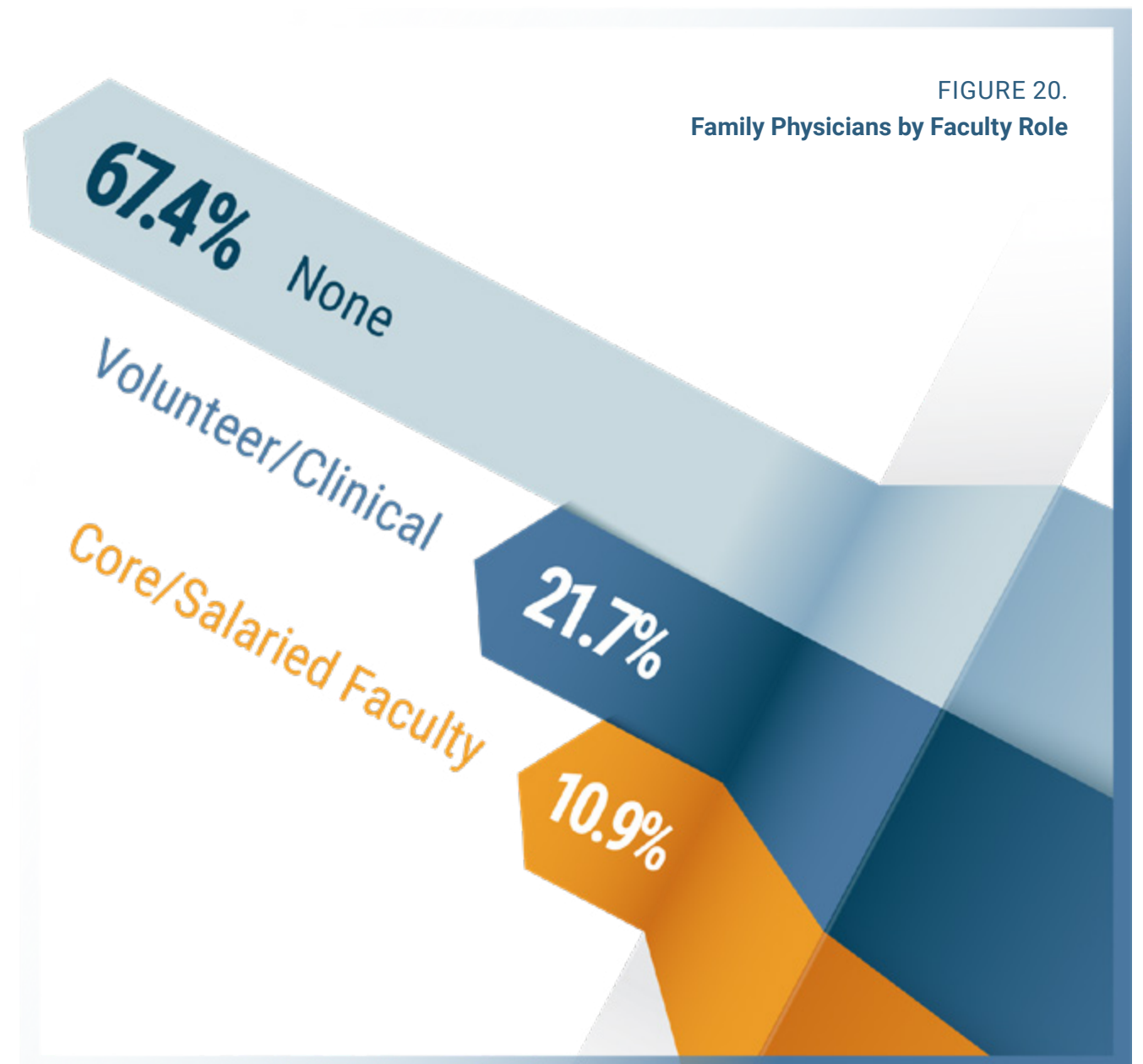
FIGURE 19. Comparing Procedure Intention of Family Medicine Residents with Procedure Scope of Family Physicians



Academic Family Physicians

Formal family medicine education involves graduation from an accredited medical school, formal family medicine residency completion (3-4 years), and optional fellowship(s) if a candidate elects to do additional training or sub-specialization. Family physicians can subsequently participate as educators through roles in medical school curriculum teaching, clinical precepting of trainees, and residency/fellowship programming and development. About 1 in 3 ABFM Diplomates report having a faculty role of some form and, of this faculty group, 1 in 3 serve as core or salaried faculty.

