CHARACTERISTICS OF GENERAL INTERNISTS WHO PRACTICE ONLY OUTPATIENT MEDICINE: RESULTS FROM THE PHYSICIAN WORKLIFE STUDY

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- *Purpose:* Several recent articles have focused on the emerging new career path of hospitalists, yet little attention has been paid to the concomitant development of outpatient-focused internists. The purpose of this study was to learn more about the characteristics of outpatient-focused internists.
- *Design:* Analysis of data from the Physician Worklife Study, a national random stratified survey of primary care and specialty physicians conducted from 1996 to 1997.
- *Method:* The analysis focused on self-identified general internists who worked greater than or equal to 30 hours per week (n = 353). Respondents were categorized into two groups: "exclusively outpatient internists" (0% inpatient time; n = 59); and "any inpatient internists" (inpatient time greater than 0%; n = 294), which was a combination of "mixed internists" (0% to 50% inpatient time; n = 286) and "primarily inpatient internists" (inpatient time greater than 50%; n = 8). The demographic, practice, and patient case mix characteristics of these two groups were compared.
- *Results:* Of general internal medicine respondents, 17% were "exclusively outpatient internists" whereas 83% were "any inpatient internists" (of this group, 2% were "primarily inpatient internists"). Exclusively outpatient internists earned less in salary, worked fewer hours per week, were more likely to work part-time or in an emergency department or urgent care setting, and were more likely to intend to change their specialty within 5 years. A greater proportion of exclusively outpatient internists were women and unmarried. Compared with their male counterparts, female exclusively outpatient internists treated a greater percentage of female patients, were more likely to be salaried, and were less likely to intend to leave direct patient care within 5 years.
- *Conclusions:* As of the 1996–1997 Physician Worklife Study, approximately 17% of internists worked exclusively outside the hospital. Important differences were found between these general internists and internists who maintain or favor an inpatient practice. These differences show that the practice of internal medicine is changing and that substantial heterogeneity in the career paths and practice patterns of general internists can be expected in the near and distant future.

General internal medicine (GIM), traditionally a discipline involving mixed inpatient and outpatient care, is evolving toward new and separate career paths for exclusively outpatient, primarily inpatient, and conventional mixed inpatient and outpatient care. Specifically, *hospitalists* have been described as physicians who specialize in the care of inpatients [1]. The advent of hospital medicine has coincided with the development of physicians who exclusively care for outpatients, occasionally referred to as *officists* [2] or *ambulists* [3].

Managed care, with its emphasis on efficiency and cost saving, may be partly responsible for the development of these new career paths [1]. The challenges presented by increasing patient complexity also may lead some physicians to focus their efforts primarily on the outpatient or inpatient arena. Desires to exert more control over work hours and professional demands also may prompt physicians to limit the scope of their practice.

These workforce developments are likely to affect both residents, who will need to choose between these diverging career paths, and medical educators, who will need to train future participants in these careers. Additionally, as

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inpatient and outpatient medicine begin to be viewed as practices requiring separate skills, specialized tracks and curricula may need to be established for teaching and training physicians in these skills.

Background

Although discussions within GIM have focused on the hospitalist movement [4], relatively little attention has been devoted to understanding an emerging group of internists who provide solely outpatient care. Recent studies have evaluated the effect of hospitalists on the quality and cost of health care [5–8] and have described the demographic characteristics and practice profiles of hospitalists [9,10]. Little information, however, is available about these characteristics of exclusively outpatient internists. Accordingly, we used data collected in the national population-based Physician Worklife Study to describe the characteristics of exclusively outpatient general internists and to compare this group with general internists who maintain an inpatient practice.

The Physician Worklife Study was coordinated through the Society of General Internal Medicine and conducted by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill. We used the Physician Worklife Study for our analysis because it represents one of the largest population-based studies of physician work-related characteristics and satisfaction in the United States. The purpose of the study is to collect self-reported data about general physician satisfaction and work-related issues (eg, stress level, burnout, practice patterns) from a large, geographically and ethnically diverse group of physicians representing various specialties.

