

# **Office Visits to Internists**

## **The National Ambulatory Medical Care Survey**

**United States, 1975**

Using data obtained from a national sample of office-based internists and other specialists, statistics are presented which describe ambulatory medical care rendered in the offices of specialists in internal medicine. Data are given on physician utilization patterns developed from selected physician and patient characteristics. Data describe patients' demographic characteristics and principal problems, as well as physicians' diagnoses, in terms of visit status, diagnostic and therapeutic services rendered, and seriousness, disposition, and duration of visit. Characteristics of visits to internists are compared with those of general and family practitioners and other specialists.

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### SYMBOLS

Data not available-----	---
Category not applicable-----	...
Quantity zero-----	-
Quantity more than 0 but less than 0.05-----	0.0
Figure does not meet standards of reliability or precision (more than 30 percent relative standard error)-----	*

# OFFICE VISITS TO INTERNISTS

## NATIONAL AMBULATORY MEDICAL CARE SURVEY

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### INTRODUCTION

This report, the third series report based on 1975 data, presents national estimates of the public's utilization of ambulatory medical care services that are provided by non-Federal, office-based specialists in internal medicine in the conterminous United States during 1975. The data were collected in the National Ambulatory Medical Care Survey (NAMCS) by the Division of Health Resources Utilization Statistics.

General summary statistics for 1973 and 1975, which included national estimates of characteristics of visits to most medical, surgical, and other specialists, were presented in earlier Series 13 publications.<sup>1,2</sup> Detailed information on the background and methodology of the survey was provided in a report in Series 2 of *Vital and Health Statistics*.<sup>3</sup> A description of the 1975 survey, including statistical design, data collection and processing, and estimation procedures, may be found in appendix I of this report. Technical details regarding reliability of estimates, definitions of terms used in the survey, facsimiles of data-gathering instruments, and other survey materials are also in the appendixes to this report.

Although the general objective of NAMCS is to provide basic national estimates on the utilization of ambulatory medical care services provided by all non-Federal office-based physicians, the design of the sample used in the survey permits valid national estimates of the patterns of services provided by internists as well as other specialists.

The physician who specializes in internal

medicine, or internist, diagnoses and treats diseases of the internal organ systems of adults. The estimates presented in this report will amplify this definition according to the clinical pattern of the internist's actual practice as measured by the patient encounter in NAMCS. The report will also contrast statistical estimates of the specialty in internal medicine with estimates of similar characteristics of other leading specialties reported in the 1975 NAMCS.

An important distinction should be made between estimates which describe visits to *internists* and those which describe visits to the total physician population defined by the 1975 NAMCS. This distinction is important when examining tables and viewing figures, since it is easy to incorrectly generalize about the whole population from data which are representative only of patient visits to internists.

Although complete technical details of the survey are provided in the appendixes and the references, a brief description of the scope of the survey and the source and limitations of the data is provided before delineation of the topics concerned with patient encounter data. This section also describes the selection of the sample of specialists in internal medicine from which the estimates for this report were calculated.

### Scope of the Survey

The basic sampling unit for the NAMCS is the physician-patient encounter or visit. "Encounter" and "visit" are used interchangeably in this report. Only visits in the offices of non-Federally employed physicians classified by the

American Medical Association (AMA) or the American Osteopathic Association (AOA) as "office-based, patient care" were included in the 1975 NAMCS. In addition, physicians in the specialties of anesthesiology, pathology, and radiology were excluded from the physician universe. Major types of ambulatory encounters not included in the 1975 NAMCS were those made by telephone or home visits and those made in hospital or institutional settings. If resources permit, future NAMCS's will include some of these types of encounters. However, some complex methodological and sampling problems must first be resolved.

### Source and Limitation of Data

The data presented in this report were derived from information provided by a national probability sample of office-based physicians. A sample of 3,507 physicians representing AMA and AOA listed specialties including internal medicine was contacted during 1975. Of the 3,069 physicians who were eligible for the study, 2,472 (80.5 percent) participated in the study. The sample included 446 internists who were determined in scope for the survey. Of these, 347 (77.8 percent) participated.

Specially trained interviewers visited the physicians prior to their designated reporting week, provided survey materials, and informed each physician and staff member of the methods and definitions to be used. During a randomly

assigned 7-day reporting period, the sample physician maintained a listing of all office visits. For a systematic random sample of those visits, data were recorded on an encounter form provided for that purpose (see appendix III).

The three appendixes to this report provide information necessary to correctly understand and interpret the statistics presented. Since these statistics are based on a sample of ambulatory visits rather than on all visits, they are subject to sampling errors. Therefore particular attention should be paid to the section in appendix I entitled "Reliability of Estimates." Charts of relative standard errors and instructions for their use are also give in appendix I.

Definitions of the terms used in this report and in the survey operations are presented in appendix II. Facsimiles of survey materials, including letters, patient records, and induction interview forms, are reproduced in appendix III.

Another program of the National Center for Health Statistics, the Health Interview Survey (HIS), collects data on the utilization of physician services, including internists, from a sample survey of the civilian, noninstitutionalized population of the United States. The HIS estimates for visits to internists are generally larger for the number of visits than NAMCS estimates because of differences in collection procedures, populations sampled, and definitions. Data from HIS are published in Series 10 of *Vital and Health Statistics*.

## SECTION I. GEOGRAPHIC AND DEMOGRAPHIC UTILIZATION PATTERNS

### Specialty, Type, and Location of Practice

The over 62 million visits to internists during 1975, shown in table A, accounted for almost 11 percent of all visits to office-based physicians estimated in the NAMCS. This number was exceeded only by the number of visits made to offices of general and family practitioners (234 million or about 41 percent of all visits).

Table 1 shows the geographic distribution of visits to internists by the four census regions, by metropolitan or nonmetropolitan area, and by type of practice. The highest proportion of visits (almost 30 percent) occurred in the Northeast

Table A. Number, percent, and annual rate of visits per 100 in population by selected specialists: United States, January-December 1975

Specialty	Number of visits in thousands	Percent of visits	Annual rate of visits per 100 in population
<i>Internal medicine.....</i>	62,117	10.9	30
General and family practice.....	234,660	41.3	113
Obstetrics and gynecology.....	48,076	8.5	23
Pediatrics.....	46,684	8.2	22
General surgery.....	41,292	7.3	20



Region, with the least number of visits (about 20 percent) in the West Region. However, the annual rate of visits also shown in table 1, indicates that more frequent visits were made by the population in the West Region (34 per 100 persons) than by the population in the North Central Region (28 per 100 persons) or South (24 per 100 persons). The highest annual visit rate was in the most densely populated Northeast Region (38 per 100 persons).

This configuration of visits may be partly a result of the physical location of internists' offices. Table B compares the 1975 regional distribution of internists estimated from American Medical Association data with the distribution of NAMCS visits.

As shown in table 1, 85 percent of the visits to internists were to offices located within standard metropolitan statistical areas (SMSA's). The visit rate is more than twice as high for visits to offices in metropolitan locations (37 visits for each 100 persons) than for visits to nonmetropolitan offices (14 of 100).

Information regarding the type of practice selected by internists is obtained during the induction interview.<sup>a</sup> Participants designate whether they are in solo, partnership, group, or

<sup>a</sup>Summary data obtained during NAMCS induction interviews are available from NCHS.

Table B. Percent distribution of visits to internists by geographic region: United States, January-December 1975

Region	Visits to internists	
	Non-Federal office-based <sup>1</sup>	NAMCS <sup>2</sup>
	Percent distribution	
United States.....	100.0	100.0
Northeast.....	31.1	29.7
North Central.....	23.0	25.1
South.....	25.0	25.6
West.....	20.9	19.6

<sup>1</sup>Roback, G., and Mason, H. R.: *Physician Distribution and Medical Licensure in the U.S.* Chicago. American Medical Association, 1975.

<sup>2</sup>Alaska and Hawaii not included.

other types of practice. The number of visits to internists in solo practice (about 54 percent) indicated in table 2 was probably a reflection of the fact that about 52 percent of internists estimated by the NAMCS sample were engaged in solo practice in 1975. In the Northeast Region the highest concentration of visits (over 68 percent) to internists was to those in solo practice. A reversal of the solo practice visit trend occurred in the West Region where almost 62 percent of visits to internists were in offices classified as having arrangements other than solo practice.

While more visits were made to metropolitan-based offices of internists in solo practice (about 55 percent) than to other types of office practices (about 46 percent), there was no significant difference in visits by type of practice for nonmetropolitan-based offices.

### Characteristics of Patients

Distributions of visits by sex, age, and color are shown in table 3. Since females (51 percent) outnumbered males (49 percent) in the general population in 1975, a higher number of visits by females might be expected. Three of five visits to internists' offices were made by females. Visits by each sex increased with age up to age 65, with the highest proportion in the category 45 to 64 years old, which accounted for almost 40 percent of all male visits and about 37 percent of all female visits.

The rate of visits also increased with each advancing age group with the visit rate for females exceeding that for males in every age category except under 15 years. The visit rate for patients 45 to 64 years of age was more than double the rate for patients 25 to 44 years, while the rate for the 65 years and over category was more than three times higher.

The age categories shown in tables 1 and 3 are useful for making demographic comparisons between the data representing visits to internists and to other specialties. However, the distribution of visits to internists is more highly concentrated at the upper end of the age scale than is the visit distribution for all ambulatory medical care visits. As shown in table C, over 53 percent of internists' visits were made by pa-

Table C. Percent distribution of visits to office-based internists by age of patient: United States, January-December 1975

Age of patient	Percent distribution
All ages.....	100.0
Under 40 years.....	27.8
40-54 years.....	23.5
55-69 years.....	29.9
70 years and over.....	18.9

tients between ages 40 and 69. Therefore, the age categories shown in table C are used in some sections of this report to provide additional detailed analyses of internal medicine data. To partially overcome any bias which might be introduced by a greater number of visits by older patients, age groups were redistributed so that approximately equal numbers were in each group. Thus, the effects of variables such as patients' complaints, diagnoses, and seriousness of problem can be examined more validly.

The proportion of visits by members of the white race (91 percent) was higher than the proportion made by members of other races (9 percent) paralleling, to some degree, the population ratio. The *rate* of office visits was higher for white females, who visited at the rate of 36 per 100, than for females of other races, whose rate was 26 of 100 in the population. For each 100 white males in the population, 26 visits were made to internists' offices whereas males of other races visited at a rate of 16 of 100. These data are similar to percentages found for general and family practitioners<sup>5</sup> and could indicate that members of other races avail themselves more often of other means of ambulatory medical care since the NAMCS includes only office-based care. The Health Interview Survey reported that about 9 percent of medical care visits by white persons were to hospital clinics or emergency rooms whereas 21 percent of visits by members of other races were in similar settings.<sup>4</sup>

Thus, a typical patient visit in the internist's office was made by a white female from 45 to 64 years old.

## Patient's Principal Problem, Complaint, or Symptom

"Problem," "complaint," and "symptom" are used interchangeably in this report. Patient problems have been coded and classified according to a system developed for the NAMCS.<sup>6</sup>

The data on patient problems were derived from an item on the survey form that elicits the reasons for visit as nearly as possible in the *patient's own words*. The patients' complaints are recorded by the physician in the order of importance. The "principal problem" is the first listed.

### Most Frequent Principal Problems

The 24 principal problems most frequently presented to internists are listed in table 4. Because most estimates are not statistically different from other *near* estimates due to sampling variability, actual ranks may vary somewhat when the sampling error is taken into account.

The first six problems accounted for about 25 percent of all visits; the first 12 problems motivated 40 percent of patient visits; and the second 12 problems presented by patients increased the total to over 55 percent. If only illness-related complaints are considered, 22 problems accounted for 48 percent of the visits.

Almost 6 percent of all visits were due to a general or required physical examination. This category consisted mainly of visits for routine checkups. Prominent among the 12 most frequent problems were pain in chest, fatigue, vertigo (dizziness), and shortness of breath. Together these four problems caused over 13 percent of visits. Another 8 percent were attributed to the common complaints of cough, cold, sore throat, and headache.

Similarities and differences exist among lists of complaints presented during visits to various specialties. To bring the practice of internal medicine into clear focus, it is desirable to examine congruence of complaints among specialties. This is discussed in Section IV of this report.

### Principal Problems and Age of Patient

It is also of practical interest to examine the relationship of the patient's principal problem to

the age of the patient visiting. The reader is reminded of a limitation in the data as an aid in interpretation. It is not appropriate within the scope of the NAMCS to count patients since the basic unit of measurement is the *visit*. Thus, in reporting age we can report only on age of patients *visiting*. For example, a patient aged 40 years who makes three visits contributes three times to the calculation of the age category "40;" a patient aged 70 years who makes six visits contributes six times to the age category "70." By calculating averages from this example we obtain a *visit* age of 60, but a *patient* age of 55. Since the "patient" is not the NAMCS basic sampling unit, the average patient age can be somewhat misleading in certain contexts and is not used in this report.

The hypothesis that patient symptoms are not randomly distributed throughout all ages in the internist's visit load was investigated by treating each selected symptom as a focal point and determining its percent distribution by age.

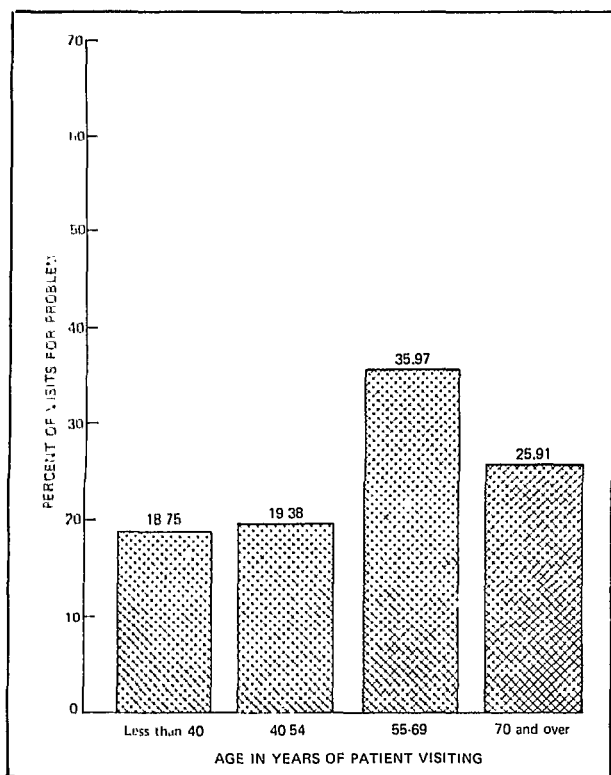


Figure 1. Percents of visits to office-based internists with principal problem of fatigue by age: United States, January-December, 1975

For example, there were about 2.5 million visits to internists in which the chief complaint was "fatigue." Which age groups visited internists most often for this problem? Which age group tended to present this problem in few visits? Figure 1 shows that fatigue occurred most frequently when the age of the patient visiting was between 55 and 69 years (36 percent of all visits prompted by fatigue); and less often when the patients visiting were younger or older. This pattern is also demonstrated for the symptoms of chest pain, dizziness, and shortness of breath graphed in figures 2, 3, and 4. These data support the above hypothesis that for each of these four symptoms the proportion of visits increased with age.

Another group of reasons for visit: general and required physical examinations, cough and cold, sore throat, and headache are charted in figures 5, 6, 7, and 8. The first three symptoms appear to be inversely related to age, i.e., proportions of visits seem to decrease as age in-

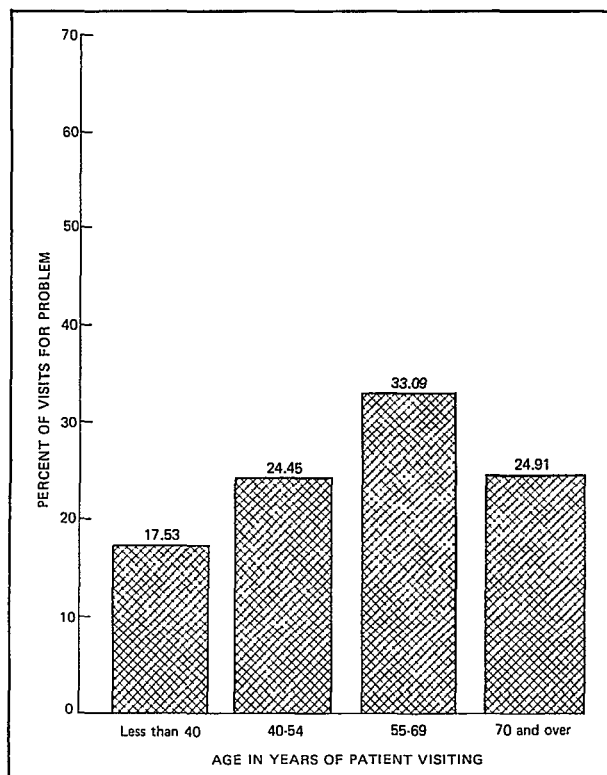


Figure 2. Percents of visits to office-based internists with principal problem of chest pain by age: United States, January-December, 1975

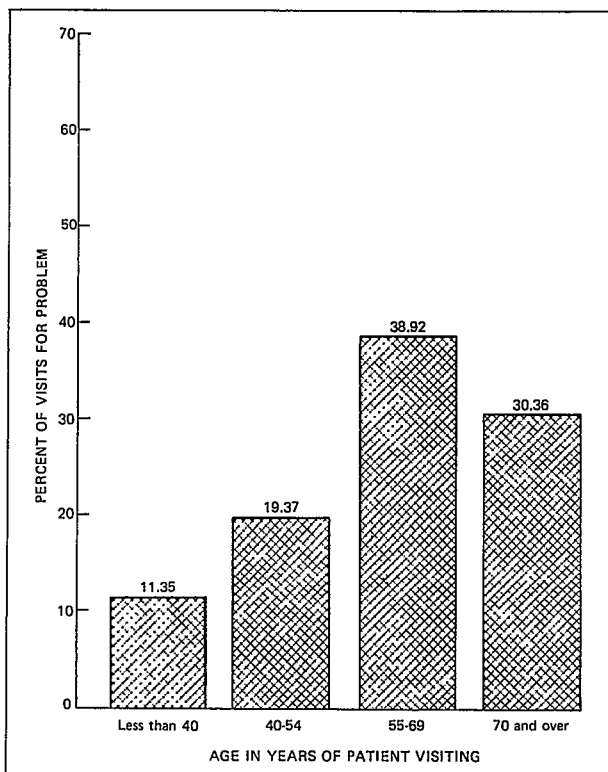


Figure 3. Percents of visits to office-based internists with principal problem of dizziness by age: United States, January-December, 1975

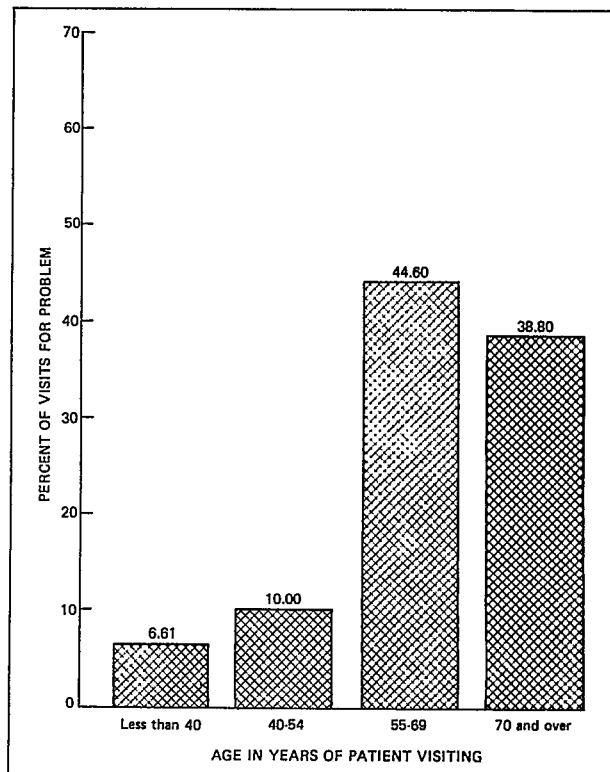


Figure 4. Percents of visits to office-based internists with principal problem of shortness of breath by age: United States January-December, 1975

creases. On the other hand, visits for "headache" do not seem to be age dependent according to the data.