FIGURE 20. Family Physicians by Faculty Role





7. How Is Health Information Technology Used in Family Medicine?

The use of Health Information Technology (HIT) in primary care practice has undergone enormous changes in recent years. One of the most significant shifts has been in the use of electronic health records (EHRs), which are digital versions of the previously used paper charting system. Almost 97% of American Board of Family Medicine (ABFM) Diplomates report using an electronic health record.

EHR Advancing Patient Care

EHR technology may be used to facilitate reporting of patient outcomes data for quality-based contracting, such as for a CMS Medicare Accountable Care Organization (ACO) population, or for general population health, such as outreach for chronic disease management or preventive health measures. The majority of surveyed family physicians report that their practice has the capability to generate a registry of patients with a given diagnosis (81.4%) and a registry of services patients are due to have (82.9%).

HIT encompasses communications between the primary care physician and patients, including patient data access through a portal and secure messaging. Eighty-five percent of family physicians work at practices that have the capacity to exchange secure messages with patients. Of this group, 1 in 3 report that they exchange messages with patients at least 5 times a day (33.4%).

HIT is not only useful for patient-provider communication, but is also a promising tool for chronic disease care coordination and continuity of care. For instance, if a patient were to start on a new dose of hypertension medication, home blood pressure readings can be documented and uploaded to the EHR for provider review. Of surveyed physicians, 34.6% report that their practice has the capability for patients to add patient-generated health data into their EHR records.

TABLE 13. Reported Electronic Health Record Capabilities in Family Practices

	Family Physicians
Practice has capability to generate registry/list of patients with a given diagnosis N (Column Percent)	N = 1,831
Yes	1,490 (81.4%)
No	77 (4.2%)
Don't Know	264 (14.4%)
Practice has capability to generate registry/list of services patients are due to have N (Column Percent)	N = 1,491
Yes	1,236 (82.9%)
No	99 (6.6%)
Don't Know	156 (10.5%)
Practice has capability to exchange secure messages with patients (e.g. patient portal) N (Column Percent)	N = 1,831
Yes	1,556 (85.0%)
No	182 (9.9%)
Don't Know	93 (5.1%)
How often secure messages are exchanged with patients N (Column Percent)	N = 1,557
Five or more times a day	520 (33.4%)
1-4 times a day	427 (27.4%)
Occasionally, but less than once a day	377 (24.2%)
Rarely or never	233 (15.0%)
Practice has capability for patients to add patient-generated health data through a portal into their EHR records N (Column Percent)	N = 1,830
Yes	633 (34.6%)
No	656 (35.8%)
Don't Know	542 (29.6%)

EHR Information Exchange

Interoperability promotes data sharing between health care provider settings, including primary care, medical specialists, and inpatient care. In 2011, the Centers for Medicare & Medicaid Services (CMS) developed a program of EHR interoperability – establishing priority of goals such as quality, safety, efficiency, care coordination, patient engagement, and medical record privacy and security in the implementation of EHR programs.³⁷ While some primary care practices engage in health information exchanges and can share data between medical providers in a certain state or geographic region, gaps in care coordination still exist due to variable EHR platforms and structural and procedural limitations.

Seventy-one percent of family physician respondents have the capability to electronically receive a summary of care from a hospital or specialist outside of their own medical group. However, of this group that has the capability, almost 30% report that they never receive the summaries or only receive them less than half of the time. For transmitting a summary of care to another provider outside of the medical group, only 54.1% report that they have the capability to create and electronically send such summaries. For those that do have the capability, the majority (54.5%) report resending these summaries of care to hospitals/specialists more than half the time.