The specifics of the Physician Worklife Study design have been described previously [11–14]. Briefly, 5704 physicians were randomly selected from the American Medical Association's Masterfile and stratified by ethnicity, penetration of managed care (high versus low), and specialty (ie, family medicine, GIM, general pediatrics, internal medicine or pediatric subspecialty). Minority physicians were oversampled (ie, the number of minority physicians in our sample was disproportionately higher compared with the number of minority physicians in the Masterfile). Four survey mailings were conducted from 1996 to 1997. The final questionnaire had been extensively validated [13] and included a total of 8 pages with 140 items. The overall adjusted response rate was 52%. A wave analysis comparing late respondents with early respondents showed that the correlation between the survey item response and the time interval between survey mailing and return was greater than 0.10 for only 4 of the 140 items in the survey, suggesting minimal nonresponse bias.

Method

We focused our analysis on general internists. (The adjusted response rate for general internists was 46%.) Because we were interested only in clinically active general internists, we limited the analysis to responding physicians who worked 30 clinical hours per week or more, listed internal medicine as their primary specialty, and did not list a secondary specialty. Thus, our subjects were primarily full-time, clinically active general internists (n = 353).

Respondents were then grouped into one of two categories based on self-reported estimates of the percentage of clinical time spent in the hospital seeing inpatients. The two categories were internists who reported spending 0% of their clinical time seeing inpatients ("exclusively outpatient internists," n = 59) and internists who reported spending any proportion of their clinical time seeing inpatients ("any inpatient internists," n = 294). The "any inpatient internists" group consisted of both internists who reported spending between 0% and 50% of their clinical time in the hospital (ie, "mixed internists," n = 286) and internists who reported spending 50% or more of their clinical time in the hospital (ie, "primarily inpatient internists," n = 8).

For most of the variables evaluated (**Table 1**, **Table 2**), the definitions are straightforward. However, three variables require further explanation. First, the "mean percent of net compensation due to individual productivity" refers to the percentage of the respondent's total income that is derived from revenue generated by that individual physician, after accounting for group overhead expenses. Thus, physicians on a straight salary would have a score of 0%, whereas those on a straight fee-for-service arrangement (typical of most solo practices and many small partnerships) would have a score of 100%. Consistent with managed care compensation schemes, many group practices have adopted some combination of a base salary augmented by individual or departmental productivity incentives. Second, the variable "elderly" was defined as anyone over the age of 65 years. Finally, the variable "burnout" ranged from 1 ("I enjoy my work. I have no symptoms of burnout.") to 5 ("I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help."). Respondents were asked to use their own definition of burnout.

Statistical Analysis

Because we were interested primarily in describing the characteristics of the two provider groups rather than testing explanatory hypotheses, we compared the characteristics of the groups without controlling for covariates. Student's t test was used to compare continuous

Table 1. Demographic and General Characteristics of the Respondents by Group*

Characteristics	Exclusively Outpatient Internists (*n* = 59)	Any Inpatient Internists (*n* = 294)	*P* value
Demographics			
Mean age, y (SD)	48 (11.5)	47 (10.1)	0.65
Mean medical school graduation year (SD)	1977 (12.2)	1977 (10.5)	0.67
Female, *n* (%)	27 (47)	58 (20)	< 0.001
White, *n* (%)	38 (64)	199 (68)	0.62
International medical graduate, *n* (%)	13 (22)	80 (27)	0.41
Married, *n* (%)	43 (73)	245 (84)	0.022
Mean number of children (SD)	2 (1.6)	2 (1.3)	0.32
Practice patterns			
Mean 1995 net income (SD)	$110,433 ($55,462)	$138,609 ($61,571)	0.002
Mean % of net compensation due to individual productivity (SD)	29 (40.2)	66 (42.4)	< 0.001
Mean total work hours per week (SD)	47 (10.4)	58 (17)	< 0.001
Work 30–39 hours per week, *n* (%)	13 (22)	13 (4.4)	< 0.001
Mean dollars earned per hour (SD)	46 (21.8)	48 (19)	0.64
Mean years in practice (SD)	13 (10.1)	14 (9.5)	0.54
Practice setting			
Solo/small group practice (2–9 MDs), *n* (%)	19 (32.2)	174 (59)	< 0.001
Large group practice (10+ MDs), *n* (%)	11 (19)	66 (23)	0.52
Group/staff model HMO, *n* (%)	7 (12)	33 (11)	0.89
Academic group practice, *n* (%)	4 (7)	12 (4)	0.36
Other (eg, urgent care, ED), *n* (%)	17 (29)	8 (3)	< 0.001
Patient case mix			
Mean % female patients (SD)	57 (17.7)	58 (13.5)	0.83
Mean % white patients (SD)	60 (29.7)	69 (25.4)	0.023
Mean % elderly patients (SD)	33 (26.5)	46 (22.1)	< 0.001
Mean % patients who speak little or no English (SD)	15 (22.7)	7 (14.5)	< 0.001
Mean % patients with complex medical problems (SD)	42 (30)	44 (23.9)	0.47
Mean % patients with complex psychosocial problems (SD)	33 (26.2)	28 (21)	0.14
Mean % patients with substance abuse problems (SD)	14 (16)	8 (9.7)	< 0.001
Mean % patients who are frustrating to treat (SD)	14 (16.3)	10 (12.8)	0.059
Possible future work life changes			
Percent who thought the following likely or definitely likely:			
Leave current practice within 2 years, *n* (%)	13 (22)	47 (16)	0.25
Decrease work hours within 5 years, *n* (%)	18 (32)	77 (27)	0.46
Change specialty within 5 years, *n* (%)	6 (11)	6 (2)	0.002
Leave direct patient care within 5 years, *n* (%)	10 (18)	44 (15)	0.66
Experiencing any burnout, *n* (%)†	13 (22)	79 (27)	0.46