While the percents of visits for problems plotted in figures 1 through 4 show a pattern of increase up to age 69 years with a decline thereafter, the reasons for visit in figures 5 through 8 exhibit a higher percentage of visits for each problem in the under 40 years age group, and a substantial decrease in the percent of visits made by older groups. Visits for general and required physical examinations (figure 5) declined steadily—ranging from 44 percent of all visits for that reason by persons less than 40 years to 7 percent by patients 70 years and over. Visits by patients under 40 years accounted for 69 percent of all visits for sore throat (figure 7); while only 9 percent of such visits were accounted for by patients 55 to 69 years (the age group covering 30 percent of all visits as shown in table C), and only 5 percent in the over 70 years age group. Of all the reasons for visit plotted, figure

8 illustrates that visits due to headache appear to be most evenly (and probably randomly) distributed among age groups. Visits for cough and cold, shown in figure 6, appear to be more frequent in the under 40 year age group (34 percent) and fairly close in the middle range (25 percent for visits by 40- to 54-year-old patients, and 28 percent by ages 55 to 69).

Statistical tests of the regression of these variables on age show a significant inverse relationship between general and required examination and age, and between sore throat and age; but not between cough and cold and age, nor between headache and age.

### Principal Problems and Diagnostic Services

The NAMCS was designed to gather data on the types of diagnostic services ordered or provided by the physician during the current visit. The 1975 Patient Record did not have the flexibility to probe whether procedures were single

or multiple. Diagnostic services data, therefore, are lacking in this dimension. For example, if "clinical laboratory test" was checked on the form it was not known whether a blood test alone was performed or whether blood, urine, and sputum tests were ordered. (See definitions in appendix II.) However, the data provided information about the general nature of the physician's workup for the problem presented.

Table 5 lists 13 most frequent patient problems with the percents of limited history and examination, general history and examination, laboratory procedure, blood pressure check, electrocardiogram (EKG), and X-ray services which were indicated as having been ordered or provided when the problem was presented. Data for therapeutic services are described in Section II of this report which deal with diagnoses.

Of all internist visits, over 61 percent included limited history and examinations as well as blood pressure checks. A general examination

was performed during 20 percent of all visits. About 39 percent included a laboratory procedure or test. EKG was the diagnostic tool used during 14 percent of all visits, and X-rays were taken in 13 percent of the visits.

Blood pressure was measured during more than 70 percent of visits when the patient complained about chest pain, high blood pressure, dizziness, or shortness of breath. An extensive workup was probably used for chest pain since over 47 percent of such visits involved EKG's and 20 percent included X-rays. Another frequent use of EKG's occurred when the complaint was shortness of breath (28 percent). X-rays were also employed often when the reason for visit was problems of the upper extremity (24 percent), abdominal pain (23 percent), and cough and cold (about 21 percent).

Internists performed general examinations in over one quarter of visits for fatigue, abdominal pain, and headache. Laboratory procedures were frequently utilized during visits for diabetes

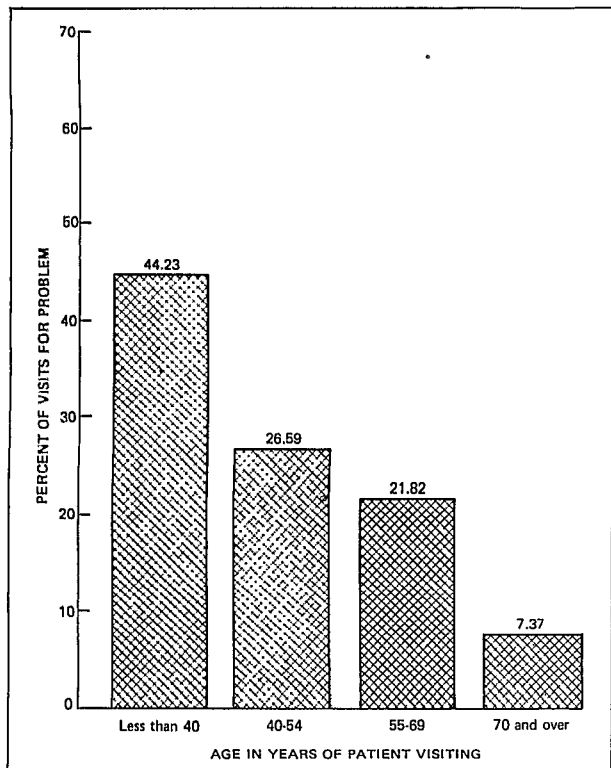


Figure 5. Percents of visits to office-based internists with principal problem of general required physical examination by age: United States, January-December, 1975

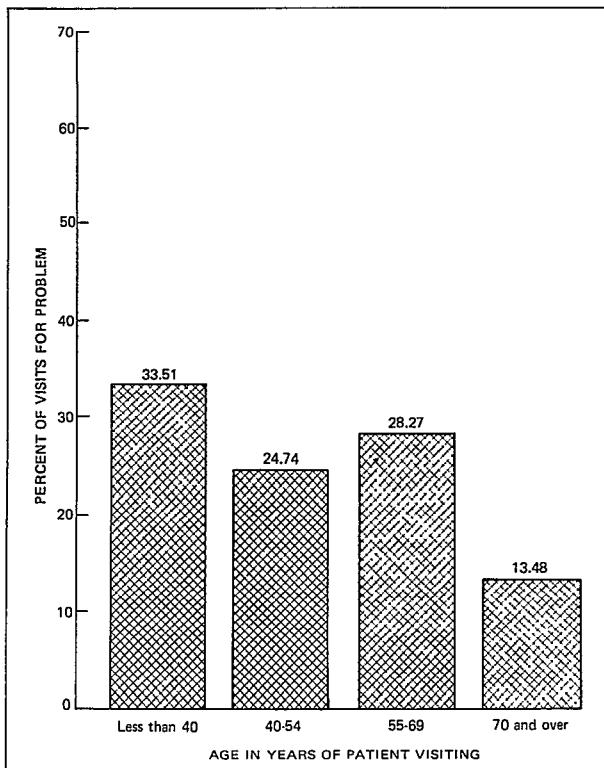


Figure 6. Percents of visits to office-based internists with principal problem of cough and cold by age: United States, January-December, 1975

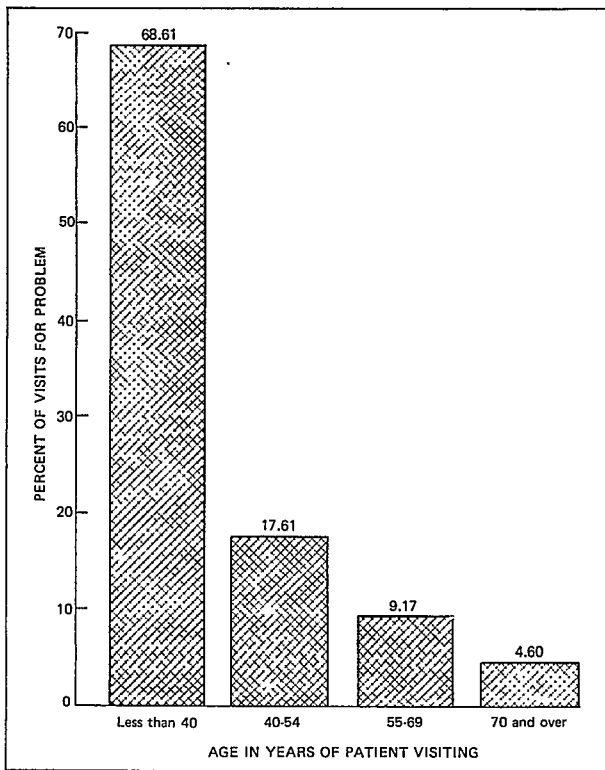


Figure 7. Percents of visits to office-based internists with principal problem of sore throat by age: United States, January-December, 1975

mellitus (79 percent) and fatigue (52 percent). Over one-third of visits prompted by chest pains, lower extremity problems, abdominal pain, dizziness, and shortness of breath also required a laboratory procedure in the internist's judgment.

### Seriousness of Patient's Principal Problem

Data on the seriousness of a patient's principal problem express the physician's clinical judgment as to the extent of impairment that might result if no care were available. Using this criterion the physician assigned the principal

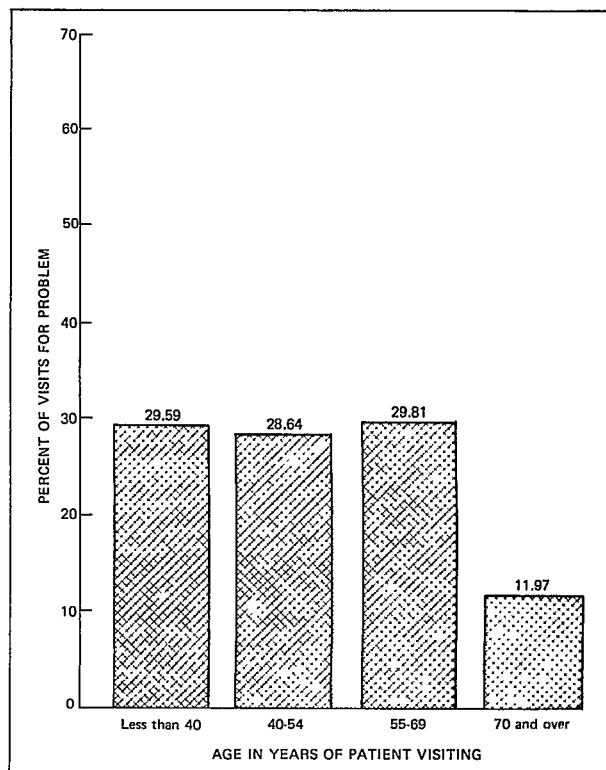


Figure 8. Percents of visits to office-based internists with principal problem of headache by age: United States, January-December, 1975

problem to one of four degrees of seriousness: "very serious," "serious," "slightly serious," or "not serious." Since this was the physician's subjective evaluation, many variables may have been brought to bear on the decision, and the data should be viewed in this context.

According to table 6 shortness of breath (66 percent) was most often classified as "serious" or "very serious." Other symptoms presented in this table seemed to vary in degree of seriousness assigned, but differences were not statistically significant. Degree of seriousness according to age groups is addressed in Section III, Condition and Management of Patients.

## SECTION II. PRINCIPAL DIAGNOSIS

### Most Frequent Diagnoses

The 24 conditions most commonly diagnosed during visits to internists are listed in table 7. As with table 4, the rank order may be artificial due to sampling variability.

These conditions describe the diagnosis assigned by the physician to the patient's principal problem (table 4). In the event of multiple diagnoses, physicians were instructed to list them in order of importance. The data presented here deal only with the first listed or "principal" diagnosis.

Although other significant diagnoses indicated on the survey form are not used in this analysis, patterns of concomitant diagnoses are discussed in other publications on selected diagnostic categories.<sup>b</sup>

Diagnostic groupings and code number inclusions used in the NAMCS and in this text are based on the International Classification of Diseases (ICDA).<sup>7</sup>

The diagnoses listed in table 7 accounted for 54 percent of all patient visits to the internist. Prominent among these are essential benign hypertension (9 percent), chronic ischemic heart disease (8 percent), and diabetes mellitus (5 percent). Together, these three conditions were diagnosed in over 22 percent of all internist visits. Table 8 shows that these diseases also had very high return visit rates. Thus, it is expected that they constituted a high proportion of total visits since total visits included initial and return visits. However, return visits are significant in developing a profile of the internist's practice since these conditions consume much of the physician's time and energy. Heart disease, represented in table 7 by chronic ischemic heart disease, symptomatic heart disease, and angina pectoris, accounted for almost 11 percent of all visits; 6 percent of visits were diagnosed as a form of arthritis or rheumatism. Of interest is

the fact that the diagnostic category "neuroses" is among the first third of *principal* diagnoses treated in visits to internists.

### Principal Diagnosis and Mean Duration of Visit

The average number of minutes spent by the patient in face-to-face encounter with the internist for visits encompassing highly frequent diagnoses is shown in table 7. The average time for all visits to internists was 18.2 minutes, which exceeded the average of 15 minutes for all specialties.<sup>2</sup> Due to statistical variability there are few significant differences in time among diagnoses. Visits for medical and special examinations, osteoarthritis and allied conditions, obesity, observation, and ill-defined conditions, on the average, consumed the most time, possibly due to more intensive workup and need for counseling. The many routine or return visits associated with essential benign hypertension, chronic ischemic heart disease, and diabetes mellitus were probably made by patients whose medical history was known to the physician. This may have contributed to the close to average time involved in treating patients with these diagnoses. Lower than average durations were a result of visits for acute upper respiratory infection, hay fever, other eczema and dermatitis, and bronchitis. Comparison of the mean duration of internist visits with that of other specialists is shown in Section IV of this report.

### Principal Diagnosis and Sex and Age of Patient

Information regarding the relationship of a patient's sex to diagnosis is given in table 8. In some major ICDA groups, notably mental disorders, diseases of the genitourinary system, and diseases of the musculoskeletal system, female visits were proportionately greater than visits by males. Except for chronic ischemic heart disease; bronchitis, emphysema, and asthma; and medical or special examinations, the number of female visits exceeded male visits to internists in all specific three digit ICDA categories shown in table 8.

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<sup>b</sup> For example, see Advance Data Report No. 28, "Office Visits for Hypertension: National Ambulatory Medical Care Survey, 1975-1976."

Figures 9 through 12 provide graphic evidence of the allocation of visits diagnosed as essential benign hypertension, ischemic heart disease, diabetes mellitus, and acute upper respiratory infection across age groups. Like figures 1 through 8 which illustrate symptoms, figures 9 through 12 plot the proportions of diagnosis-related visits by age group. The decline in proportions of upper respiratory infection diagnosed during visits, from 54 percent of all visits for this diagnosis made by patients under 40 years to 9 percent in the 70 years and over group, is immediately apparent. In the opposite direction, figures 9 and 11 illustrate that proportions of visits for essential benign hypertension and diabetes mellitus rose with advancing age up to 69 years. While there appears to be a trend of increasing visits with age for chronic ischemic heart disease, it is not statistically significant, possibly due to the lack of reliability in the number of visits by the under 40 age group.

### Principal Diagnosis: Status of the Problem

In NAMCS the sampled visit is classified by the physician according to whether or not he had seen the patient before and if he had seen the patient before, whether it was for the problem of concern at the current visit. This information yields a measure of problem status independent of the status of the patient. New problem visits were calculated by adding new patient, or initial visits, and visits by returning patients with new problems. Recurring problems were estimated from visits made by returning patients with "old" problems.

Applying the problem status concept, table 8 reveals that 66 percent of visits to internists for all diagnoses were return visits for recurring problems with higher than average proportions of old problem visits when the specific diagnosis was diabetes mellitus; essential benign hypertension; chronic ischemic heart disease; bron-

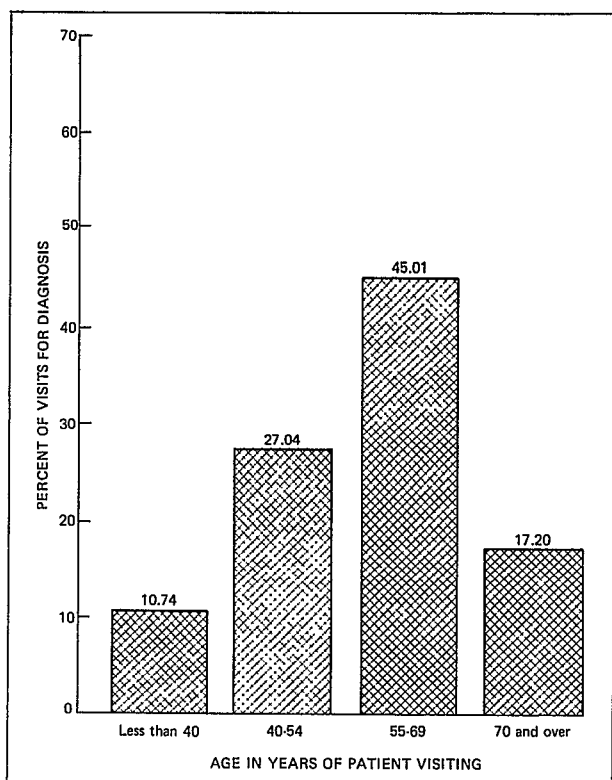


Figure 9. Percents of visits to office-based internists with principal diagnosis of hypertension (ICDA 401) by age: United States, January-December, 1975

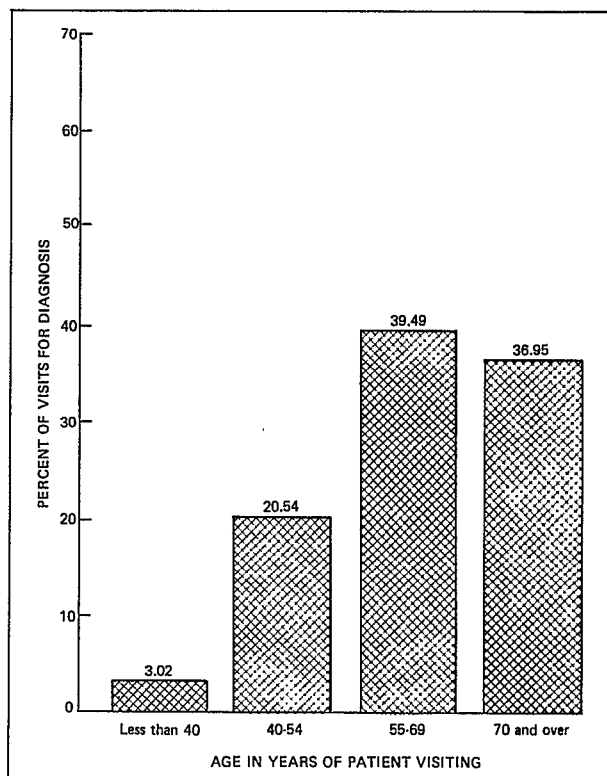


Figure 10. Percents of visits to office-based internists with principal diagnosis of ischemic heart disease (ICDA 410-413) by age: United States, January-December, 1975



chitis, emphysema, and asthma; or arthritis and rheumatism. Only in the two major ICDA categories of infective and parasitic diseases and of accidents, poisonings, and violence did new problem visits substantially exceed return visits for the same problem.