TABLE 14. Reported Electronic Health Record Exchanges in Family Practices

	Family Physicians
Practice has capability to electronically receive a summary of care from hospitals and/or specialists outside of medical group N (Column Percent)	N = 1,831
Yes	1,301 (71.1%)
No	278 (15.2%)
Don't Know	252 (13.8%)
How often summaries are received from hospitals and/or specialists outside of medical group N (Column Percent)	N = 1,302 (from Yes group above)
More than half the time	927 (71.2%)
Less than half the time	285 (22.0%)
Rarely or never	89 (6.8%)

Continued on page 48

TABLE 14. Reported Electronic Health Record Exchanges in Family Practices (Continued)

	Family Physicians
Practice has capability to create a summary of care and electronically transmit it to hospitals or physicians outside of medical group N (Column Percent)	N = 1,831
Yes	990 (54.1%)
No	371 (20.3%)
Don't Know	470 (25.75%)
How often summaries are electronically submitted to hospitals and/or specialists outside of medical group N (Column Percent)	N = 991 (from Yes group above)
More than half the time	540 (54.5%)
Less than half the time	257 (25.9%)
Rarely or never	194 (19.6%)

TABLE 15. Reported Electronic Health Record Documentation Burden by Family Physicians

	Family Physicians
The amount of time I spend on the EHR at home is n (Percent)	N = 4,749
Excessive	877 (18.5%)
Moderately high	1,524 (32.1%)
Satisfactory	928 (19.5%)
Modest	568 (12.0%)
Minimal/none	852 (17.9%)
My proficiency with EHR use is n (Percent)	N = 4,748
Poor	32 (0.7%)
Marginal	246 (5.2%)
Satisfactory	1,281 (27.0%)
Good	2,338 (49.2%)
Optimal	851 (17.9%)

EHR Documentation Burden

Although advances in HIT have brought about unprecedented opportunities in data sharing and quality evaluation, implementation has at times presented serious challenges at the physician or practice level. Accordingly, ABFM asks survey respondents not just about the use of HIT in the clinical settings in which they work, but also about their own proficiency with these technologies and their level of satisfaction with them. Over 50% of ABFM Diplomates surveyed report that the amount of time they spend on the EHR at home is moderately high or excessive. While the plurality of respondents report “Good” EHR proficiency (49.2%), only 17.9% have “Optimal” proficiency, 27% report “Satisfactory” proficiency, and 5.2% report “Marginal.”

FIGURE 21. The amount of time I spend on the EHR at home

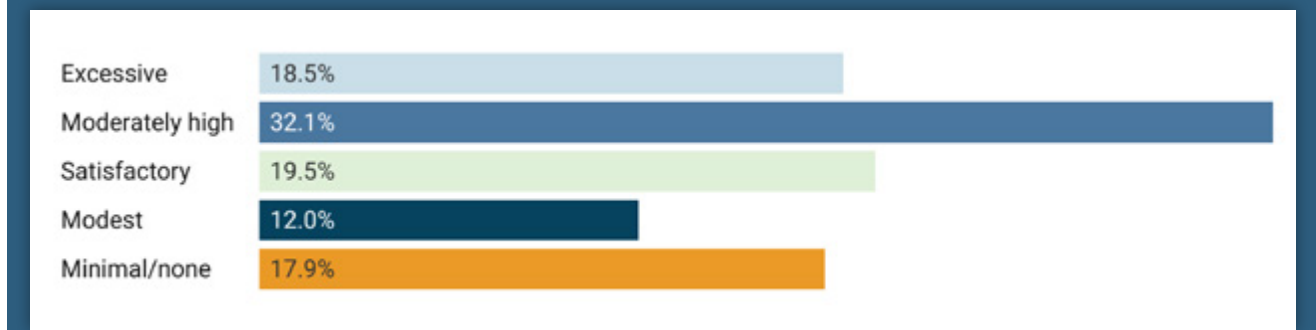
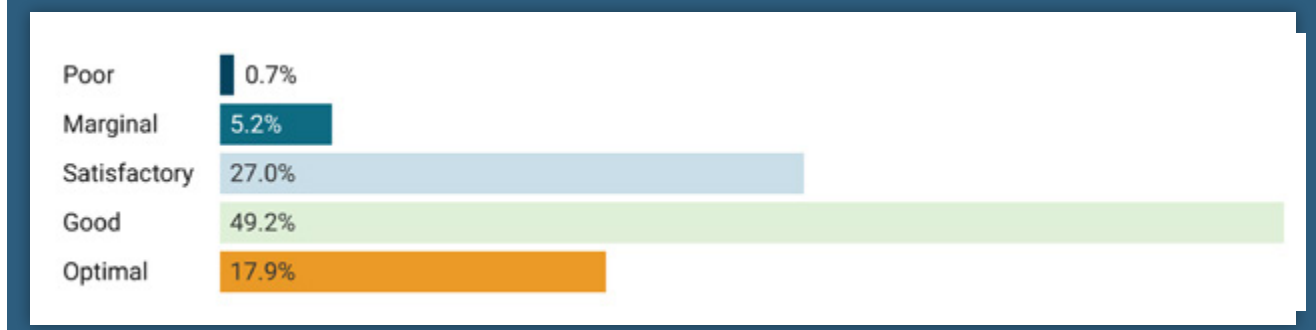