ED = emergency department; HMO = health maintenance organization; MDs = physicians; SD = standard deviation.

*Percents may not equal 100% because of rounding error.

†Defined as ≥ 3 on the burnout scale, which ranged from 1 to 5 (see text for definition).

Table 2. Demographic and General Characteristics of the Exclusively Outpatient Group by Gender*

Characteristics	Male (*n* = 31)	Female (*n* = 27)	*P* value
Demographics			
Mean age, y (SD)	50 (11.7)	45 (11.3)	0.13
Mean medical school graduation year (SD)	1974 (12.5)	1980 (11.5)	0.070
White, *n* (%)	21 (68)	16 (59)	0.50
International medical graduate, *n* (%)	10 (32)	3 (11)	0.066
Married, *n* (%)	24 (77)	18 (67)	0.25
Mean number of children (SD)	2 (1.8)	1.6 (1.3)	0.31
Practice patterns			
Mean 1995 net income (SD)	$123,328 ($65,536)	$94,174 ($34,190)	0.059
Mean % of net compensation due to individual productivity (SD)	42 (43.3)	12 (29)	0.007
Mean total work hours per week (SD)	50 (11.5)	45 (8.6)	0.069
Work 30–39 hours per week, *n* (%)	4 (13)	9 (33)	0.11
Mean dollars earned per hour (SD)	49 (24.9)	43 (17.1)	0.28
Mean years in practice (SD)	15 (11.2)	12 (8.5)	0.23
Practice setting			
Solo/small group practice (2–9 MDs), *n* (%)	12 (39)	7 (26)	0.40
Large group practice (10+ MDs), *n* (%)	6 (19)	5 (19)	0.94
Group/staff model HMO, *n* (%)	4 (13)	3 (11)	0.83
Academic group practice, *n* (%)	1 (3)	3 (11)	0.33
Other (eg, urgent care, ED), *n* (%)	8 (26)	8 (30)	0.78
Patient case mix			
Mean % female patients (SD)	52 (16.4)	63 (18)	0.017
Mean % white patients (SD)	61 (30)	58 (29.7)	0.73
Mean % elderly patients (SD)	37 (30.3)	29 (21.7)	0.26
Mean % patients who speak little or no English (SD)	16 (27.5)	14 (16.7)	0.82
Mean % patients with complex medical problems (SD)	46 (32.7)	38 (26.4)	0.30
Mean % patients with complex psychosocial problems (SD)	32 (30.3)	34 (21.8)	0.83
Mean % patients with substance abuse problems (SD)	13 (16.8)	14 (15.6)	0.77
Mean % patients who are frustrating to treat (SD)	13 (17.8)	15 (15.1)	0.61
Possible future work life changes			
Percent who thought the following likely or definitely likely:			
Leave current practice within 2 years, *n* (%)	8 (26)	5 (19)	0.55
Decrease work hours within 5 years, *n* (%)	11 (35)	7 (27)	0.57
Change specialty within 5 years, *n* (%)	4 (13)	2 (8)	0.68
Leave direct patient care within 5 years, *n* (%)	9 (29)	1 (4)	0.016
Experiencing any burnout, *n* (%)†	7 (23)	6 (22)	0.92

ED = emergency department; HMO = health maintenance organization; MDs = physicians; SD = standard deviation.