### Principal Diagnosis and Therapeutic Services

Table 9 provides information about the kinds of therapeutic services ordered or provided by internists relative to selected ICDA categories of diagnoses. Like table 5, which links principal problems and diagnostic services, these estimates

do not offer guidance on the multiple nature of each category of services. They show only a profile of the type of therapeutic services associated with visits. For all diagnoses, 50 percent of visits included prescription or nonprescription drugs, 14 percent involved injection or immunization, and in almost 21 percent patients received medical counseling or a form of psychotherapy or therapeutic listening. Drug therapy was most often applied when the diagnosis involved diseases of the upper respiratory system (66 percent). Medical counseling or therapeutic listening was employed in 43 percent of visits for mental disorders.

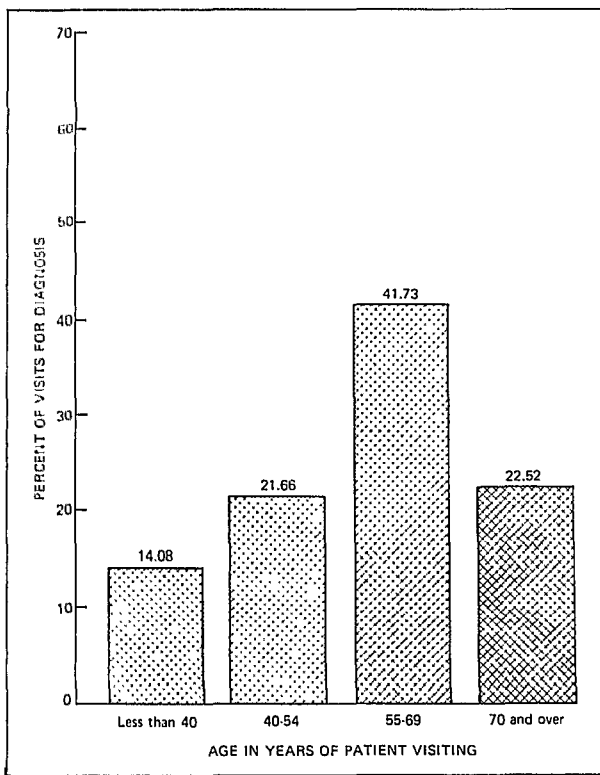


Figure 11. Percents of visits to office-based internists with principal diagnosis of diabetes mellitus (ICDA 250) by age: United States, January-December, 1975

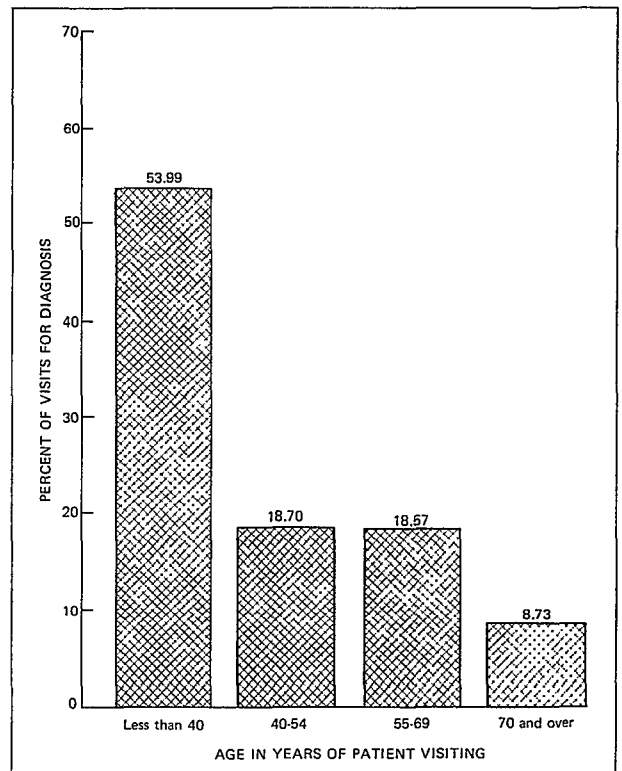


Figure 12. Percents of visits to office-based internists with principal diagnosis of acute upper respiratory infection except influenza (ICDA 460-466) by age: United States, January-December, 1975

## SECTION III. CONDITION AND MANAGEMENT OF PATIENTS

A rough profile of patient condition and management in the internist's office can be established by examining data on variables included in NAMCS, such as visit status, services, etc., in terms of the age and sex of the patient visiting.

### Prior Visit Status

The percent of visits labeled "prior visit status" in table 10 yields measures of patient status or problem status. In this section, *patient* status is the primary concern. Thus, table 10 shows that 87 percent of all patient visits to the internist were made by returning patients (the sum of columns 2 and 3) with about 3 of 4 return visits involving a problem the patient had presented in a prior visit. While only 13 percent of all visits (column 1) were made by new patients, visits by patients under 25 years reflected a higher proportion of initial visits than other age groups with proportions of new patient visits declining with increasing age. A similar pattern is evident for visits by returning patients with new problems. Conversely, proportions of visits by returning patients with problems the physician had previously treated increased with age. However, in terms of whether the patient was making a first visit or a return visit, regardless of problem status, table 10 shows that the highest proportions of visits are in the return visit category for all age groups. These patterns apply to both sexes and underscore the continuity of patient care in the internist's practice.

### Seriousness

Qualification of the problem by its degree of seriousness was presented earlier. Table 10 focuses on seriousness in terms of age and sex characteristics of visitors. Of all visits, 38 percent were considered "not serious" by internists. Proportions judged "not serious" declined with advancing age for both sexes as the proportions judged "serious" or "very serious" advanced. This is not surprising in view of the high percentage of visits made by older patients with cardiovascular diseases.

### Time Spent With the Physician

According to the data described in table 10, most patient visits fell in the duration interval of 11 to 30 minutes. This time span hovers around the mean duration of 18.2 minutes given in table 7 for all diagnoses. Again, as in data for "prior visit status" and "seriousness," the variable is age-dependent. A greater proportion of visits by younger age groups required less time. For example, 44 percent of visits by patients under 25 years took 10 minutes or less, while only 24 percent of visits by patients 65 years and over were in that time interval. On the other hand, 31 percent of visits by age group 65 years and over lasted from 16 to 30 minutes, with only 19 percent of visits by patients under 25 in that category. Table 10 shows that visits exceeding 30 minutes were rare for all ages and both sexes.

Table 10 reveals a fuller utilization pattern by patients of both sexes, over 45 years of age, who presented a high proportion of serious problems and who spent more time in face-to-face contact with the physician than did younger patients.

### Diagnostic and Therapeutic Services

Diagnostic services in connection with the chief complaint and therapeutic services associated with principal diagnosis were discussed previously. In this section and in table 11 information about treatments and services are related to characteristics of the patients.

The proportion of visits which included blood pressure checks increased with age. Almost 70 percent of visits by patients 65 years and over included measurement of arterial pressure while about 40 percent of visits by patients under 25 years included this procedure. Blood pressure was measured more frequently as patients aged, correlating with NAMCS data regarding increasing hypertension visit rates for aging patients.<sup>8</sup> Electrocardiograms were used most often when the visiting patient was a male between 25 to 64 years. This was also consistent with NAMCS data which indicated a higher pro-

portion of male visits for heart disease.<sup>c</sup> There was a decline in the proportion of general examinations performed during visits by the oldest group. The increasing proportions of laboratory procedures used as the visiting patient's age increased highly correlates with the increasing number of laboratory tests performed during diabetes mellitus visits (table 5) and the high visit incidence of diabetes mellitus among older patients seen by internists (figure 11).

The use of medical counseling, a service provided in almost 18 percent of all visits, did not appear to be influenced by the patient's age or sex.

### Disposition of Visit

Table 12 indicates that more than two-thirds of the visits to internists' offices resulted in the direction to return at a specified time. This highly correlates with the finding that two of three visits were made by returning patients with recurring problems. Another 17 percent were instructed to return if needed. Only in about 9 percent of visits was no followup planned. Of the approximately 13 percent of visits reported as having other types of disposition, a small number (slightly less than 2 percent) were admitted to the hospital. Followup was most often recommended as patient age increased. Together with the finding shown previously that serious problems were often related to longer visits, these estimates offer additional evidence of continuity of care.

### Seriousness, Duration of Visit, and Services According to Prior Visit Status

Table 13 offers data about the condition (seriousness of the patient's principal problem) and management (duration of visit and diagnostic and/or therapeutic services) of the patient in terms of the status of the visit. When patients made initial visits, almost 82 percent were judged "not serious" or "slightly serious" by the internist. Similarly, in visits by returning pa-

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<sup>c</sup>A NAMCS report concerning diseases of the circulatory system is in preparation.

tients presenting new problems, about 86 percent were evaluated as "not serious" or "slightly serious." However, returning patients visiting because of a recurring problem were judged "not serious" or "slightly serious" in about 65 percent of that group's visits, and "serious" or "very serious" during 35 percent of return visits.

According to these data, new patients or new problems were more likely to be judged "not serious" or "slightly serious" than "serious or very serious," but more recurring problem visits involved a higher degree of seriousness. The latter can be expected since many of the chronic diseases are more often judged "serious" and they also claim a higher proportion of return visits than of initial visits.

About half of all *new* patient visits took 15 minutes or less, while more than two-thirds of visits by *returning* patients with both new and recurring problems consumed 15 minutes or less. Return visits may have consumed less time than did initial visits because medical data were already in the patient's record. A higher percentage of new patient visits (21 percent) lasted from 31 to 60 minutes than did visits by returning patients for either new problems or old problems (both about 6 percent). This was probably due to a greater need for data gathering during the initial visit.

New patient visits had a higher proportion of general examinations (46 percent of all visits by this group) than did returning patients (20 percent for new problems and 15 percent for recurring or old problems), a possible explanation for the longer visit duration of the new patient as compared to the returning patient visit. However, 64 percent of return visits in both new and old problem categories included a limited history and examination. This procedure was also used during 41 percent of new patient visits. EKG's were taken more often during new patient visits (23 percent) than in return visits. This was probably due to their inclusion in general examinations and the frequent need for the EKG in acute cases which, according to table 14, accounted for 57 percent of new patient visits. Similarly, X-rays were ordered or provided in a higher proportion of new patient visits (27 percent) than in return visits (17 percent) for new problems and 9 percent for recurring problems.

## Type of Condition Treated and Disposition of Visit

Table 14 designates the propositions of acute and chronic conditions seen by the internist and the disposition of the visit in terms of the prior visit status. When the physician had seen a patient during a *prior* visit, the patient's *new* problem was likely to be an acute condition—an indication that patients tended to return frequently to their regular physicians for treatment of acute, self-limiting conditions or at an early stage of illness. Since *new patients* were *less* likely to have acute conditions (about 57 percent) than patients the physician had seen before (76 percent of new problem visits), these data may also suggest that patients having a regular physician seek medical attention at an earlier stage of illness than those without regular medical care.

In terms of patient status, visits by returning patients with *recurring* problems were more likely to include the instructions to return at a

specified time (80 percent) than were new problem visits, either by new or returning patients. New problem visits were more likely to have no followup planned than were recurring problem visits.

Visits for chronic conditions (57 percent of all visits) exceeded visits for acute conditions (39 percent) as shown in table 15. However, this general finding was not consistent among all age groups. Higher proportions of acute conditions were found in visits by both females and males under 25 years of age than for other age groups. Conversely, there was a higher than average incidence of chronic conditions represented by visiting patients who were 45 years and over. It was previously demonstrated that visits for certain chronic diseases (e.g., hypertension, chronic ischemic heart disease) were more closely related to older age group visits while acute diseases, such as upper respiratory infection, were more likely to be presented by younger patients. The data in table 15 confirm these findings.

## SECTION IV. COMPARISONS OF VISITS TO INTERNISTS AND TO OTHER LEADING SPECIALISTS

Estimates of visits to specialists in internal medicine, general and family practice, obstetrics and gynecology, pediatrics, general surgery, and cardiovascular diseases by age of patient, problem status, seriousness of the patient's problem, and duration of visit are included in table 16. Table 17 provides comparisons of types of conditions treated, selected diagnostic and/or therapeutic services, and disposition of visit for the same specialties. Contrasts of visits to internists and general and family practitioners (GFP) according to ICDA categories and principal diagnoses are made in tables 18 and 19 respectively.

Tables 16 and 17 provide comparative data for the five most visited specialties according to the 1975 NAMCS (table A), plus the specialty in cardiovascular diseases. While the latter specialty was not among the most frequently visited, diseases of the circulatory system were a major portion of internists' visits, and a comparison

would not be complete without including the specialty in cardiovascular diseases.

### Patient Age and Visit Status

Two of three visits to the internist were made by patients 45 years and older. Except for the specialty in cardiovascular diseases, where 86 percent of visits were made by patients 45 years and over, this was a higher proportion than any other leading specialty. Differences in visit age between internists' visits and those of specialists in obstetrics and gynecology or pediatrics may be expected. However, certain assumptions regarding the similarity of general and family practitioners and internists as primary care providers suggest that visit data for these two specialties should be viewed in a parallel manner. Figure 13 presents cumulative frequency polygons derived from visit age percent distributions

of general and family practice and of internal medicine. This figure visually represents the percent of visits falling above or below different age values. According to figure 13, the median visit age (or point on the age scale which includes 50 percent of visits) was approximately 50.4 years for internists and about 40.1 years for GFP's. In connection with these findings, it should be noted that the median age of the resident population of the United States in 1975 was 28.8 years.<sup>9</sup>

A return visit index by age group was developed for the two primary care specialties of internal medicine and general and family practice. These return visit indexes displayed in table D are the ratios of total return visits (including both new and recurring problems) to total initial visits for each age group. For all ages there were 6.65 return visits for each initial visit to internists' offices, and a ratio of 6.86 to 1 for visits to GFP's offices. For both specialties, return visit ratios increased steadily from age 25

Table D. Return visit index by specialty visited and age of patient: United States, January-December 1975

Age of patient	Specialty	
	Internal medicine	General and family practice
All ages.....	6.65	6.86
Under 15 years.....	2.49	4.77
15-19 years.....	2.42	4.41
20-24 years.....	2.07	3.88
25-29 years.....	2.93	4.55
30-34 years.....	3.57	5.57
35-39 years.....	5.36	6.37
40-44 years.....	6.07	6.59
45-49 years.....	7.01	9.41
50-54 years.....	9.09	9.78
55-59 years.....	9.57	11.30
60-64 years.....	13.51	10.48
65-69 years.....	12.37	13.49
70-74 years.....	15.18	17.15
75-79 years.....	30.25	36.04
80 years and over.....	19.62	17.32

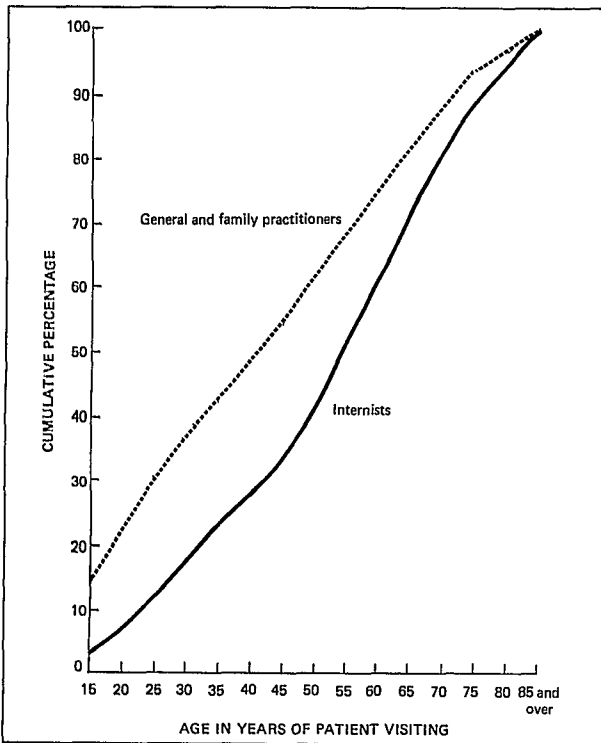


Figure 13. Cumulative frequency polygons: age of patients visiting office-based general and family practitioners and internists: United States, January-December, 1975

years to age 80 years, with an expected drop at age 80.

**Problem Status**

To obtain a measure of problem status, as opposed to patient status, initial visits and return visits for a new problem were combined to form the "new problem" category. It was assumed that initial visits, or new patient visits, always involved a new problem. On the other hand, it may have been a lingering problem for the patient. This difference should be considered when using the data.

According to the data in table 16, about one-third of the internists' visits concerned new problems and two-thirds involved treatment of recurring or continuing problems. Ratios of new to recurring problems were similar for the specialties of obstetrics and gynecology and general surgery; higher proportions of new problem visits appeared for general and family practice and pediatrics. Specialists in cardiovascular diseases, however, treated a higher ratio of recurring to new problem visits than did internists or any other specialty listed in table 16.

## Seriousness of the Patient's Problem and Duration of Visit

Except for specialists in cardiovascular diseases, internists treated the highest proportion of serious or very serious problems (29 percent) of the specialties shown in table 16. That visits to the internist were longer than visits to the other four leading specialists is attested to by the finding that over 60 percent of all internist visits fell in the intervals of 11 to 15 minutes (about 36 percent) and 16 to 30 minutes (almost 25 percent). Percents of visits in these time intervals were smaller for the other specialists. Average duration of visit shown in table E indicates that the typical visit to internists' offices was longer (18.2 minutes) than the average visit to the other four leading specialties, and similar

to the average duration of visits to cardiovascular specialists when the statistical error is taken into account.

## Type of Condition Treated, Diagnostic and Therapeutic Services, and Referral Pattern

Specialists in internal medicine and cardiovascular diseases treated more chronic problems than did other leading specialists, thus showing similarity of practice with respect to the variables of age of patient visiting, duration of visit, seriousness of the patient's problem, and type of condition.

Compared to the other specialists in table 17, internists used the limited history and examination most often (61 percent of visits) and provided medical counseling more frequently (18 percent of visits). Blood pressure checks performed by internists during 61 percent of visits was exceeded only by the number provided by cardiovascular specialists (73 percent). Similarity between the internist's practice and that of the specialist in cardiovascular diseases did not persist for the number of EKG's employed. The internist used EKG's during 14 percent of visits while the cardiovascular specialist utilized this procedure in 42 percent of visits, an expected difference in view of the greater concentration of circulatory diseases in the latter practice.