FIGURE 21A. My proficiency with EHR use





8. How Are Family Physicians Compensated?

The American Board of Family Medicine (ABFM) collects income data as part of its Graduate Survey Report (see **Methods Appendix**). It is reasonable to consider that the family physicians in this self-reported sample are in the early part of their career and may be in the early staged of income growth as they progress professionally. Of this group, the plurality (31.5%) earned between \$200,000 and \$249,999 annually, with just over one-tenth earning at the lower (less than \$125,000) and higher (\$300,000 or more) ends of the distribution.

Compensation in family medicine has risen over the past decade, while still lagging specialty peers. Less well documented is its variation. Of particular interest is the gap in pay according to race and gender, which has been well documented in other sectors of the U.S. economy. Looking at compensation by demographics illustrates income disparities in this sample of more than 11,000 ABFM Diplomates. It is important to note that because this data was taken from the Graduate Survey Report, which all Diplomates complete upon their third year after residency graduation, years of clinical experience post-residency do not contribute to these income disparities. While nearly 20% of male physicians are in the highest income bracket (>\$300,000), only 5.6% of their female colleagues report making as much. Although there are no significant differences in income distribution by degree type, Diplomates who trained abroad (international medical graduates) are more likely than Diplomates who trained in the U.S. or Canada to make over \$300,000 (16.6% to 9.5%). Self-reported income tends to be lower for Native Hawaiian or other Pacific Islander Diplomates than members of other racial groups, and White physicians are slightly more likely (12.9%) to be in the highest income group than Black or African American physicians (11.8%) or Asian physicians (10.6%). We also see that the proportion of highest income earners is slightly greater among those who don't identify as Hispanic or Latinx (12.5%) than those who do (10.6%).

TABLE 16. Reported Income by Early Career Family Physicians

		Early Career Family Physicians
Total		11,317
Income N (Column Percent)	Under \$125,000	1,162 (10.3%)
	\$125,000 to \$174,999	1,910 (16.9%)
	\$175,000 to \$199,999	1,831 (16.2%)
	\$200,000 to \$249,999	3,565 (31.5%)
	\$250,000 to \$299,999	1,518 (13.4%)
	\$300,000 or Higher	1,331 (11.8%)