*One respondent was excluded because of unknown gender.

†Defined as ≥ 3 on the burnout scale, which ranged from 1 to 5 (see text for definition).

variables. Pearson's chi-square test was used to compare categorical outcomes. Also performed were gender-stratified analyses of exclusively outpatient providers, as we hypothesized that perhaps gender-based differences may be likely in this group. For all analyses, a two-sided P value of less than 0.05 was used to indicate statistical significance. All analyses were performed using STATA 6.0 (College Station, TX).

Results

Characteristics of the Two Provider Groups

In our sample, there were 59 (17%) "exclusively outpatient internists" and 294 "any inpatient internists" [286 (81%) "mixed internists" and 8 (2%) "primarily inpatient internists"] (Table 1). A greater proportion of "exclusively outpatient internists" were women (47% versus 20%; $P < 0.001$) and unmarried, compared with the other group of internists. "Exclusively outpatient internists" earned less in salary ($110,433 versus $138,609; $P = 0.002$), worked fewer hours per week (47 versus 58; $P < 0.001$), had a lower percentage of net compensation due to individual productivity (29% versus 66%; $P < 0.001$), and were more likely to work part-time (22% versus 4%; $P < 0.001$). However, after adjusting for different number of hours per week, the dollar amount earned per hour was similar for both groups ($46 versus $48; $P = 0.64$).

Regarding practice setting, compared with "any inpatient internists," a lesser percentage of "exclusively outpatient internists" worked in a solo or small group practice, whereas a greater percentage worked in an emergency department or urgent care environment. Regarding patient case mix, "exclusively outpatient internists" had a lesser percentage of white, elderly, or English-speaking patients but a greater percentage of substance abusing patients. Finally, "exclusively outpatient internists" were 5 times more likely to report that they would change their specialty within 5 years (11% versus 2%; $P = 0.002$), although the numbers in each category were small. The groups did not differ significantly with regard to age, race, number of children, years in practice, or percentage currently experiencing burnout (ie, rating greater than or equal to 3 on the burnout scale, which ranged from 1 to 5).

Gender-Related Differences in the Exclusively Outpatient Group

Among "exclusively outpatient internists," we stratified by gender to see how characteristics varied between male and female physicians (Table 2). Female outpatient internists tended to be younger than their male counterparts, although this difference was not statistically significant (45 versus 50 years of age; $P = 0.13$). Compared with male internists' compensation, a lesser proportion of female internists' compensation was due to individual productivity (12% versus 42%; $P = 0.007$), suggesting that most of the women are salaried. Also, women had a higher proportion of female patients and were less likely to plan to leave direct patient care within 5 years. Women tended to earn less than men ($94,174 versus $123,328; $P = 0.06$); but due to fewer hours worked by women (45 versus 50; $P = 0.07$), the dollars earned per hour were similar by gender ($49 per hour for men versus $43 per hour for women; $P = 0.3$). Statistically significant differences between these two groups of outpatient physicians could not be detected for the remaining variables, perhaps due to relatively small sample sizes.

Discussion

Using data from the recent population-based Physician Worklife Study, we described the demographic features and practice patterns of a national sample of general internists after stratifying them by the proportion of time each spends caring for inpatients. Our data suggest that most general internists spend at least some but less than half of their time caring for inpatients, whereas relatively few can be considered hospitalists (ie, internists who spend greater than 50% of their clinical time caring for hospitalized patients). However, more than one of every six general internists (17%) who spend at least 30 hours per week on clinical activities work exclusively outside the hospital. We also found several differences between general internists with and those without a hospital practice in terms of gender, marital status, annual income, total weekly work hours, type of practice setting, patient case mix, and possible future work life changes.

It is of great interest that a substantial proportion of the general internists in our survey reported spending none of their time in the hospital. While attention has been focused recently on those physicians primarily engaged in inpatient care (ie, hospitalists), a sizable and perhaps considerably greater percentage of general internists care only for outpatients, based on results from the Physician Worklife Study. These officists or ambulists may indeed be either a by-product of or driving force behind the hospitalist movement. As more generalists focus on inpatient care, a greater number of primarily outpatient physicians will likely result, and vice versa.