As explained previously, the NAMCS Patient Record is not structured to collect information on the number of diagnostic and therapeutic services rendered within each category; it provides estimates of only the number of *types* of services. Table F compares the number of service

Table E. Mean patient contact duration in minutes and standard error of mean contact duration by selected specialties: United States, January-December 1975

Specialty	Mean patient contact duration	Standard error of mean contact duration
All specialties.....	15.0	0.31
<i>Internal medicine</i> .....	18.2	0.38
General and family practice.....	12.6	0.50
Obstetrics and gynecology.....	13.1	0.48
Pediatrics.....	12.1	0.32
General surgery.....	12.7	0.45
Cardiovascular diseases.....	21.5	2.00

Table F. Percent distributions of visits by number of types of diagnostic and therapeutic services ordered or provided, according to medical specialty of physician: United States, January-December 1975

Specialty	Total	Number of types of diagnostic and therapeutic services ordered or provided			
		None	One	Two	Three or more
		Percent distribution			
<i>Internal medicine</i> .....	100.0	1.3	14.2	22.9	61.6
General and family practice.....	100.0	1.7	22.7	29.9	45.6
Pediatrics.....	100.0	2.9	27.9	40.0	29.3
General surgery.....	100.0	7.6	40.2	26.0	26.3
Obstetrics and gynecology.....	100.0	3.1	18.7	25.6	52.7
Cardiovascular diseases.....	100.0	1.1	9.8	31.9	57.2

types provided by each specialty. Leading all other specialties listed except that of cardiovascular diseases, specialists in internal medicine provided 3 or more types of service in 62 percent of visits. On the average, internists and cardiovascular specialists provided 3 diagnostic or therapeutic services per visit, a higher average than the other specialists shown in table G. According to table H, internists provided 61 blood pressure checks for each 100 visits made to office-based internists during 1975. Except for visits to cardiovascular specialists, this exceeded the number provided during visits to other leading specialists.

The percent of new patient visits referred by other physicians, and the percent of all patient visits referred to other physicians are listed by selected specialty in table J. Internists referred more patient visits to other physicians than did other primary care specialists. Of the *primary* care specialties, internists' visits accounted for the highest proportion (20 percent) of new patient visits referred by other physicians.

Table G. Average number of diagnostic or therapeutic services ordered or provided per visit by selected medical specialties: United States, January-December 1975

Specialty	Average number of types of services ordered or provided per visit
<i>Internal medicine</i> .....	3.0
General and family practice.....	2.5
Obstetrics and gynecology.....	2.5
Pediatrics.....	2.1
General surgery.....	1.9
Cardiovascular diseases.....	3.0

Table H. Annual rate of blood pressure checks performed per 100 visits by selected medical specialties: United States, January-December 1975

Specialty	Annual rate per 100 visits
<i>Internal medicine</i> .....	61.0
General and family practice.....	40.0
Obstetrics and gynecology.....	57.0
Pediatrics.....	8.0
General surgery.....	23.0
Cardiovascular diseases.....	72.0

Table J. Percent of new patient visits referred by other physicians and percent of all patient visits referred to other physicians by selected specialties: United States, January-December 1975

Specialty	Percent of new patient visits referred by other physicians	Percent of all patient visits referred to other physicians
<i>Internal medicine</i> .....	19.7	4.4
General and family practice..	7.6	3.0
Obstetrics and gynecology....	11.3	1.6
Pediatrics.....	7.5	2.9
General surgery.....	27.5	2.9
Cardiovascular diseases.....	64.4	3.1

### Principal Diagnosis: Internists and General and Family Practitioners

Percents of visits to internists and to general and family practitioners according to ICDA categories are given in table 18. Diseases of the circulatory system accounted for almost one-quarter of internists' visits and close to 12 percent were diagnosed in the diseases of the respiratory system group. Almost the reverse was true for general and family practitioners. About 12 percent were diagnosed in the diseases of the circulatory system group and a larger proportion (19 percent) in the respiratory diseases category. According to NAMCS estimates, internists had a larger proportion of patient visits needing care for endocrine, nutritional, and metabolic diseases, as well as diseases of the digestive and musculoskeletal systems, than did general and family practitioners. A larger share of visits requiring treatment for diseases of the skin and subcutaneous tissue encountered by general and family practitioners. Percents of visits involving accidents, poisonings, and violence were also higher for general and family practitioners than for internists.

Table 19 shows the differences in the most frequent principal diagnoses rendered during visits to internists and general and family practitioners. Diarrheal disease, otitis media, pharyngitis, acute tonsillitis, bronchitis, influenza, chronic sinusitis, cystitis, menopausal symptoms, sprains and strains of sacroiliac region, prenatal care, and inoculations and vaccinations

each constituted less than 1 percent of internists' visits. However, they accounted for higher proportions of visits to general and family practitioners. On the other hand, GFP visits included less than 1 percent each of visits for symptomatic heart disease, emphysema, and rheumatoid arthritis or allied conditions, which are prominent on the internists' list. Proportions of internists' visits involving diabetes mellitus,

essential benign hypertension, and chronic ischemic heart disease were higher than proportions of visits to GFP's for the same reasons. The observations regarding age-related conditions treated by the internist, coupled with the difference in visit age distributions between internists and general and family practitioners, are reflected by this contrast of practice profiles.





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Table 1. Number of visits to office-based internists and percent distribution and annual rate per 100 population by geographic region, metropolitan and nonmetropolitan areas, and type of practice, according to age and sex of the patient: United States, January-December 1975

	Age and sex	Number of visits in thousands	Total	Geographic region	
				Northeast	North Central
1	All visits-----	62,117	100.0	29.7	25.1
	<u>ALL AGES</u>				
2	Under 15 years-----	2,047	100.0	34.9	37.9
3	15-24 years-----	5,474	100.0	29.2	28.1
4	25-44 years-----	13,106	100.0	27.1	26.3
5	45-64 years-----	23,565	100.0	30.4	24.9
6	65 years and over-----	17,925	100.0	30.2	22.0
	<u>SEX</u>				
	<u>Female</u>				
7	Under 15 years-----	993	100.0	*25.0	47.0
8	15-24 years-----	3,291	100.0	27.8	29.7
9	25-44 years-----	7,440	100.0	26.4	27.6
10	45-64 years-----	13,572	100.0	30.7	23.5
11	65 years and over-----	11,683	100.0	30.3	22.3
	<u>Male</u>				
12	Under 15 years-----	1,054	100.0	44.2	*29.3
13	15-24 years-----	2,182	100.0	31.3	25.6
34	25-44 years-----	5,667	100.0	28.0	24.7
15	45-64 years-----	9,993	100.0	30.1	26.9
16	65 years and over-----	6,243	100.0	30.1	21.6
			Visits per 100 in population		
17	Annual rate-----	...	29.9	37.6	27.5

<sup>1</sup>Includes partnership and group practices.

Table 1. Number of visits to office-based internists and percent distribution and annual rate per 100 population by geographic region, metropolitan and nonmetropolitan areas, and type of practice, according to age and sex of the patient: United States, January-December 1975—Con.

Geographic region—Con.		Area		Type of practice		
South	West	Metropolitan	Nonmetropolitan	Solo	Other <sup>1</sup>	
Percent distribution—Con.						
25.6	19.6	84.6	15.4	54.3	45.7	1
21.8	*5.5	74.1	25.9	66.9	33.1	2
27.1	15.6	84.4	15.6	52.0	48.0	3
27.3	19.2	84.2	15.8	51.5	48.5	4
25.4	19.3	85.6	14.4	55.2	44.8	5
24.5	23.2	84.8	15.2	54.3	45.7	6
*20.2	*7.9	68.7	31.3	64.2	35.8	7
24.9	17.5	82.5	17.5	52.7	47.3	8
25.4	20.6	84.8	15.2	51.9	48.1	9
24.8	21.0	86.6	13.4	57.5	42.5	10
23.8	23.6	85.8	14.2	54.8	45.2	11
*23.3	*3.2	79.1	*20.9	69.5	30.5	12
30.4	*12.8	87.2	*12.8	51.0	49.0	13
29.9	17.4	83.4	16.6	50.9	49.1	14
26.2	16.9	84.3	15.7	52.0	48.0	15
26.0	22.4	82.9	17.1	53.5	46.5	16
Visits per 100 in population—Con.						
24.0	33.8	37.2	14.4	---	---	17

Table 2. Number and percent distribution of visits to office-based internists by type of practice, according to geographic region and type of area: United States, January-December 1975

Geographic region and type of area	Type of practice					
	Total	Solo	Other <sup>1</sup>	Total	Solo	Other <sup>1</sup>
	Number in thousands			Percent distribution		
All visits-----	62,117	33,706	28,411	100.0	54.3	45.7
<u>Geographic region</u>						
Northeast-----	18,452	12,604	5,848	100.0	68.3	31.7
North Central-----	15,585	8,465	7,120	100.0	54.3	45.7
South-----	15,898	7,952	7,946	100.0	50.0	50.0
West-----	12,182	4,685	7,496	100.0	38.5	61.5
<u>Area</u>						
Metropolitan-----	52,543	28,623	23,921	100.0	54.5	45.5
Nonmetropolitan-----	9,574	5,084	4,490	100.0	53.1	46.9

<sup>1</sup>Includes partnership and group practices.

Table 3. Number of visits to office-based internists and percent distribution and annual rate by age of patient, according to sex and color of the patient: United States, January-December 1975

Sex and color	Number of visits in thousands	All ages	Age				
			Under 15 years	15-24 years	25-44 years	45-64 years	65 years and over
Percent distribution							
All visits-----	62,117	100.0	3.3	8.8	21.1	37.9	28.9
<u>SEX</u>							
Female-----	36,978	100.0	2.7	8.9	20.1	36.7	31.6
Male-----	25,139	100.0	4.2	8.7	22.5	39.8	24.8
<u>COLOR</u>							
<u>White</u>							
Female-----	33,347	100.0	2.7	8.8	18.8	36.9	32.9
Male-----	23,091	100.0	4.1	8.9	21.7	39.8	25.5
<u>All other</u>							
Female-----	3,631	100.0	*3.0	*10.2	32.3	34.7	19.8
Male-----	2,049	100.0	*5.6	*6.7	31.7	39.0	*17.0
Visits per 100 in population							
All visits-----	62,117	29.9	3.9	14.0	25.1	55.5	82.1
<u>SEX</u>							
Female-----	36,978	34.7	3.9	17.7	27.3	61.3	90.6
Male-----	25,139	24.8	4.0	11.1	22.1	49.2	69.8
<u>COLOR</u>							
<u>White</u>							
Female-----	33,347	36.1	4.1	17.7	27.3	62.2	93.0
Male-----	23,091	26.2	4.2	12.2	22.2	50.3	72.8
<u>All other</u>							
Female-----	3,631	25.5	2.5	12.8	32.7	53.5	64.5
Male-----	2,049	15.8	3.2	4.9	21.7	39.2	40.9

Table 4. Number, percent distribution, and cumulative percent of visits to office-based internists by the 24 most frequent patient problems in rank order of number of visits: United States, January-December 1975

Rank	Patient's principal problem classified by NAMCS symptom classification <sup>1</sup>	Visits to office-based internists		
		Number in thousands	Percent distribution	Cumulative percent
	All problems-----	62,117	100.0	100.0
1	General and required physical examinations-----900,901	3,455	5.6	5.6
2	Pain in chest-----322	2,834	4.6	10.2
3	Problems of lower extremity-----400	2,724	4.4	14.6
4	Fatigue-----004	2,460	4.0	18.6
5	Abdominal pain-----540	2,292	3.7	22.3
6	High blood pressure-----205	1,823	2.9	25.2
7	Problems of back region-----415	1,756	2.8	28.0
8	Cough-----311	1,694	2.7	30.7
9	Problems of upper extremity-----405	1,500	2.4	33.1
10	Vertigo-dizziness-----069	1,427	2.3	35.4
11	Shortness of breath-----306	1,365	2.2	37.6
12	Headache-----056	1,262	2.0	39.6
13	Throat soreness-----520	1,137	1.8	41.4
14	Diabetes mellitus-----991	1,072	1.7	43.1
15	Cold-----312	960	1.6	44.7
16	Visits for medication-----910	884	1.4	46.1
17	Nervousness-----810	831	1.3	47.4
18	Problems of face, neck-----410	749	1.2	48.6
19	Allergic skin reactions-----112	716	1.2	49.8
20	Other symptoms referable to cardiovascular system-----220	672	1.1	50.9
21	Arthritis-rheumatism, including osteoarthritis-----427	669	1.1	52.0
22	Irregular pulsations and palpitations-----200	667	1.1	53.1
23	Other symptoms referable to the respiratory system, NEC--330	593	1.0	54.1
24	Weight gain-obesity-----010	591	1.0	55.1
25	All other problems <sup>2</sup> -----Residual	27,983	45.0	100.1

<sup>1</sup>Symptomatic groupings and code number inclusions are based on a symptom classification developed for use in NAMCS.

<sup>2</sup>Includes 10.1 million "progress" visits 980,985.



Table 5. Number of visits to office-based internists and percents of visits by selected diagnostic services ordered or provided, by selected frequent patient problems in rank order of number of visits: United States, January-December 1975

Rank	Principal problem classified by NAMCS symptom classification <sup>1</sup>	Number of visits in thousands	Limited history and examination	General history and examination	Laboratory procedure or test	Blood pressure check	Electrocardiogram	X-ray
	All problems-----	62,117	61.4	20.1	38.5	61.4	14.0	13.1
			Percent <sup>2</sup>					
1	Pain in chest-----322	2,834	64.6	22.3	34.0	73.0	47.3	20.4
2	Problems of lower extremity-----400	2,724	72.2	14.4	33.3	58.8	*7.1	15.1
3	Cough and cold-----311,312	2,654	74.8	15.0	18.6	53.0	*5.5	20.6
4	Fatigue-----004	2,460	59.0	26.7	52.3	69.3	18.8	15.9
5	Abdominal pain-----540	2,292	63.3	25.3	37.7	58.6	*10.5	22.7
6	High blood pressure-----205	1,823	69.1	*15.1	28.9	78.2	*14.4	*6.3
7	Problems of back region-----415	1,756	72.6	*12.8	27.1	54.7	*6.1	*13.9
8	Problems of upper extremity-----405	1,500	61.0	*18.5	*19.1	44.2	*9.4	23.6
9	Vertigo-dizziness-----069	1,427	68.1	*19.4	46.8	76.5	*15.0	*9.3
10	Shortness of breath-----306	1,365	72.8	*18.8	33.4	70.1	28.0	*17.5
11	Headache-----056	1,262	59.2	25.2	*25.2	64.0	*9.9	*12.5
12	Throat soreness-----520	1,137	75.9	*6.1	29.3	40.6	*3.5	*2.8
13	Diabetes mellitus-----991	1,072	54.4	*18.1	79.1	64.7	*11.3	*3.4

<sup>1</sup>Symptomatic groupings and code numbers are based on a symptom classification developed for use in NAMCS.

<sup>2</sup>Percents will not add to 100 because most patient visits required the provision of more than one service.

Table 6. Number of visits to office-based internists and percent distributions by seriousness of patient's principal problem, according to selected patient problems: January-December 1975

Rank	Selected frequent principal problem and NAMCS code <sup>1</sup>	Number of visits in thousands	Total	Degree of seriousness		
				Serious or very serious	Slightly serious	Not serious
	All problems -----	62,117	100.0	28.6	33.6	37.8
				Percent distribution		
1	Pain in chest-----322	2,834	100.0	49.9	28.3	21.9
2	Problems of lower extremity-----400	2,724	100.0	35.8	40.5	23.7
3	Cough and cold-----311,312	2,654	100.0	20.4	33.0	46.6
4	Fatigue-----004	2,460	100.0	35.9	32.6	31.5
5	Abdominal pain-----540	2,292	100.0	29.1	44.3	26.7
6	High blood pressure-----205	1,823	100.0	42.3	33.7	24.0
7	Problems of back region-----415	1,756	100.0	28.9	42.6	28.6
8	Problems of upper extremity-----405	1,500	100.0	*19.6	30.9	49.5
9	Vertigo-dizziness-----069	1,427	100.0	32.1	40.0	28.0
10	Shortness of breath-----306	1,365	100.0	66.2	24.3	*9.5
11	Headache-----056	1,262	100.0	*19.4	44.3	36.4
12	Throat soreness-----520	1,137	100.0	*4.9	39.5	55.6
13	Diabetes mellitus-----991	1,072	100.0	41.2	39.6	*19.2

<sup>1</sup>Symptomatic groupings and code number inclusions are based on a symptom classification developed for use in NAMCS.

Table 7. Number, percent distribution, cumulative percent, mean duration, and standard error of mean duration in minutes of visits to office-based internists by the 24 most common principal diagnoses classified by ICDA category code in rank order of number of visits: United States, January-December 1975

Rank	Principal diagnosis classified by ICDA 3-digit category <sup>1</sup>	Visits to office-based internists				
		Number in thousands	Percent distribution	Cumulative percent	Mean duration in minutes <sup>2</sup>	Standard error of mean duration in minutes
	All visits-----	62,117	100.0	100.0	18.2	0.38
1	Essential benign hypertension-----401	5,781	9.3	9.3	17.9	0.54
2	Chronic ischemic heart disease-----412	4,894	7.9	17.2	18.6	0.91
3	Diabetes mellitus-----250	2,777	4.5	21.7	18.9	1.10
4	Medical or special examination-----Y00	2,566	4.1	25.8	25.3	1.33
5	Acute upper respiratory infection, site unspecified-----465	1,588	2.6	28.4	14.3	0.93
6	Neuroses-----300	1,430	2.3	30.7	19.1	1.27
7	Osteoarthritis and allied conditions-----713	1,414	2.3	33.0	23.2	1.29
8	Symptomatic heart disease-----427	1,253	2.0	35.0	19.0	1.39
9	Medical and surgical aftercare-----Y10	1,101	1.8	36.8	16.7	1.09
10	Rheumatoid arthritis and allied conditions-----712	1,011	1.6	38.4	17.6	0.92
11	Obesity-----277	983	1.6	40.0	22.0	2.52
12	Observation without need for further medical care-----793	838	1.3	41.3	23.2	2.57
13	Emphysema-----492	837	1.3	42.6	20.4	0.80
14	Hay fever-----507	749	1.2	43.8	11.8	0.88
15	Other eczema and dermatitis-----692	746	1.2	45.0	12.8	1.22
16	Other nonarticular rheumatism-----717	727	1.2	46.2	16.2	2.42
17	Synovitis, bursitis-----731	662	1.1	47.3	18.3	2.00
18	Arthritis, unspecified-----715	628	1.0	48.3	19.1	2.79
19	Symptoms referable to the respiratory system-----783	614	1.0	49.3	20.0	1.13
20	Bronchitis, unqualified-----490	577	0.9	50.2	14.7	3.11
21	Myxedema-----244	574	0.9	51.1	20.7	2.48
22	Other ill-defined and unknown causes of morbidity and mortality-----796	527	0.8	51.9	23.0	2.28
23	Diarrheal disease-----009	509	0.8	52.7	17.9	1.77
24	Angina pectoris-----413	503	0.8	53.5	20.8	1.77
25	All other diagnoses <sup>3</sup> -----Residual	28,828	46.4	99.9	18.2	0.38

<sup>1</sup>Diagnostic groupings and code number inclusions are based on the Eighth Revision International Classification of Diseases, Adapted for Use in the United States.

<sup>2</sup>Actual time spent in face-to-face encounter with physician.

<sup>3</sup>Diagnoses coded to 280-289, 680-709, 630-678, or 740-759 and those given as "none" or "unknown."