FIGURE 22. Family Physicians by Income

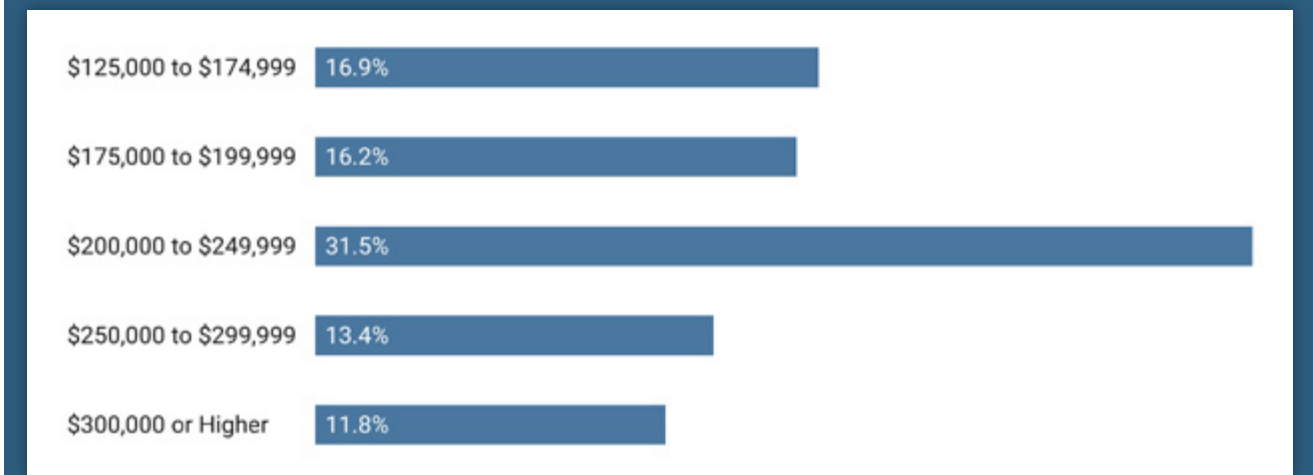
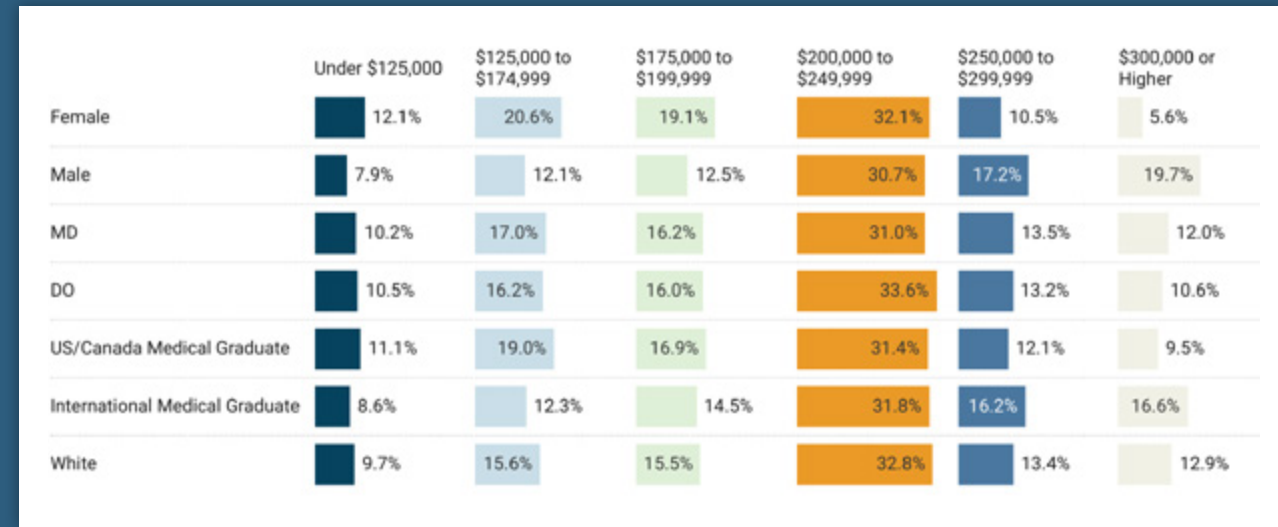


TABLE 17. Demographic Distribution of Family Physicians by Income

		Under \$125,000	\$125,000 to \$174,999
Total		1,162	1,910
Gender N (Row Percent)	Female	770 (12.1%)	1,312 (20.6%)
	Male	392 (7.9%)	598 (12.1%)
Degree Type N (Row Percent)	MD	942 (10.2%)	1,570 (17.0%)
	DO	220 (10.5%)	340 (16.2%)
International Medical Graduate (US/CAN) N (Row Percent)	US/CAN Medical Graduate	855 (11.1%)	1,468 (19.0%)
	International Medical Graduate	307 (8.6%)	442 (12.3%)
Race N (Row Percent)	White	602 (9.7%)	969 (15.6%)
	Asian	200 (10.2%)	263 (13.5%)
	Black or African American	61 (9.1%)	91 (13.6%)
	American Indian or Alaska Native	5 (5.7%)	9 (10.3%)
	Native Hawaiian or Other Pacific Islander	6 (12.2%)	9 (18.4%)
	Other	11 (5.7%)	30 (15.5%)
Ethnicity N (Row Percent)	Not Hispanic or Latino	796 (9.5%)	1,275 (15.2%)
	Hispanic or Latino	89 (11.4%)	96 (12.3%)