Who are the physicians who practice exclusively outpatient medicine? This potentially growing new segment of general internists tends to work either in group

practices, emergency departments, or urgent care settings. Compared with other general internists, members of this group are more likely to be female and unmarried, work fewer hours per week, and work part-time. Exploratory analyses among these exclusively outpatient internists showed some differences between men and women. Female outpatient internists treated a greater percentage of female patients and were less likely to have their incomes tied to productivity. They also were less likely than male outpatient internists to plan to leave direct patient care within 5 years, although this result might be due in part to the age differential between male and female exclusively outpatient internists.

These exclusively outpatient general internists may be carving out a niche in outpatient practice with strong boundaries, exchanging salary and productivity bonuses for fewer work hours in a more controllable setting such as an emergency department or urgent care center. This new path in GIM seems not to be a phenomenon related only to the presence of children, as the number of children for physicians in this group is no different than for other internists. These internists may be responding to a sense of dissatisfaction among general internists that has been documented recently [15]. Internists are one of the few primary care groups that maintain a substantial presence within the hospital; however, the satisfaction of general internists is lower than that of family physicians [15]. The success of exclusively outpatient general internists should be carefully watched to see whether job satisfaction sustains long-term careers in this capacity. If so, outpatient GIM may represent a new alternative career path for general internists.

The percentage of our respondents performing only outpatient care is similar to the estimate of one other study evaluating Medicare claims in Washington State during 1994 [16]. In that study, approximately 18% of general internists did not bill Medicare for any inpatient care visits [16]. We are unaware of more recent data addressing this question. As the hospitalist movement continues to accelerate, it will be useful to track the varying proportions of general internists choosing between inpatient and outpatient care. We suspect that the proportion of both officists and hospitalists will increase, while generalists who care for both hospitalized and ambulatory patients will concomitantly decrease.

Recent data have emerged indicating that hospitalists are likely to provide equal or higher quality of inpatient care at the same or less cost compared with nonhospitalist inpatient providers [5–8]. More work is needed to tease out the complex relationship between the number of hours physicians spend caring for hospitalized patients, other physician characteristics and outcomes (eg, burnout), case mix considerations, and important health outcomes before we can fully understand the most efficient and appropriate care of hospitalized patients.

The results from the Physician Worklife Study should be interpreted in the context of some important limitations. First, although the overall response rate compares reasonably well with the average response rate for physician surveys [17,18], the lesser response rate for general internists is of some concern. Fortunately, the wave analysis indicates that nonresponse bias may be modest. Second, as we evaluated only general internists, our results cannot be extrapolated to other physician specialties. It will be interesting to see the results of similar analyses performed for other specialties such as family medicine, pediatrics, and various medical subspecialties.

Despite these limitations, our study provides an important window into the practice patterns of general internists in the United States. As of 1997, 17% of internists worked exclusively outside the hospital, and we would suspect the number is higher now. As the practice patterns of general internists evolve, it will be important to track the change in some of the differences noted in this study. Following these patterns over time will help us understand the determinants of changing career paths for general internists. Future studies that longitudinally assess physician and patient satisfaction, as well as other patient outcomes, will be important for further characterizing these new types of general internists.

Both residents, who may want to pursue these new career paths, and medical educators, who must provide adequate training for their learners, will want to be aware of these developments in the physician workforce. Specifically, medical residents should be aware that practicing exclusively outpatient medicine is a possible career option. This career seems to provide a reasonably controllable lifestyle that allows for part-time employment while still providing a challenging patient mix typical of internal medicine.

Medical educators should consider offering new and diverse training pathways that provide internal medicine residents who want to practice exclusively outpatient medicine with the necessary skills prior to completing a residency and, perhaps, with considerably less focus on inpatient training sites. Such training could involve substantially increased time spent in the outpatient setting caring for patients with complex medical and psychosocial problems. Specific skills that would be emphasized in such an outpatient-oriented training pathway include optimizing chronic disease management, promoting health behavior changes, and enhancing counseling

techniques and preventive care. Just as additional training opportunities are emerging for hospitalists (eg, specialized tracks during residency, research-based fellowships), perhaps specific curricula can be made available for outpatient-oriented providers (eg, proficiency in office-based procedures, increased psychosocial training). Finally, this group of learners may benefit from a new breed of teachers and role models.

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Acknowledgment: The Physician Worklife Study was supported by grant #27069 from the Robert Wood Johnson Foundation. Sanjay Saint, MD, MPH, was supported by a Health Services Research & Development Award from the Department of Veterans Affairs.

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