Table 8. Number of visits to office-based internists and percent distribution by problem status, time actually spent with the physician, and sex of the patient, according to principal diagnosis classified by ICDA category code: United States, January-December 1975

Principal diagnosis classified by ICDA category <sup>1</sup>		Number of visits in thousands	All visits
1	All diagnoses-----	62,117	100.0
2	Infective and parasitic diseases-----000-136	1,737	100.0
3	Neoplasms-----140-239	2,310	100.0
4	Endocrine, nutritional, and metabolic diseases-----240-279	5,678	100.0
5	Diabetes mellitus-----250	2,777	100.0
6	Mental disorders-----290-315	2,250	100.0
7	Diseases of the nervous system and sense organs-----320-389	2,033	100.0
8	Diseases of the circulatory system-----390-458	15,436	100.0
9	Essential benign hypertension-----401	5,781	100.0
10	Chronic ischemic heart disease-----412	4,894	100.0
11	Diseases of the respiratory system-----460-519	7,295	100.0
12	Acute upper respiratory infections except influenza---460-466	3,047	100.0
13	Bronchitis, emphysema, and asthma-----490-493	2,044	100.0
14	Diseases of the digestive system-----520-577	3,422	100.0
15	Diseases of the genitourinary system-----580-629	2,327	100.0
16	Diseases of the skin and subcutaneous tissue-----680-709	1,597	100.0
17	Diseases of the musculoskeletal system-----710-738	5,332	100.0
18	Arthritis and rheumatism-----712-717	3,876	100.0
19	Symptoms and ill-defined conditions-----780-796	4,085	100.0
20	Accidents, poisonings, and violence-----800-999	2,674	100.0
21	Special conditions and examinations without sickness---Y00-Y13	4,317	100.0
22	Medical or special examinations-----Y00	2,566	100.0

<sup>1</sup>Diagnostic groupings and code number inclusions are based on the Eighth Revision International Classification of Diseases, Adapted for Use in the United States. Listing does not include 280-289, Diseases of the blood and blood-forming organs; 630-678, Complications of pregnancy and the puerperium; 740-759, Congenital anomalies; other diagnoses coded "none" and unknown; blank, noncodeable, and illegible diagnoses.

<sup>2</sup>Includes all new problems regardless of the status of the patient.

<sup>3</sup>Includes 420,000 visits during which a patient was provided care by someone other than the physician and the form entry was "zero" minutes.

Table 8. Number of visits to office-based internists and percent distribution by problem status, time actually spent with the physician, and sex of the patient, according to principal diagnosis classified by ICDA category code: United States, January-December 1975—Con.

Problem status		Time actually spent with physician			Sex of patient		
New problem <sup>2</sup>	Return visit for continuing problem	10 minutes or less <sup>3</sup>	11-15 minutes	16 minutes and over	Female	Male	
Percent distribution							
34.0	66.0	31.1	35.6	33.3	59.5	40.5	1
64.9	35.1	41.6	39.0	*19.4	49.3	50.8	2
*15.2	84.8	40.3	31.4	28.3	56.3	43.7	3
17.1	82.9	24.0	43.5	32.5	64.1	35.9	4
*12.3	87.8	23.0	46.6	30.4	59.2	40.8	5
34.0	66.0	27.7	36.4	35.9	73.5	26.6	6
51.1	48.9	32.5	35.2	32.3	56.0	44.0	7
13.1	86.9	28.3	37.7	34.0	54.4	45.6	8
8.7	91.3	32.5	38.9	28.6	62.8	37.2	9
11.3	88.7	24.3	38.5	37.2	43.3	56.7	10
49.7	50.3	40.6	35.8	23.6	54.3	45.7	11
68.2	31.8	46.4	34.1	19.6	62.9	37.1	12
27.9	72.1	26.3	38.2	35.4	47.4	52.6	13
39.0	61.0	26.1	36.3	37.6	62.0	38.0	14
48.3	51.7	32.5	35.5	32.0	80.4	19.6	15
54.8	45.2	46.7	31.8	*21.6	56.8	43.2	16
29.9	70.2	21.7	37.7	40.5	70.2	29.9	17
23.9	76.1	20.5	38.5	41.0	72.6	27.4	18
54.1	45.9	27.6	28.6	43.8	61.6	38.4	19
61.1	38.9	38.0	39.1	22.9	58.5	41.5	20
45.7	54.3	31.9	23.7	44.4	50.9	49.2	21
60.5	39.5	21.6	21.3	57.2	46.6	53.5	22

Table 9. Number of visits to office-based internists and percents by selected therapeutic services ordered or provided, by principal diagnoses classified by ICDA code: United States, January-December 1975

Principal diagnosis classified by ICDA category <sup>1</sup>	Selected therapeutic services ordered or provided			
	Number of visits in thousands	Drug therapy <sup>2</sup>	Injection or immunization	Medical counseling and psychotherapy or therapeutic listening
All diagnoses-----	62,117	49.5	14.2	20.5
Infective and parasitic diseases-----000-136	1,737	58.1	19.1	*11.8
Neoplasms-----140-239	2,310	39.2	32.0	16.3
Endocrine, nutritional, and metabolic diseases-----240-279	5,678	39.6	8.7	30.2
Diabetes mellitus-----250	2,777	33.2	*8.2	27.0
Mental disorders-----290-315	2,250	51.5	*13.3	42.7
Diseases of the nervous system and sense organs-----320-389	2,033	63.5	*17.2	21.3
Diseases of the circulatory system-----390-458	15,436	54.5	7.2	20.4
Essential benign hypertension-----401	5,781	56.3	*5.6	20.9
Chronic ischemic heart disease-----412	4,894	52.1	*8.0	22.7
Diseases of the respiratory system-----460-519	7,295	65.8	22.3	14.2
Acute upper respiratory infection, except influenza-----460-466	3,047	78.5	20.4	*10.5
Bronchitis, emphysema, and asthma-----490-493	2,044	58.0	17.7	*18.2
Diseases of the digestive system-----520-577	3,422	52.1	*10.0	27.6
Diseases of the genitourinary system-----580-629	2,327	51.2	*13.4	17.7
Diseases of the skin and subcutaneous tissue-----680-709	1,597	54.5	*21.2	15.4
Diseases of the musculoskeletal system-----710-738	5,332	55.2	21.5	18.9
Arthritis and rheumatism-----712-717	3,876	55.5	20.1	17.9
Symptoms and ill-defined conditions-----780-796	4,085	37.4	*7.0	18.4
Accidents, poisonings, and violence-----800-899	2,674	45.4	*12.3	20.1
Special conditions and examinations without sickness-----Y00-Y13	4,317	20.7	15.0	18.7

<sup>1</sup>Diagnostic groupings and code number inclusions are based on the Eighth Revision International Classification of Diseases, Adapted for Use in the United States. Listing does not include 280-289, Diseases of the blood and blood-forming organs; 630-678, Complications of pregnancy and the puerperium; 740-759, Congenital anomalies; other diagnoses coded "none" and unknown; blank, noncodeable, and illegible diagnoses.

<sup>2</sup>Prescription and nonprescription drugs.

<sup>3</sup>Percents will not add to 100 since most patient visits required the provision of more than one service.

Table 10. Number of visits to office-based internists and percent distributions by prior visit status, seriousness of patient's principal problem, and time actually spent with physician, according to age and sex of the patient: United States, January-December 1975

	Age and sex of patient	Number of visits in thousands	Total	Prior visit status		
				New patient	Patient seen before	
					New problem	Old problem
1	All patients-----	62,117	100.0	13.1	20.9	66.0
	<u>Both sexes</u>					
2	Under 25 years-----	7,521	100.0	30.3	34.4	35.3
3	25-44 years-----	13,106	100.0	19.4	23.7	56.8
4	45-64 years-----	23,565	100.0	9.6	19.0	71.5
5	65 years and over-----	17,925	100.0	5.8	15.8	78.4
	<u>Female</u>					
6	Under 25 years-----	4,284	100.0	30.7	32.0	37.4
7	25-44 years-----	7,440	100.0	17.2	23.1	59.7
8	45-64 years-----	13,572	100.0	9.5	20.7	69.8
9	65 years and over-----	11,683	100.0	5.4	16.6	77.9
	<u>Male</u>					
10	Under 25 years-----	3,237	100.0	29.9	37.5	32.6
11	25-44 years-----	5,667	100.0	22.4	24.6	53.0
12	45-64 years-----	9,993	100.0	9.6	16.7	73.7
13	65 years and over-----	6,243	100.0	*6.5	14.1	79.4

<sup>1</sup>Includes 420,000 visits during which the patient was under the care of someone other than the physician and the form entry was "zero" minutes.

Table 10. Number of visits to office-based internists and percent distributions by prior visit status, seriousness of patient's principal problem, and time actually spent with physician, according to age and sex of the patient: United States, January-December 1975—Con.

Seriousness of patient's principal problem			Time actually spent with physician				
Serious or very serious	Slightly serious	Not serious	10 minutes or less <sup>1</sup>	11-15 minutes	16-30 minutes	31 minutes or more	
Percent distribution—Con.							
28.6	33.6	37.8	31.1	35.6	24.6	8.7	1
11.6	27.9	60.5	43.6	31.5	18.6	6.4	2
20.6	33.0	46.5	36.1	34.8	20.2	9.0	3
32.5	33.6	34.0	29.8	35.7	24.2	10.3	4
36.5	36.5	27.0	23.9	37.7	31.0	7.4	5
9.8	31.7	58.6	42.0	33.1	17.3	*7.6	6
20.8	31.8	47.4	37.5	36.4	18.4	7.8	7
29.4	35.2	35.5	30.0	36.5	23.3	10.2	8
33.7	37.8	28.5	23.6	37.7	31.3	7.5	9
14.0	23.0	63.0	45.7	29.4	20.3	*4.7	10
20.2	34.5	45.3	34.2	32.6	22.5	10.7	11
36.6	31.5	31.9	29.5	34.7	25.5	10.4	12
41.7	34.1	24.2	24.5	37.9	30.5	7.2	13



Table 11. Number of visits to office-based internists and percents by selected diagnostic and therapeutic services, by age and sex of the patient: United States, January-December 1975

Age and sex of patient		Diagnostic and therapeutic services		
		Number of visits in thousands	Limited history and examination	General history and examination
1	All patients-----	62,117	61.4	20.1
	<u>Both sexes</u>		Percent <sup>2</sup>	
2	Under 25 years-----	7,521	55.7	22.9
3	25-44 years-----	13,106	59.8	20.2
4	45-64 years-----	23,565	59.2	22.5
5	65 years and over-----	17,925	67.7	15.8
	<u>Female</u>			
6	Under 25 years-----	4,284	60.2	20.8
7	25-44 years-----	7,440	63.8	17.0
8	45-64 years-----	13,572	59.5	21.7
9	65 years and over-----	11,683	67.4	16.0
	<u>Male</u>			
10	Under 25 years-----	3,236	49.7	25.8
11	25-44 years-----	5,667	54.7	24.5
12	45-64 years-----	9,993	58.9	23.6
13	65 years and over-----	6,243	68.3	15.4

<sup>1</sup>Prescription and nonprescription drugs.

<sup>2</sup>Percents will not add to 100 because most patient visits required the provision of more than one treatment or service.

Table 11. Number of visits to office-based internists and percents by selected diagnostic and therapeutic services, by age and sex of the patient: United States, January-December 1975—Con.

Diagnostic and therapeutic services—Con.							
Laboratory procedure or test	Blood pressure check	Electrocardiogram	X-ray	Drug therapy <sup>1</sup>	Injection or immunization	Medical counseling	
Percent <sup>2</sup> —Con.							
38.5	61.4	14.9	13.1	49.5	14.2	17.8	1
31.7	39.5	*3.5	8.5	45.4	14.9	18.5	2
36.0	52.4	11.7	15.1	49.4	12.4	18.5	3
39.7	67.2	17.0	14.1	48.7	13.0	18.0	4
41.5	69.6	15.9	12.2	52.4	16.7	16.8	5
37.1	39.0	*1.9	*6.1	47.9	11.7	19.9	6
36.4	51.2	7.7	11.8	53.0	13.0	19.1	7
39.8	67.5	13.8	13.6	50.4	16.0	16.7	8
42.7	71.4	15.4	13.0	53.7	17.9	16.4	9
24.6	40.3	*5.7	*11.8	42.1	19.2	16.7	10
35.5	54.0	16.8	19.5	44.8	11.7	17.8	11
39.6	66.8	21.5	14.9	46.2	8.9	19.9	12
39.3	66.3	17.0	10.7	50.0	14.6	17.4	13

Table 12. Number of visits to office-based internists and percent by disposition of visit, by age and sex of patient: United States, January-December 1975

Age and sex of patient	Number of visits in thousands	Disposition of visit			
		No followup planned	Return at specified time	Return if needed	Other disposition <sup>1</sup>
All visits-----	62,117	9.1	68.4	16.5	12.5
<u>Both sexes</u>					
Under 25 years-----	7,521	21.6	38.6	29.9	15.0
25-44 years-----	13,106	11.9	56.8	22.5	14.4
45-64 years-----	23,565	7.0	75.6	13.0	11.7
65 years and over-----	17,925	4.5	79.8	11.2	11.2
<u>Female</u>					
Under 25 years-----	4,284	20.3	37.9	31.3	17.1
25-44 years-----	7,440	10.1	57.8	23.7	14.5
45-64 years-----	13,572	6.5	75.2	14.3	12.6
65 years and over-----	11,683	3.9	80.1	12.5	11.1
<u>Male</u>					
Under 25 years-----	3,236	23.4	39.5	28.0	12.2
25-44 years-----	5,667	14.3	55.4	20.9	14.3
45-64 years-----	9,993	7.6	76.2	11.1	10.3
65 years and over-----	6,243	*5.7	79.2	8.8	11.4

<sup>1</sup>Includes telephone followup planned, return to referring physician, admit to hospital, and all other dispositions.

<sup>2</sup>Percents will not add to 100 because some patient visits had more than one disposition.

Table 13. Number of visits to office-based internists and percent distribution by selected characteristics of the visit, according to prior visit status: United States, January-December 1975

Selected characteristics of the visit	Prior visit status		
	New patient	Patient seen before	
		New problem	Old problem
	Number in thousands		
All visits-----	8,122	12,995	41,000
	Percent distribution		
Total-----	100.0	100.0	100.0
<u>Seriousness of the patient's problem</u>			
Serious or very serious-----	18.2	14.3	35.2
Slightly serious-----	31.0	32.4	34.5
Not serious-----	50.8	53.3	30.3
<u>Time spent with the physician</u>			
10 minutes or less <sup>1</sup> -----	25.3	33.3	31.5
11-15 minutes-----	24.6	35.6	37.8
16-30 minutes-----	25.3	24.8	24.4
31-60 minutes-----	21.2	5.6	5.8
61 minutes or more-----	*3.5	*0.7	*0.5
<u>Diagnostic and therapeutic services<sup>2</sup></u>			
Limited history and examination-----	41.1	64.0	64.6
General examination-----	45.8	19.8	15.1
Laboratory procedure or test-----	47.4	33.7	38.2
Blood pressure check-----	55.5	51.6	65.7
Electrocardiogram-----	23.2	12.2	12.7
X-ray-----	27.0	17.4	9.0
Drug therapy <sup>3</sup> -----	42.7	52.0	50.1
Injection or immunization-----	8.8	10.6	16.4
Medical counseling-----	18.2	14.7	18.8
Other <sup>4</sup> -----	16.8	13.3	11.4

<sup>1</sup>Includes 420,000 visits during which a patient was provided care by someone other than the physician and the form entry was "zero" minutes.

<sup>2</sup>Percents will not add to 100 because most patient visits required the provision of more than one service or treatment.

<sup>3</sup>Includes prescription and nonprescription drugs.

<sup>4</sup>Includes hearing test, vision test, endoscopy, office surgery, physiotherapy, psychotherapy or therapeutic listening, and all other services or treatments provided.

Table 14. Number of visits to office-based internists and percents by type of condition treated and disposition of visit, by prior visit status: United States, January-December 1975

Type of condition treated <sup>1</sup> and disposition of visit	Prior visit status		
	New patient	Patient seen before	
		New problem	Old problem
	Number in thousands		
All visits-----	8,122	12,995	41,000
	Percents		
<u>Type of condition treated<sup>1</sup></u>			
Acute-----	56.6	75.6	24.6
Chronic-----	23.5	22.1	74.9
<u>Disposition of visit<sup>2</sup></u>			
No followup planned-----	20.6	14.6	5.1
Return at specified time-----	42.0	48.2	80.0
Return if needed-----	23.0	27.3	11.8
Telephone followup planned-----	7.3	8.8	3.3
Referred to other physician-----	5.6	6.9	3.4
Other <sup>3</sup> -----	8.2	3.4	2.0

<sup>1</sup>Percents will not add to 100 because acute and chronic categories include visits for morbid conditions only. Some visits, such as family planning, counseling, administrative, and others, were not related to morbidity.

<sup>2</sup>Percents will not add to 100 because some patient visits had more than one disposition.

<sup>3</sup>Includes return to referring physician, admit to hospital, and all other dispositions.

Table 15. Number of visits to office-based internists and percents by type of condition treated, by age and sex of patient: United States, January-December 1975

Age and sex of patient	Number of visits in thousands	Type of condition treated	
		Acute	Chronic
All visits-----	62,117	39.4	57.2
<u>Both sexes</u>			
Under 25 years-----	7,521	58.9	26.2
25-44 years-----	13,106	46.4	42.8
45-64 years-----	23,565	35.5	62.9
65 years and over-----	17,925	31.3	73.0
<u>Female</u>			
Under 25 years-----	4,284	60.1	28.5
25-44 years-----	7,440	46.1	46.4
45-64 years-----	13,572	34.8	65.1
65 years and over-----	11,683	32.1	73.0
<u>Male</u>			
Under 25 years-----	3,236	57.3	23.3
25-44 years-----	5,667	46.8	38.1
45-64 years-----	9,993	36.4	60.0
65 years and over-----	6,243	29.9	73.0

<sup>1</sup>Percents will not add to 100 because acute and chronic categories include visits for morbid conditions only. Some visits, such as family planning, counseling, administrative, and others, were not related to morbidity.

Table 16. Number of visits to office-based internists and percent distribution by age of patient and selected characteristics of visit, according to selected specialties: United States, January-December 1975

Age of patient and characteristic of the visit	Specialty					
	Internal medicine	General and family practice	Obstetrics and gynecology	Pediatrics	General surgery	Cardiovascular diseases
All visits-----	62,117	234,660	48,076	46,684	41,292	7,556
<u>Age of Patient</u>	Percent distribution					
Total-----	100.0	100.0	100.0	100.0	100.0	100.0
Under 15 years-----	3.3	14.4	2.2	92.7	6.3	*1.4
15-24 years-----	8.8	16.0	33.3	6.3	13.2	*2.4
25-44 years-----	21.1	24.1	50.3	0.5	28.7	10.3
45-64 years-----	37.9	27.5	11.7	*0.4	34.0	43.9
65 years and over-----	28.9	18.0	2.4	*0.2	17.8	42.1
<u>Problem status</u>						
New problem <sup>1</sup> -----	34.0	43.2	32.2	50.7	34.9	23.3
Return visit for continuing problem-----	66.0	56.8	67.9	49.3	65.1	76.7
<u>Seriousness of the problem</u>						
Serious or very serious-----	28.6	17.0	7.7	10.1	18.0	32.4
Slightly serious-----	33.6	35.1	15.7	29.6	28.8	42.1
Not serious-----	37.8	47.9	76.6	60.4	53.2	25.6
<u>Duration of visit in minutes</u>						
0 minutes <sup>2</sup> -----	0.7	1.7	*0.1	2.5	1.3	*0.7
1-10 minutes-----	30.4	54.6	50.1	56.3	54.4	19.4
11-15 minutes-----	35.6	24.9	30.1	27.9	26.0	28.9
16-30 minutes-----	24.6	17.0	17.4	12.0	16.4	38.8
31-60 minutes-----	7.8	1.7	2.3	1.3	1.9	11.2
61 minutes or more-----	0.9	*0.1	*0.0	*0.2	*0.1	*1.0

<sup>1</sup>Includes all visits for new problems regardless of the patient status.