\$175,000 to \$199,999	\$200,000 to \$249,999	\$250,000 to \$299,999	\$300,000 or Higher
1,831	3,565	1,518	1,331
1,213 (19.1%)	2,045 (32.1%)	668 (10.5%)	354 (5.6%)
618 (12.5%)	1,520 (30.7%)	850 (17.2%)	977 (19.7%)
1,495 (16.2%)	2,860 (31.0%)	1,241 (13.5%)	1,108 (12.0%)
336 (16.0%)	705 (33.6%)	277 (13.2%)	223 (10.6%)
1,311 (16.9%)	2,427 (31.4%)	939 (12.1%)	736 (9.5%)
520 (14.5%)	1,138 (31.8%)	579 (16.2%)	595 (16.6%)
960 (15.5%)	2,037 (32.8%)	832 (13.4%)	802 (12.9%)
334 (17.1%)	637 (32.6%)	311 (15.9%)	207 (10.6%)
122 (18.2%)	227 (33.8%)	91 (13.6%)	79 (11.8%)
12 (13.8%)	39 (44.8%)	10 (11.5%)	12 (13.8%)
7 (14.3%)	18 (36.7%)	6 (12.2%)	3 (6.1%)
23 (11.9%)	69 (35.6%)	34 (17.5%)	27 (13.9%)
1,331 (15.9%)	2,758 (32.9%)	1,165 (13.9%)	1,047 (12.5%)
127 (16.2%)	269 (34.4%)	119 (15.2%)	83 (10.6%)

FIGURE 23. Comparing Demographic Distributions of Family Physicians by Income



Our demographic breakdown of self-reported income data does not account for actual practice work hours that may contribute to salary differences and disparities. For instance, full-time employment will result in higher income levels than partial-time employment. Two recent studies have been published using additional ABFM data to account for annual hours worked. One of these studies found a nearly 16% difference in hourly pay between female respondents compared to male respondents (Jabbarpour et. al).³⁸ Other research found that male family physicians had higher hourly wages than female family physicians across all racial/ethnic groups except for Black/African American males – although this group reported more working hours than any other group (Anderson, et. al).³⁹ Thus, family physician income disparities prevail despite accounting for hours worked.

TABLE 18. Family Physician Mean Income and Hours Worked by Gender

	Income	Weekly Hours worked	Weekly hours worked (Clinical Work Only)	Hourly Compensation (\$)	Hourly Compensation (Clinical Work Only) (\$)
Overall	217,018	53.6	41.2	85.7	114
Female	197,623	51.9	39.5	79	105.6
Male	240,720	55.8	43.2	93.8	124.2

Source: ABFM Graduate Survey Report 2019

TABLE 19. Family Physician Mean Income and Hours Worked by Race/Ethnicity and Gender

Male/Female	Annual Average Income	Hourly Compensation
White Male (n=1200)	\$246,934.00	\$97.25
Asian Male (n=333)	\$246,295.00	\$91.51
Black or African American Male (n=74)	\$243,864.00	\$82.46
Hispanic or Latino Male(n=138)	\$241,466.00	\$92.99
Other Male (n=60)	\$237,890.00	\$87.44
Average (n=3719)	\$224,645.00	\$88.06
Other Female (n=99)	\$213,039.00	\$82.46
Hispanic or Latino Female (n=166)	\$209,254.00	\$84.04
White Female (n=1337)	\$208,258.00	\$83.44
Black or African American Female (n=177)	\$206,494.00	\$79.16
Asian Female (n=439)	\$200,568.00	\$79.71