<sup>2</sup>Includes visits during which the patient was under the care of someone other than the physician and the form entry was "zero" minutes.

Table 17. Number of visits to office-based internists and percents by selected characteristics of the visit, by selected specialties: United States, January-December 1975

Characteristic of the visit	Specialty					
	Internal medicine	General and family practice	Obstetrics and gynecology	Pediatrics	General surgery	Cardiovascular diseases
All visits-----	62,117	234,660	48,076	46,684	41,292	7,556
<u>Type of condition treated<sup>1</sup></u>	Percent					
Acute-----	39.4	53.7	19.6	57.8	40.2	38.1
Chronic-----	57.2	35.4	15.4	10.1	29.6	60.3
<u>Selected diagnostic and therapeutic services ordered or provided<sup>2</sup></u>						
No treatments or services-----	1.3	1.7	3.1	2.9	7.6	*1.1
Drug therapy <sup>3</sup> -----	49.5	55.6	35.6	41.2	27.3	43.5
Limited history or examination----	61.4	55.6	54.1	41.0	46.6	47.0
General history and examination----	20.1	12.6	25.4	33.4	11.0	22.1
Laboratory procedure or test-----	38.5	21.6	52.4	22.4	11.8	25.2
Blood pressure check-----	61.4	40.2	57.4	7.7	23.1	72.5
Electrocardiogram-----	14.0	2.3	*0.3	*0.2	2.1	41.5
X-ray-----	13.1	6.2	1.8	4.1	7.3	14.8
Medical counseling-----	17.8	11.7	11.5	15.7	11.7	5.9
<u>Disposition of visit<sup>4</sup></u>						
No followup planned-----	9.1	15.5	7.3	23.6	10.5	4.5
Return at specified time-----	68.4	51.3	75.7	44.5	61.6	78.2
Return if needed-----	16.5	29.2	13.0	23.6	18.2	9.6
Telephone followup planned-----	5.0	3.7	2.5	9.9	1.7	*1.0
Referred to other physician or agency-----	4.4	3.0	1.6	2.9	2.9	*3.1
Return to referring physician-----	0.8	0.4	*0.7	*0.3	1.1	6.5
Admit to hospital-----	1.7	1.2	3.2	*0.9	5.8	*1.8
Other-----	*0.7	0.6	1.2	*0.8	2.2	*0.3

<sup>1</sup>Percents will not add to 100 because acute and chronic condition categories include visits for morbid conditions only. Some visits, such as family planning, counseling, administrative, and others, were not related to morbidity.

<sup>2</sup>Percents will not add to 100 because most patient visits required the provision of more than one treatment or service.

<sup>3</sup>Prescription and nonprescription drugs.

<sup>4</sup>Percents will not add to 100 because some patient visits required more than one disposition.



Table 18. Number of visits to office-based internists and percent distribution by principal diagnoses classified by ICDA category code, according to selected specialties: United States, January-December 1975

Principal diagnosis classified by ICDA category <sup>1</sup>	Specialty	
	Internal medicine	General and family practice
	Number in thousands	
All principal diagnoses-----	62,117	234,660
	Percent distribution	
Total-----	100.0	100.0
Infective and parasitic diseases-----000-136	2.8	4.6
Neoplasms-----140-239	3.7	1.2
Endocrine, nutritional, and metabolic diseases-----240-279	9.1	5.8
Diseases of the blood and blood-forming organs-----280-289	1.2	1.3
Mental disorders-----290-315	3.6	3.0
Diseases of the nervous system and sense organs-----320-389	3.3	4.7
Diseases of the circulatory system-----390-458	24.9	12.4
Diseases of the respiratory system-----460-519	11.7	18.5
Diseases of the digestive system-----520-577	5.5	3.9
Diseases of the genitourinary system-----580-629	3.8	6.4
Diseases of the skin and subcutaneous tissue-----680-709	2.6	4.6
Diseases of the musculoskeletal system -----710-738	8.6	7.1
Symptoms and ill-defined conditions-----780-796	6.6	3.9
Accidents, poisonings, and violence-----800-999	4.3	8.6
Special conditions and examinations without sickness-----Y00-Y13	7.0	12.9
Other diagnoses <sup>2</sup> -----Residual	1.4	1.3

<sup>1</sup>Diagnostic grouping and code number inclusions are based on the Eighth Revision International Classification of Diseases, Adapted for use in the United States.

<sup>2</sup>Includes diagnoses 630-678 Complications of pregnancy and the puerperium; 740-759 Congenital anomalies; and "none" or unknown.

Table 19. Number of visits to office-based internists and general and family practitioners and percents by principal diagnoses classified by ICDA category code, by specialties: United States, January-December 1975

Principal diagnosis classified by ICDA 3-digit category <sup>1</sup>	Specialty	
	Internal medicine	General and family practice
	Number in thousands	
All visits-----	62,117	234,660
	Percent	
Diarrheal disease-----009	(2)	1.2
Diabetes mellitus-----250	4.5	2.5
Obesity-----277	1.6	2.1
Neuroses-----300	2.3	1.8
Otitis media-----381	(2)	1.3
Essential benign hypertension-----401	9.3	5.9
Chronic ischemic heart disease-----412	7.9	2.2
Symptomatic heart disease-----427	2.0	(2)
Acute pharyngitis-----462	(2)	2.2
Acute tonsillitis-----463	(2)	1.7
Acute upper respiratory infection-----465	2.6	3.6
Influenza, unqualified-----470	(2)	2.1
Bronchitis, unqualified-----490	(2)	1.7
Emphysema-----492	1.3	(2)
Chronic sinusitis-----503	(2)	1.1
Hay fever-----507	1.2	1.1
Cystitis-----595	(2)	1.4
Menopausal symptoms-----627	(2)	1.1
Other eczema and dermatitis-----692	1.2	2.2
Rheumatoid arthritis and allied conditions-----712	1.6	(2)
Osteoarthritis and allied conditions-----713	2.3	1.2
Arthritis, unspecified-----715	1.0	1.5
Other nonarticular rheumatism-----717	1.2	1.2
Synovitis, bursitis-----731	1.1	1.2
Symptoms referable to respiratory system-----783	1.0	(2)
Sprains, strains of sacroiliac region-----846	(2)	1.0
Medical or special examinations-----Y00	4.1	6.3
Inoculations and vaccinations-----Y02	(2)	1.0
Prenatal care-----Y06	(2)	2.3
Medical and surgical aftercare-----Y10	1.8	2.4

<sup>1</sup>Diagnostic groupings and code number inclusions are based on the Eighth Revision International Classification of Diseases, Adapted for Use in the United States.

<sup>2</sup>Less than 1 percent.

# APPENDIXES

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## APPENDIX I

### TECHNICAL NOTES<sup>d</sup>

#### Statistical Design

*Scope of the survey.*—The target population of the NAMCS encompasses office visits within the conterminous United States made by ambulatory patients to nonfederally employed physicians who are principally engaged in office practice, but not in the specialties of anesthesiology, pathology, and radiology. Telephone contacts and nonoffice visits are excluded.

*Sampling frame and sample size.*—The sampling frame for the NAMCS is composed of all physicians contained in the master files maintained by the American Medical Association (AMA) and American Osteopathic Association (AOA) as of December 31, 1974, who met the following criteria:

Office-based, as defined by the AMA and AOA;

Principally engaged in patient care activities;

Nonfederally employed;

Not in the specialties of anesthesiology, pathology, clinical pathology, forensic pathology, radiology, diagnostic radiology, pediatric radiology, or therapeutic radiology.

The 1975 physician universe included 180,125 doctors of medicine and 9,696 doctors of osteopathy.

The 1975 NAMCS sample included 3,507 physicians. Sample physicians were screened at

the time of the survey to assure that they met the above-mentioned criteria; 438 physicians did not meet all of the criteria and were, therefore, ruled out of scope (ineligible) for the study.

The most frequent reasons for being out of scope were that the physician was retired, deceased, or employed in teaching, research, or administration. Of the 3,069 in-scope (eligible) physicians, 2,472 (80.5 percent) participated in the study. The physician universe, sample size, and response rates by physician specialty are shown in table I. Of the participating physicians, 391 physicians saw no patients during their assigned reporting period because of vacations, illness, or other reasons for being temporarily not in practice.

*Sample design.*—The 1975 NAMCS utilized a multistage probability design that involved probability samples of primary sampling units (PSU's), physician practices within PSU's, and patient visits within practices. The first-stage sample of 87 PSU's was selected by the National Opinion Research Center (NORC), the organization responsible for field operations under contract to the National Center for Health Statistics (NCHS). A PSU is a county, a group of adjacent counties, or a standard metropolitan statistical area (SMSA). A modified probability-proportional-to-size procedure using separate sampling frames for SMSA's and for nonmetropolitan counties was employed. After sorting and stratifying by size, region, and demographic characteristics, each frame was divided into sequential zones of 1,000,000 residents, and a random number was drawn to determine which PSU came into the sample from each zone.

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<sup>d</sup>Prepared by Thomas McLemore, M.S.P.H., Division of Health Resources Utilization Statistics.

Table 1. Distribution of physicians in the universe (American Medical Association and American Osteopathic Association) and the National Ambulatory Medical Care Survey sample, by physician's specialty: United States, January-December 1975

Physician's specialty	Universe	Gross total	Out of scope	Net total	Non-respondents	Respondents	Response rate
	Number of physicians						
All specialties .....	189,821	3,507	438	3,069	597	2,472	80.5
General and family practice.....	53,069	911	122	789	179	610	77.3
Medical specialties.....	49,801	942	121	821	165	656	79.9
Internal medicine .....	26,125	505	59	446	99	347	77.8
Pediatrics.....	12,229	239	39	200	28	172	86.0
Other medical specialties.....	11,447	198	23	175	38	137	78.3
Surgical specialties.....	65,434	1,255	89	1,166	214	952	81.6
General surgery .....	19,606	371	22	349	63	286	81.9
Obstetrics and gynecology.....	15,124	311	25	286	53	233	81.5
Other surgical specialties .....	30,704	573	42	531	98	433	81.5
Other specialties.....	21,517	399	106	293	39	254	86.7
Psychiatry .....	12,993	242	32	210	20	190	90.5
Other specialties.....	8,524	157	74	83	19	64	77.1

The second stage consisted of a probability sample of practicing physicians selected from the master files maintained by the American Medical Association (AMA) and American Osteopathic Association (AOA). Within each PSU, all eligible physicians were arranged by nine specialty groups: general and family practice, internal medicine, pediatrics, other medical specialties, general surgery, obstetrics and gynecology, other surgical specialties, psychiatry, and other specialties. Then, within each PSU, a systematic random sample of physicians was selected in such a way that the overall probability of selecting any physician in the United States was approximately constant.

The final stage was the selection of patient visits within the annual practices of sample physicians. This involved two steps. First, the total physician sample was divided into 52 random subsamples of approximately equal size, and each subsample was randomly assigned to 1 of the 52 weeks in the survey year. Second, a systematic random sample of visits was selected by the physician during the assigned week. The sampling rate varied for this final step from a 100-percent sample for very small practices to a

20-percent sample for very large practices as determined in a presurvey interview. The method by which the sampling rate was determined is described in the Induction Interview form displayed in appendix III.

### Data Collection and Processing

*Field procedures.*—Both mail and telephone contacts were used to enlist sample physicians into the NAMCS. Physicians received introductory letters from the NCHS (see appendix III) and the AMA or AOA. When appropriate, a letter from the physician's specialty organization, endorsing the survey and urging his participation, was enclosed with the NCHS letter. A few days later, a field representative telephoned the sample physician to briefly explain the study and arrange an appointment for a personal interview. An initially nonresponding physician was generally recontacted via a telephone call or special explanatory letter and requested to reconsider participation in the study.

During the personal interview the field representative determined the sample physician's eligibility, ascertained his cooperation, delivered

survey materials with verbal and printed instructions, and assigned a predetermined Monday through Sunday reporting period. A short interview concerning basic practice characteristics, such as type of practice and expected number of office visits, was administered. Office staff who were to assist with data collection were invited to attend the instruction session or were offered separate instruction sessions.

Before the beginning of and again during the week assigned for data collection, the interviewer telephoned the sample physician to answer possible questions and to insure that procedures were going smoothly. At the end of the survey week, the participating physician mailed finished survey materials to the interviewer who edited the forms for completeness before transmitting them for central data processing. Problems or missing data at this stage were resolved by interviewer telephone followup to the sample physician; if there were no problems, field procedures were complete with respect to the sample physician's participation in the NAMCS. After the end of the survey year each sample physician was sent a thank-you letter from the NCHS along with one of the survey's statistical reports.

*Data collection.*—The actual data collection for the NAMCS was carried out by the physician aided by his office staff when possible. Two data collection forms were employed by the physician: the Patient Log and the Patient Record (appendix III). The Patient Log is a sequential listing of patients seen in the physician's office during his assigned reporting week. This list served as the sampling frame to indicate the visit for which data were to be recorded. A perforation between the patient names and patient visit characteristics permitted the physician to remove patient names and protect confidentiality.

Based on the physician's estimate of the expected number of office visits, each physician was assigned a patient sampling ratio. These ratios were designed so that about 30 Patient Records were completed during the assigned reporting week. Physicians expecting 10 or fewer visits each day recorded data for all of them, while those expecting more than 10 visits per day recorded data for every second, third, or fifth visit, based on the predetermined sampling interval. These procedures minimized the data

collection workload and maintained approximate equal reporting levels among sample physicians regardless of practice size. For physicians assigned a patient sampling ratio, a random start was provided on the first page of the log, so that predesignated sample visits on each succeeding page of the log provided a systematic random sample of patient visits during the reporting period.

*Data processing.*—In addition to completeness checks made by the field staff, clerical edits were performed upon receipt of the data for central processing. These procedures proved quite efficient, reducing the item nonresponse rates to a negligible amount—2 percent or less for all data items.

Information contained in item 5 (patient's problem) of the Patient Record was coded according to a special classification system developed for that purpose.<sup>6</sup> Diagnostic information, item 9 of the Patient Record, was coded according to the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States*(ICDA).<sup>7</sup> A maximum of three problems and three diagnoses were coded. A two-way independent verification procedure with 100-percent verification was used to control the medical coding operation. Differences between coders were adjudicated at the National Center for Health Statistics.

Information from the Induction Interview and Patient Record was keypunched, with 100-percent verification, and converted to computer tape. At this time, extensive computer consistency and edit checks were performed. Data items still unanswered at this point were imputed by assigning a value from a Patient Record with similar characteristics; imputations were based on physician specialty, major reason for visit, and broad diagnostic categories.

### Estimation Procedures

Statistics produced from the 1975 National Ambulatory Medical Care Survey were derived by a multistage estimating procedure. The procedure produces essentially unbiased national estimates and has basically three components: (1) inflation by reciprocals of the probabilities

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NOTE: A list of references follows the text.

of selection, (2) adjustment for nonresponse, and (3) a ratio adjustment to fixed totals. Each of these components is described briefly below.

*Inflation by reciprocals of sampling probabilities.*—Since the survey utilized a three-stage sample design, there were three probabilities: (1) the probability of selecting the PSU, (2) the probability of selecting a physician within the PSU, and (3) the probability of selecting a patient visit with the physician's practice. The last probability was defined to be the exact number of office visits during the physician's specified reporting week divided by the number of Patient Records completed. All weekly estimates were inflated by a factor of 52 to derive annual estimates.

*Adjustment for nonresponse.*—Estimates from the NAMCS data were adjusted to account for sample physicians who did not participate in the study. This was done in such a manner as to minimize the impact of nonresponse on final estimates by imputing to nonresponding physicians the practice characteristics of similar responding physicians. For this purpose, similar physicians were judged to be physicians having the same specialty designation and practicing in the same PSU.

*Ratio adjustment.*—A poststratification adjustment was made within each of nine physician specialty groups. The ratio adjustment was a multiplication factor which had as its numerator the number of physicians in the universe in each physician specialty group, and as its denominator the estimated number of physicians in that particular specialty group. The numerator was based on figures obtained from the AMA-AOA master files, and the denominator was based on data from the sample.

## Reliability of Estimates

Since the statistics presented in this report are based on a sample, they will differ somewhat from the figures that would be obtained if a complete census had been taken using the same forms, instructions, and procedures. However, the probability design of the NAMCS permits the calculation of sampling errors. The standard error is primarily a measure of sampling variability that occurs by chance because only a sample

rather than the entire population is surveyed. As calculated in this report, the standard error also reflects part of the variation which arises in the measurement process. It does not include estimates of any systematic biases that may be in the data. The chances are about 68 out of 100 that an estimate from the sample would differ from a complete census by less than the standard error. The chances are about 95 out of 100 that the difference would be less than twice the standard error and about 99 out of 100 that it would be less than 2½ times as large.

The relative standard error of an estimate is obtained by dividing the standard error by the estimate itself and is expressed as a percentage of the estimate. For this report, asterisks (\*) are presented along with the estimate for any estimate with more than a 30-percent relative standard error.

Estimates of sampling variability were calculated using the method of half-sample replication. This method yields overall variability through observation of variability among random subsamples of the total sample. A description of the development and evaluation of the replication technique for error estimation has been previously published.<sup>10,11</sup>

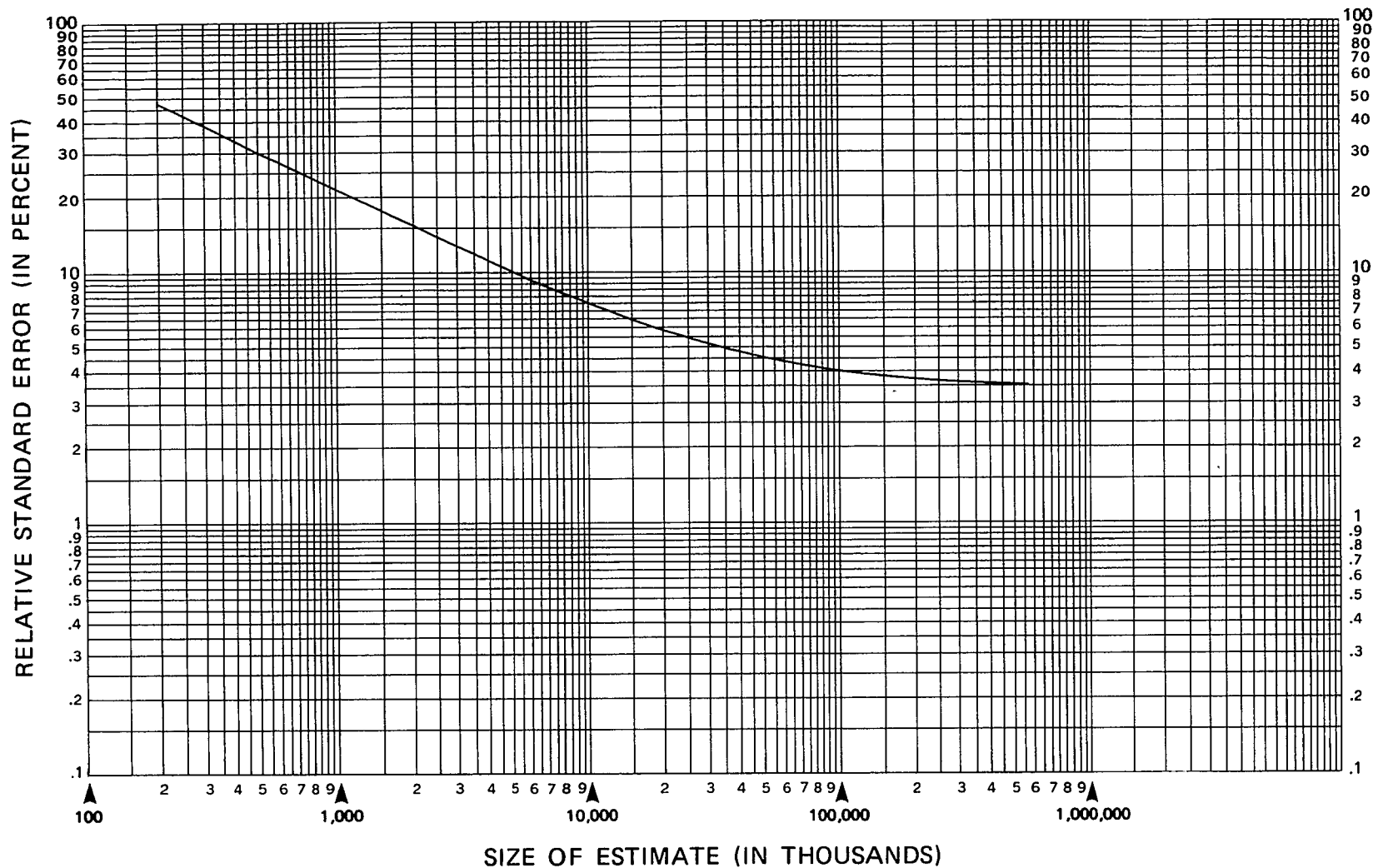
Approximate relative standard errors for aggregates and percentages are presented in figures I and II. In order to derive error estimates that would be applicable to a wide variety of statistics and could be prepared at moderate cost, several approximations were required. As a result, the relative standard errors shown in figures I and II should be interpreted as approximate rather than exact for any specific estimate. Directions for determining approximate relative standard errors from the figures follow.

1. *Estimates of aggregates:* Approximate relative standard errors (in percent) for aggregate statistics, such as the number of office visits with a given characteristic, are obtained from the curve in figure I, or calculated by the formula

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NOTE: A list of references follows the text.

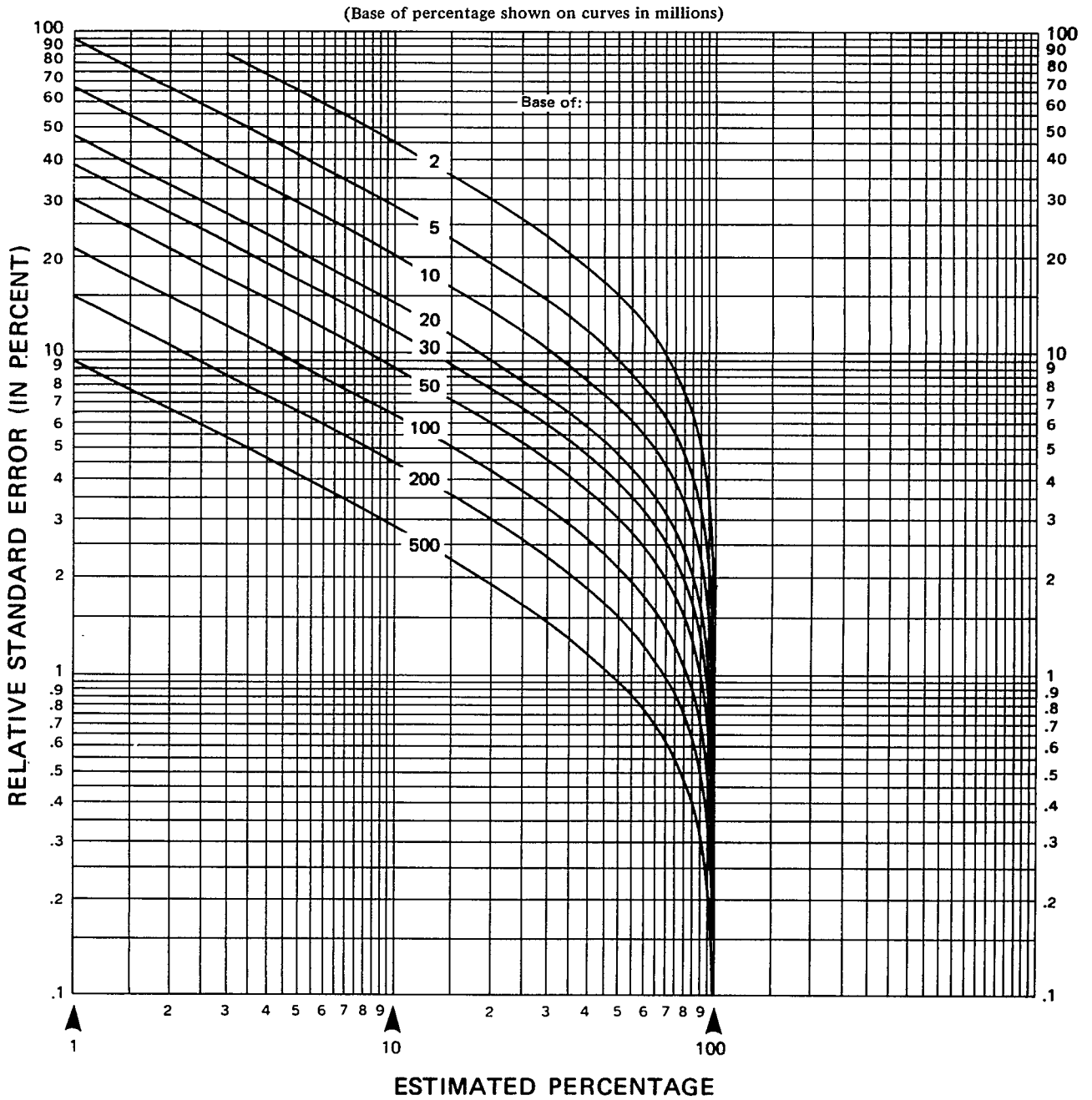
Figure I. Approximate relative standard errors for estimated numbers of office visits, 1975 National Ambulatory Medical Care Survey



*Example of use of this chart:* An estimate of 10 million office visits (read from scale at bottom of chart) has a relative standard error of 7.5 percent (read from scale at left side of chart) or a standard error of 750,000 office visits (7.5 percent of 10 million visits).



**Figure II. Approximate relative standard errors for percentages of estimated numbers of office visits, 1975 National Ambulatory Medical Care Survey**



*Example of use of this chart:* An estimate of 20 percent (read at bottom of chart) based on an estimate of 10 million office visits has a relative standard error of 13.4 percent (read from scale at left of chart) or a standard error of 2.7 percentage points (13.4 percent of 20 percent).

$$\text{RSE}(x) = \sqrt{.001160252 + \frac{44.6697}{x}} \cdot 100$$

where  $x$  is the aggregate of interest in thousands.

2. *Estimates of percentages:* Approximate relative standard errors (in percent) for estimates of this type can be calculated from the curve in figure I as follows. Obtain the relative standard error of the numerator and denominator. Square each of the relative standard errors, subtract the resulting value for the denominator from the resulting value for the numerator, and extract the square root. This calculation has been made for several percentages and bases and is presented in figure II. Alternatively, the formula

$$\text{RSE}(p) = \sqrt{\frac{44.6697 \cdot (1 - p)}{p \cdot x}} \cdot 100$$

can be used to calculate RSE for any percentage ( $p$ ) and base ( $x$ , in thousands).

3. *Estimates of rates where the numerator is not a subclass of the denominator:* Approximate relative standard errors for rates where the denominator is the total U.S. population or one or more of the age-sex-race groups of the total population are equivalent to the relative standard error of the numerator that can be obtained from figure I.
4. *Estimates of differences between two statistics:* The relative standard errors shown in this appendix are not directly applicable to differences between two sample estimates. The standard error of a difference is approximately the square root of the sum of the squares of each standard error considered separately. This formula will represent the standard error quite accurately for the difference between separate and uncorrelated characteristics, although it is only a rough approximation in most other cases.

In addition to sampling error, survey results are subject to reporting and processing errors and biases due to nonresponse or incomplete response. There is no way to compute the magnitude of these errors. However, these types of errors were kept to a minimum by methods built into the survey procedures. Extensive pretesting and careful attention was given to phrasing of the questions and the terms employed and their definitions in order to eliminate ambiguities and encourage uniformity. Steps taken to reduce nonresponse bias were discussed in the sections on field procedures and data collection. Errors in coding and processing were reduced by verification and consistency checks.

### Tests of Significance

In this report, the determination of statistical inference is based on the  $t$ -test with a critical value of 1.96 (0.05 level of significance). Terms relating to differences, such as "higher," "less," etc., indicate that the differences were statistically significant. Terms such as "similar," "no difference," etc., mean that no statistical significance exists between the statistics being compared. Lack of comment regarding the difference between any two statistics does not mean the difference was tested and found to be not significant.

Hypotheses involving the regression of symptom and diagnosis variables on age groups were tested by a weighted least squares technique based on a modified regression model.

### Population Figures

The base population used in computing annual visit rates is presented in table II. These figures are based on provisional estimates for the civilian noninstitutionalized population as of July 1, 1975, provided by the U.S. Bureau of the Census. Because the NAMCS includes data for only the coterminous United States, the original census estimates were modified to account for the exclusion of Alaska and Hawaii from the study. For this reason the population estimates should not be considered as official population estimates and are presented here

Table II. Estimates of the civilian noninstitutionalized population of the United States,<sup>1</sup> by age, race, sex, geographic region, and metropolitan and nonmetropolitan area as of July 1, 1975

[Used in the calculation of rates for tables 1 and 2]

Race, sex, geographic region, and area	Age					
	All ages	Under 15 years	15-24 years	25-44 years	45-64 years	65 years and over
<u>Race</u>						
Number in thousands						
All races.....	207,809	52,307	39,003	52,203	42,455	21,840
Male.....	101,166	26,681	19,599	25,635	20,308	8,943
Female.....	106,643	25,627	19,404	26,568	22,147	12,897
White.....	180,568	43,685	33,324	45,627	38,062	19,872
Male.....	88,162	22,342	16,825	22,635	18,269	8,092
Female.....	92,406	21,343	16,499	22,991	19,791	11,780
All other races.....	27,242	8,622	5,679	6,578	4,394	1,969
Male.....	13,005	4,339	2,774	3,001	2,039	851
Female.....	14,237	4,284	2,905	3,576	2,356	1,117
<u>Geographic region</u>						
Northeast.....	49,030	...	...	...	...	...
North Central.....	56,607	...	...	...	...	...
South.....	66,122	...	...	...	...	...
West.....	36,059	...	...	...	...	...
<u>Area</u>						
Metropolitan.....	141,310	...	...	...	...	...
Nonmetropolitan.....	66,499	...	...	...	...	...

<sup>1</sup>Excludes Alaska and Hawaii.

solely for the purpose of providing denominators for rate computations.

### Systematic Bias

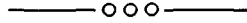
There have been no attempts to determine systematic bias in the data reported here or to measure the impact of any biases. There are several factors, however, that the user of these data should understand, all of which indicate that these data underrepresent the total number of office visits to office-based physicians. These factors are as follows:

1. The sampling universe for the 1975 NAMCS was the files of "office-based, patient-care" physicians maintained by the AMA and AOA. There are certainly physicians not so classified who, at the time of the survey, would have met the criteria for that classification. Visits to these physicians are not represented in these data.
2. A frequent reason for not participating in the NAMCS was given as "too busy"

or "too busy right now." This is an indication that the busier physician was not as likely to participate as the less busy physician.

3. Physicians who participated in the NAMCS did a thorough and conscientious

job in keeping the Patient Log; however, the probability that a patient was accidentally omitted from the survey is much greater than the probability that a patient was included who did not make a visit. This factor could also introduce a slight bias.



## APPENDIX II

### DEFINITIONS OF CERTAIN TERMS USED IN THIS REPORT

#### Terms Relating to the Survey

*Office(s).*—Premises that the physician identifies as locations for his ambulatory practice. Responsibility over time for patient care and professional services rendered there generally resides with the individual physician rather than with any institution.

*Ambulatory patient.*—An individual seeking personal health services, who is neither bedridden nor currently admitted to any health care institution on the premises.

*Physician.*—Can be classified as either:

*In-scope:* All duly licensed doctors of medicine and doctors of osteopathy currently in practice who spend some time in caring for ambulatory patients at an office location.

*Out-of-scope:* Those physicians who treat patients only indirectly, including specialists in anesthesiology, pathology, forensic pathology, radiology, therapeutic radiology, and diagnostic radiology, and the following physicians:

- Physicians in military service.
- Physicians who treat patients only in an institutional setting (e.g., patients in nursing homes and hospitals).
- Physicians employed full time by an industry or institution and having no private practice (e.g., physicians who work for the Veterans Administration, the Ford Motor Company, etc.).

- Physicians who spend no time seeing ambulatory patients (e.g., physicians who only teach, are engaged in research, or are retired).

*Patients.*—Can be classified as either:

*In-scope:* All patients seen by the physician or member of his staff in his office(s).

*Out-of-scope:* Patients seen by the physician in a hospital, nursing home, or other extended care institution, or the patient's home. [Note: If the physician has a *private* office (fitting the definition "office") located in a hospital, the ambulatory patients seen there would be considered in-scope.] The following types of patients are also considered out of scope:

- Patients seen by the physician in an institution (including outpatient clinics of hospitals) for which the institution has the primary responsibility for the care of the patient over time.
- Patients who telephone and receive advice from the physician.
- Patients who come to the office only to leave a specimen, pick up insurance forms, or pay their bills.
- Patients who come to the office only to pick up medications previously prescribed by the physician.

*Visit.*—A direct, personal exchange between an ambulatory patient and a physician (or members of his staff) for the purpose of seeking care and rendering health services.

*Physician specialty.*—Principal specialty (including general practice) as designated by the physician at the time of the survey. Those physicians for whom a specialty was not obtained were assigned the principal specialty recorded in the master physician files maintained by the American Medical Association or the American Osteopathic Association.

*Region of practice location.*—The four geographic regions, excluding Alaska and Hawaii, which correspond to those used by the U.S. Bureau of the Census, are as follows:

<i>Region</i>	<i>States included</i>
Northeast . . . . .	Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
North Central . . .	Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin
South . . . . .	Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia
West . . . . .	Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming

*Metropolitan status of practice location.*—Physician's practice is classified by its location in metropolitan or nonmetropolitan areas. Metropolitan areas are standard metropolitan statistical areas (SMSA's) as defined by the U.S. Office of Management and Budget.

The definition of an individual SMSA involves two considerations: first, a city or cities

of specified population which constitute the central city and identify the county in which it is located as the central county; second, economic and social relationships with "contiguous" counties which are metropolitan in character so that the periphery of the specific metropolitan area may be determined. SMSA's may cross State lines. In New England SMSA's consist of cities and towns rather than counties.

### Terms Relating to the Patient Record Form

*Age.*—The age calculated from date of birth was the age at last birthday on the date of visit.

*Color or race.*—On the Patient Record, color or race includes four categories: white, Negro/black, other, and unknown. The physician was instructed to mark the category which in his judgment was most appropriate for the patient based upon observation and/or prior knowledge of the patient. "Other" was restricted to Orientals, American Indians, and other races neither Negro nor white.

*Patient's principal problem(s), complaint(s), or symptom(s) (in patient's own words).*—The patient's principal problem, complaint, symptom, or reason for the visit as expressed by the patient. Physicians were instructed to record key words or phrases *verbatim* to the extent possible, listing that problem first which in the physician's judgment was most responsible for the patient's visit.

*Seriousness of problem in item 5a.*—This item includes four categories: very serious, serious, slightly serious, and not serious. The physician was instructed to check one of the four categories according to his own evaluation of the seriousness of the patient's problem causing this visit. Seriousness refers to physician's clinical judgment as to the extent of the patient's impairment that might result if no care were given.

*Major reason(s) for this visit.*—The patient's major reason(s) for the visit were classified by the physician into one or more of the following categories:

*Acute problem:* A condition or illness having a relatively sudden or recent onset (i.e., within 3 months of the visit).

*Acute problem, followup:* A return visit primarily for continued medical care of a previously treated acute problem.

*Chronic problem, routine:* A visit primarily to receive regular care or examination for a preexisting chronic condition or illness (onset of condition was 3 months or more before this visit).

*Chronic problem, flareup:* A visit primarily due to a sudden exacerbation of a preexisting chronic condition.

*Prenatal care:* Routine obstetrical care provided prior to delivery.

*Postnatal care:* Routine obstetrical care or examination provided following delivery or termination of pregnancy.

*Postoperative care:* A visit primarily for care required following surgical treatment. Includes changing dressing, removing sutures or cast, advising on restriction of activities or routine after surgery checkup.

*Well adult and/or child examination:* General health maintenance examinations and routine maintenance examinations and routine periodic examinations of presumably healthy persons, both children and adults. Includes annual physical examinations, well-child checkups, school, camp, and insurance examinations.

*Family planning:* Services or advice that enable patients to determine the number and spacing of their children. Includes both contraception and infertility services.

*Counseling and/or advice:* Information of a health nature which would enable the patient to maintain or improve his physical or mental well-being. Included would be advice regarding diet, changing habits or behavior, and general information regarding a specific problem.

*Immunization:* Administration of any inoculation of specific substances to produce a desired immunity; this includes oral vaccines. (Allergy shots are not included in this category, but are entered in "other.")

*Referred by another physician or agency:* Medical attention prompted by advice or referral for consultation by advice or referral for consultation or treatment from another physician, hospital, clinic, health center, school nurse, minister, pharmacist, etc. *Does not* include self-referral or referral by family or friends.

*Administrative purpose:* Reasons such as completing insurance forms, school forms, work permits, or discussion of patient's bill.

*Other:* The reason for this visit is not covered in the preceding list.

*Principal diagnosis.*—The physician's diagnosis of the patient's principal problem or complaint. In the event of multiple diagnoses, the physician was instructed to list them in order of decreasing importance; "principal" refers to the first-listed diagnosis. The diagnosis represents the physician's best judgment at the time of the visit and may be tentative, provisional, or definitive.

*Other significant current diagnosis.*—The diagnosis of any other condition known to exist for the patient at the time of the visit. Other diagnoses may or may not be related to the reason for that visit.