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 *Other: American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Other race/ethnicity
 Source: ABFM Graduate Survey Report 2019, 2020



9. Conclusion

As the largest and most widely distributed physician primary care specialty in the U.S.¹², family medicine plays an essential role in our health system. The family medicine workforce is heterogenous in both demographic and practice patterns, distributes across the country in patterns similar to the U.S. population, works in a variety of clinical settings, and has wide ranges in practice scope. Family physicians collaborate in interdisciplinary teams and innovate to adapt to rapid changes in health technology. The data presented in the Family Medicine Factbook is intended to promote further understanding of the characteristics and contributions of family medicine as a discipline. We hope that use of information from the Factbook will inform physicians, patients, policymakers, educators, and other readers interested in advancing health but also in supporting family medicine research, education, reform, and advocacy. 🌐

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Methods Appendix

We used American Board of Family Medicine (ABFM) data of questionnaire respondents from January 1, 2016 to December 31, 2021 to describe the trends and current state of family physician demographics. This data includes self-reported information regarding race/ethnicity, scope of practice, ownership, income/payment models and physician well-being. These cross-sectional data points can be used to characterize the family medicine field at specific points in time, as well as allowing for the identification of trends and similarities between different cohorts.

Data Sources

ABFM Continuous Certification Candidate Demographic Report

The ABFM Continuous Certification Candidate Demographic Report is derived from a standardized questionnaire mandatory to practicing physicians who choose to continue or regain their ABFM certification.^{1,2} The data was collected during the process of registration for the examination, 3-4 months prior to the actual date of the examination. In addition, there are five rotating question sets to sample physicians on topics relating to meaningful use of electronic health records, patient-centered medical home features, types of payment their practices accept, and procedures performed, physician wellness and burnout.¹ These rotating sets are distributed in a round-robin style, where recipients are only responsible for answering their assigned set to reduce questionnaire burden. In addition to the rotating question set between respondents, some questionnaire questions were only provided depending on a certain answer to a prior question. For questions regarding practice, if a physician had previously indicated they were not practicing, these questions were omitted. Thus, the sample population (N) differed throughout survey questions. Of note, the 2020 and 2021 continuing certification examination cohorts were smaller than other years due to changes in the certification program 10 years prior. The 2020 and 2021 continuing certification examination cohorts were smaller than other years due to changes in the certification program 10 years prior.

ABFM Initial Certification Candidate Demographic Report

The ABFM Initial Certification Candidate Demographic Report is derived from a standardized questionnaire mandatory to family physicians who are seeking ABFM initial certification. The data was collected during the process of registration for the examination, 3-4 months prior to the actual date of the examination. For most candidates, this is midway through their last year of family medicine residency. Some questionnaire questions were only provided depending on a certain answer to a prior question; thus, the N differed throughout survey questions.

ABFM Graduate Survey Report

The ABFM Graduate Survey Report is derived from a standardized questionnaire given to ABFM Diplomates three years following residency graduation.³ Each year the survey opens January to December; for example, the 2021 survey contains information regarding those who completed residency in 2018. The surveys utilized in this Factbook are from 2016-2021, providing a snapshot of physicians from 2013-2018 residency graduates. This survey is voluntary; thus, survey responses do not represent the entire sample of eligible respondents. Some questionnaire questions were only provided depending on a certain answer to a prior question resulting in different sample populations (N) throughout survey questions.

Limitations and Caveats

While our data includes a large cohort of practicing family physicians in the United States, only those certified by ABFM are included. Previous studies estimate that the total family physician population that is certified by ABFM is 82-85%.^{4,5} This Factbook does not represent the entirety of U.S. family physicians but self-reported data extrapolated from this large sample population does serve as a crucial contributor towards understanding family medicine practice and trends. Furthermore, some ABFM data is acquired via rotating cross-sectional surveys (see Data Sources section above). This can only provide a snapshot of candidates at a given point in time. Due to the COVID-19 pandemic, the deadline of the 2021 ABFM Graduate Survey Report was extended into 2022. The data extracted for this Factbook only includes respondents from 2016 through December 31, 2021, thus not representing the entirety of 2021 Graduate Survey Report respondents.

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