*Treatments and services ordered or provided.*—These include the following:

*Limited history and/or examination:* History and/or physical examination which is limited to a specific body site or system, or which is concerned primarily with the patient's chief complaint, for example, pelvic examination or eye examination.

*General history and/or examination:* History and/or physical examination of a comprehensive nature, including all or most body systems.

*Clinical laboratory test:* One or more laboratory procedures or tests including examination of blood, urine, sputum, smears, exudates, transudates, feces, and gastric content, and including chemistry, serology, bacteriology, and pregnancy test.

*Hearing test:* Auditory acuity test.

*Vision test:* Visual acuity test.

*Endoscopy:* Examination of the interior of any body cavity, except ear, nose, and throat, by means of an endoscope.

*Office surgery:* Any surgical procedure performed in the office this visit, including suture of wounds, reduction of fractures, application and/or removal of casts, incision and draining of abscesses, application of supportive materials for fractures and sprains, and all irrigations, aspirations, dilatations, and excisions.

*Drug prescribed:* Drugs, vitamins, hormones, ointments, suppositories, or other medications ordered or provided, except injections and immunizations.

*X-ray:* Any single or multiple X-ray examination for diagnostic or screening purposes. Radiation therapy is *not* included in this category.

*Injection:* Administration of any substance by syringe and needle subcutaneously, intravenously, or intramuscularly. This category does not include immunizations, enemas, or douches.

*Immunization and/or desensitization:* Administration of any immunizing, vaccinating, or desensitizing agent or substance by any route, for example, syringe, needle, orally, gun, or scarification.

*Physiotherapy:* Any form of physical therapy ordered or provided, including any treatment using heat, light, sound, or physical pressure or movement, for example, ultrasonic, ultraviolet, infrared, whirlpool, diathermy, cold therapy, and manipulative therapy.

*Medical counseling:* Instructions and recommendations regarding any health problem, including advice or counsel about diet, change of habit, or behavior. Physicians are instructed to check this category only if the medical counseling is a *significant* part of the treatment.

*Psychotherapy and/or therapeutic listening:* All treatments designed to produce a mental or emotional response through suggestion, persuasion, reeducation, reassurance, or support, including psychological counseling, hypnosis, psychoanalysis, and transactional therapy.

*Other:* Treatments or services rendered which are not listed in the preceding categories.

*Disposition.*—Eight categories are provided to describe the physician's disposition of the case as follows:

*No followup planned:* No return visit or telephone contact was scheduled for the patient's problem on this visit.

*Return at specified time:* The patient was told to schedule an appointment or was instructed to return at a particular time.

*Return if needed, P.R.N.:* No future appointment was made, but the patient was instructed to make an appointment with the physician if the patient considers it necessary.

*Telephone followup planned:* The patient was instructed to telephone the physician on a particular day to report on his progress, or if the need arises.

*Referred to other physician or agency:* The patient was instructed to consult or seek care from another physician or agency. The patient may or may not return to this physician at a later date.

*Returned to referring physician:* Patient was referred to this physician and was now instructed to consult again with the physician or agency which referred him.

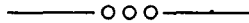
*Admit to hospital:* Patient was instructed that further care or treatment will be provided in a hospital. No further office visits were expected prior to that admission.

*Other:* Any other disposition of the case not included in the above categories.



*Duration of visit.*—Time the physician spent with the patient, but does not include the time patient spent waiting to see the physician, time patient spent receiving care from someone other than the doctor without the presence of the physician, and time spent reviewing records,

tests results, and so forth. In the event a patient was provided care by a member of physician's staff but did not see the physician during the visit, "duration of visit" was recorded as zero minutes.



# APPENDIX III

## SURVEY INSTRUMENTS

### INTRODUCTORY LETTER FROM DIRECTOR, NATIONAL CENTER FOR HEALTH STATISTICS



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
PUBLIC HEALTH SERVICE  
HEALTH RESOURCES ADMINISTRATION  
ROCKVILLE, MARYLAND 20852

NATIONAL CENTER FOR  
HEALTH STATISTICS

#### Endorsing Organizations

**American Medical Association**  
James H. Sammons, M.D.  
Executive Vice President

**National Medical Association**  
Alfred F. Fisher  
Executive Director

**American Academy of Dermatology**  
John M. Shaw, M.D.  
Secretary-Treasurer

**American Academy of Family  
Physicians**  
Roger Tusken  
Executive Director

**American Academy of Neurology**  
Stanley A. Nelson  
Executive Director

**American Academy of Orthopaedic  
Surgeons**  
Charles V. Heck, M.D.  
Executive Director

**American Academy of Pediatrics**  
Robert G. Frazier, M.D.  
Executive Director

**American College of Obstetricians  
and Gynecologists**  
Warren H. Pearse, M.D.  
Director

**American College of Physicians**  
Edward C. Rosenow, Jr., M.D.  
Executive Vice President

**American College of Preventive  
Medicine**  
Ward Bentley  
Executive Director

**American College of Surgeons**  
C. Rollins Hanlon, M.D.  
Executive Director

**American Osteopathic Association**  
Edward P. Crowell, D. O.  
Executive Director

**American Proctologic Society**  
Alejandro F. Castro, M.D.  
Secretary

**American Psychiatric Association**  
Melvin Sabshin, M.D.  
Medical Director

**American Society of Internal  
Medicine**  
William R. Ramsay  
Executive Director

**American Society of Plastic and  
Reconstructive Surgeons, Inc.**  
Dallas F. Whaley  
Executive Vice President

**American Urologic Association**  
Hal B. Jennings, Jr., M.D.  
Executive Director

**Association of American Medical  
Colleges**  
John A. D. Copper, M.D., Ph.D.  
President

Dear Dr.

The National Center for Health Statistics, as part of its continuing program to provide information on the health status of the American people, is conducting a National Ambulatory Medical Care Survey (NAMCS).

The purpose of this survey is to collect information about ambulatory patients, their problems, and the resources used for their care. The resulting published statistics will help your profession plan for more effective health services, determine health manpower requirements, and improve medical education.

Since practicing physicians are the only reliable source of this information, we need your assistance in the NAMCS. As one of the physicians selected in our national sample, your participation is essential to the success of the survey. Of course, all information that you provide is held in strict confidence.

Many organizations and leaders in the medical profession have expressed their support for this survey, including those shown to the left. They join me in urging your cooperation in this important research.

Within a few days, a survey representative will telephone you for an appointment to discuss the details of your participation. We greatly appreciate your cooperation.

Sincerely yours,

Dorothy P. Rice  
Director

# INDUCTION INTERVIEW FORM

BEGIN DECK 3

CONFIDENTIAL\*  
NORC-4233

Form Approved OMB No. 68R1498
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FOR OFFICE USE ONLY:				
(BATCH NO.)				
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5-6/				
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7-10/				

NATIONAL AMBULATORY MEDICAL CARE SURVEY  
INDUCTION INTERVIEW

<u>BEFORE STARTING INTERVIEW</u>
<ol style="list-style-type: none"> <li>1. ENTER PHYSICIAN I.D. NUMBER IN BOX TO RIGHT.</li> <li>2. ENTER DATES OF ASSIGNED REPORTING WEEK IN Q. 2, P. 2.</li> </ol>

(Phys. ID Number)

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1-4/

TIME _____ AM
BEGAN: _____ PM

Doctor, before I begin, let me take a minute to give you a little background about this survey.

\*  
The National Ambulatory Medical Care Survey is authorized by Congress in Public Law 93-353, section 308. It is a voluntary study and there are no penalties for refusing to answer any question. All information collected is confidential and will be used only to prepare statistical summaries. No information which will identify an individual or a physician's practice will be released.

Although ambulatory medical care accounts for nearly 90 per cent of all medical care received in the United States, there is no systematic information about the characteristics and problems of people who consult physicians in their offices. This kind of information has been badly needed by medical educators and others concerned with the medical manpower situation.

In response to increasing demands for this kind of information, the National Center for Health Statistics, in close consultation with representatives of the medical profession, has developed the National Ambulatory Medical Care Survey.

Your own task in the survey is simple, carefully designed, and should not take much of your time. Essentially, it consists of your participation during a specified 7-day period. During this period, you simply check off a minimal amount of information concerning patients that you see.

Now, before we get into the actual procedures, I have a few questions to ask about your practice. The answers you give me will be used only for classification and \* analysis, and of course all information you provide is held in strict confidence.

1. First, you are a \_\_\_\_\_ . Is that right?  
(ENTER SPECIALTY FROM CODE ON FACE SHEET LABEL.)

Yes . . . . . X  
No . . . . (ASK A) . . . . Y

A. IF NO: What is your specialty (including general practice)?

\_\_\_\_\_

(Name of Specialty)

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11-13/

2. Now, doctor, this study will be concerned with the ambulatory patients you will see in your office during the week of (READ REPORTING DATES ENTERED BELOW).

\_\_\_\_\_ / \_\_\_\_\_ (that's a \_\_\_\_\_ (that's a  
month date Monday) through month date Sunday)

Are you likely to see any ambulatory patients in your office during that week?

Yes . . . . . (GO TO Q. 3) . . X

No . . . . . (ASK A) . . . . Y

A. IF NO: Why is that? RECORD VERBATIM, THEN READ PARAGRAPH BELOW

Since it's very important, doctor, that we include any ambulatory patients that you do happen to see in your office during that week, I'd like to leave these forms with you anyway--just in case your plans change. I'll plan to check back with your office just before (STARTING DATE) to make sure, and I can explain them in detail then, if necessary.

GIVE DOCTOR THE A PATIENT RECORD FORMS AND GO TO Q. 9, P. 6.

3. A. At what office location will you be seeing ambulatory patients during that 7-day period? RECORD UNDER A BELOW AND THEN CODE B.

B. FOR EACH OFFICE LOCATION ENTERED IN A, CODE YES OR NO TO "IN SCOPE."

IN SCOPE (Yes)	OUT OF SCOPE (No)
Private offices	Hospital emergency rooms
Free-standing clinics (non-hospital based)	Hospital outpatient departments
Groups, partnerships	College or university infirmaries
Kaiser, HIP, Mayo Clinic	Industrial outpatient facilities
Neighborhood Health Centers	Family planning clinics
Privately operated clinics (except family planning)	Government-operated clinics (VD, maternal & child health, etc.)

IN CASE OF DOUBT, ASK: Is that (clinic/facility/institution) hospital based?  
Is that (clinic/facility/institution) government operated?

C. Is that all of the office locations at which you expect to see ambulatory patients during that week?

Yes . . . . . X  
No . . . . . Y

IF NO: OBTAIN ADDITIONAL OFFICE LOCATION(S), ENTER IN "A" BELOW, AND REPEAT.

A. Office Location	B. In Scope?	
	Yes	No
(1) _____	X	Y
_____		
(2) _____	X	Y
_____		
(3) _____	X	Y
_____		
(4) _____	X	Y
_____		

IF ALL LOCATIONS ARE OUT OF SCOPE, THANK THE DOCTOR AND LEAVE.

4. A. During that week (REPEAT DATES), how many ambulatory patients do you expect to see in your office practice? (DO NOT COUNT PATIENTS SEEN AT [OUT-OF-SCOPE LOCATIONS] CODED IN 3-B.)

ENTER TOTAL UNDER "A" BELOW AND CIRCLE ON APPROPRIATE LINE.

- B. And during those seven days (REPEAT DATES IF NECESSARY), on how many days do you expect to see any ambulatory patients? COUNT EACH DAY IN WHICH DOCTOR EXPECTS TO SEE ANY PATIENTS AT AN IN-SCOPE OFFICE LOCATION.

ENTER TOTAL UNDER "B" BELOW AND CIRCLE NUMBER IN APPROPRIATE COLUMN.

DETERMINE PROPER PATIENT LOG FORM FROM CHART BELOW. READ ACROSS ON "TOTAL PATIENTS" LINE UNDER "A" AND CIRCLE LETTER IN APPROPRIATE "DAYS" COLUMN UNDER "B."

THIS LETTER TELLS YOU WHICH OF THE FOUR PATIENT LOG FORMS (A, B, C, D) SHOULD BE USED BY THIS DOCTOR.

LOG FORM DESCRIPTION	A. Expected total patients during survey week.	B. Total days in practice during week.						
		ENTER TOTAL FROM Q. 4-B. _____ DAYS						
A--Patient Record is to be completed for <u>ALL</u> patients listed on Log. 14-16/	ENTER TOTAL FROM Q. 4-A. <input type="text"/>	1	2	3	4	5	6	7
	1- 12 PATIENTS	A	A	A	A	A	A	A
	13- 25 "	B	A	A	A	A	A	A
	26- 39 "	C	B	A	A	A	A	A
	40- 52 "	C	B	B	A	A	A	A
	53- 65 "	D	C	B	B	A	A	A
	66- 79 "	D	C	B	B	B	A	A
	80- 92 "	D	D	C	B	B	B	B
	93-105 "	D	D	C	B	B	B	B
	106-118 "	D	D	C	C	B	B	B
C--Patient Record is to be completed for every <u>SECOND</u> patient listed on Log.	119-131 "	D	D	C	C	B	B	B
	132-145 "	D	D	D	C	C	B	B
	146-158 "	D	D	D	C	C	B	B
	159-171 "	D	D	D	C	C	C	C
	172-184 "	D	D	D	C	C	C	C
	185-197 "	D	D	D	D	D	D	D
	198-210 "	D	D	D	D	D	D	D
	211+ "	D	D	D	D	D	D	D

\* In the rare instance the physician will see more than 500 patients during his assigned reporting week, give him two D Patient Log Folios and instruct him to complete a patient record form for only every tenth patient. Then you are to draw an X through the Patient Record on every other page of the two folio pads, starting with page 1 of the pad. The physician then completes the Patient Log on every page, but completes the Patient Record on every second page.

5. FIND LOG FOLIO WITH APPROPRIATE LETTER AND CIRCLE LETTER, ENTER FIRST FOUR NUMBERS OF THE FORM AND NUMBER OF LINES STAMPED "BEGIN ON NEXT LINE" FOR THE B-C-D LOG FORMS (if no lines are stamped, enter "0") BELOW.

Letter	FOLIO				No. Lines Stamped "BEGIN ON NEXT LINE"	FOR OFFICE USE ONLY
	Number					Number patient record forms completed.
A						
B						
C						
D						

17-21/  
22-24/

6. HAND DOCTOR HIS FOLIO AND EXPLAIN HOW FORMS ARE TO BE FILLED OUT. SHOW DOCTOR INSTRUCTIONS ON THE POCKET OF FOLIO, ITEMS 11 AND 12 DEFINITIONS ON CARD IN POCKET OF FOLIO AND ITEM DEFINITIONS ON THE BACK OF FOLIO, TO WHICH HE CAN REFER AFTER YOU LEAVE.

EMPHASIZE THAT EVERY PATIENT VISIT EXCEPT ADMINISTRATIVE PURPOSE ONLY IS TO BE RECORDED ON THE LOG FOR ENTIRE REPORTING PERIOD. FOR EXAMPLE, IF A MEDICAL ASSISTANT GAVE THE PATIENT AN INOCULATION, OR A TECHNICIAN ADMINISTERED AN ELECTROCARDIOGRAM AND THE PATIENT DID NOT SEE THE DOCTOR, THIS VISIT IS TO BE LISTED ON THE LOG.

RECORD VERBATIM BELOW ANY CONCERN, PROBLEMS OR QUESTIONS THE DOCTOR RAISES.

7. IF DOCTOR EXPECTS TO SEE AMBULATORY PATIENTS AT MORE THAN ONE IN-SCOPE LOCATION DURING ASSIGNED WEEK, TELL HIM YOU WILL DELIVER THE FORMS TO THE OTHER LOCATION(S). ENTER THE FORM LETTER AND NUMBER(S) AND NUMBER OF LINES STAMPED "BEGIN ON NEXT LINE" FOR THE B-C-D LOG FOR THOSE LOCATIONS BELOW, BEFORE DELIVERING FORM(S).

Location	FOLIO				No. Lines Stamped "BEGIN ON NEXT LINE"	FOR OFFICE USE ONLY:
	Letter	Number				Number patient record forms completed

25-29/  
30-32/  
33-37/  
38-40/  
41-45/  
46-48/





10. Now I have just one more question about your practice. (NOTE: IF DOCTOR PRACTICES IN LARGE GROUP, THE FOLLOWING INFORMATION CAN BE OBTAINED FROM SOMEONE ELSE.)

- A. What is the total number of full-time (35 hours or more per week) employees of your (partnership/group) practice? Include persons regularly employed who are now on vacation, temporarily ill, etc. Do not include other physicians. RECORD ON BOTTOM LINE OF COLUMN A BELOW.  
 (1) How many of these full-time employees are a . . . (READ CATEGORIES BELOW AS NECESSARY AND RECORD NUMBER OF EACH IN COLUMN A.)
- B. And what is the total number of part-time (less than 35 hours per week) employees of your (partnership/group) practice? Again, include persons regularly employed who are now on vacation, ill, etc. Do not include other physicians. RECORD ON BOTTOM LINE OF COLUMN B BELOW.  
 (1) How many of these part-time employees are a . . . (READ CATEGORIES BELOW AS NECESSARY AND RECORD NUMBER OF EACH IN COLUMN B.)

Employees	A.		B.	
	Full-time (35 or more hours/week)		Part-time (Less than 35 hours/week)	
(1) Registered Nurse . . . . .	_____	11-13/	_____	35-37/
(2) Licensed Practical Nurse . . . . .	_____	14-16/	_____	38-40/
(3) Nursing Aide . . . . .	_____	17-19/	_____	41-43/
(4) Physician Assistant* . . . . .	_____	20-22/	_____	44-46/
(5) Technician . . . . .	_____	23-25/	_____	47-49/
(6) Secretary or Receptionist . . . . .	_____	26-28/	_____	50-52/
(7) Other (SPECIFY) _____	_____	29-31/	_____	53-55/
TOTAL:	_____	32-34/	TOTAL: _____	56-58/

\* Physician Assistant must be a graduate of an accredited training program for Physician Assistants (Physician Extenders, Medex, etc.) or certified by the National Board of Medical Examiners through the Certification Exam for Assistant to the Primary Care Physician.

BEFORE YOU LEAVE, AGAIN STRESS THAT EACH AND EVERY AMBULATORY PATIENT SEEN BY THE DOCTOR OR HIS STAFF DURING THE 7-DAY PERIOD AT ALL IN-SCOPE OFFICE LOCATIONS (REPEAT THEM) IS TO BE INCLUDED IN THE SURVEY, THAT EACH PATIENT IS TO BE RECORDED ON THE LOG, AND ONLY THE APPROPRIATE NUMBER OF PATIENT RECORDS COMPLETED.

Thank you for your time, Dr. \_\_\_\_\_. If you have any (more) questions, please feel free to call me. My phone number is written in the folio. I'll call you on Monday morning of your survey week just to remind you.

11. TIME INTERVIEW ENDED . . . . . \_\_\_\_\_ AM  
 PM

12. DATE OF INTERVIEW . . . . . 

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 (Month) (Day) (Year)

COMMENTS:

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INTERVIEWER NUMBER

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INTERVIEWER'S SIGNATURE

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FOR OFFICE USE ONLY:

No. of Patients Seen:

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