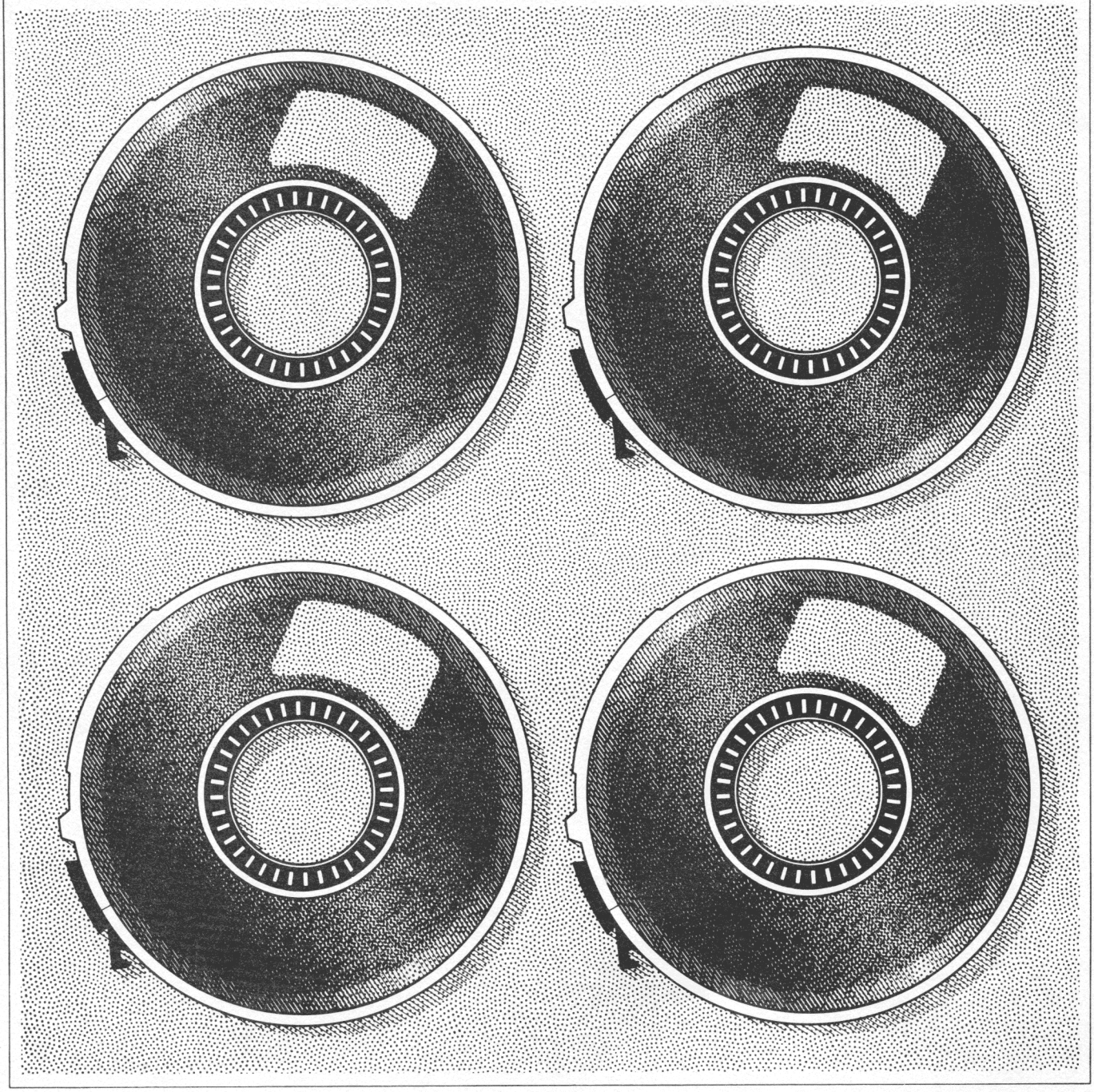
Public Use Data Tape Documentation

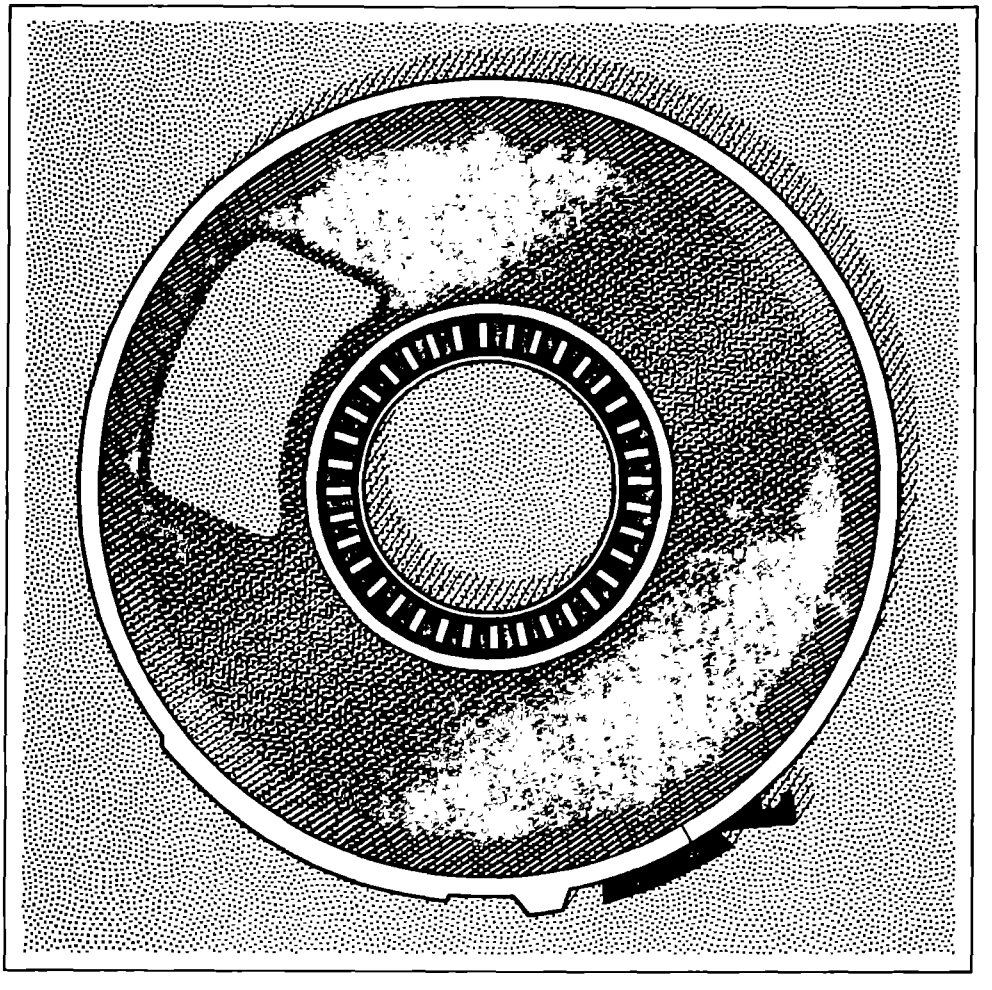
National Ambulatory Medical Care Survey 1979

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • Public Health Service • Office of Health Research, Statistics, and Technology • National Center for Health Statistics



Public Use Data Tape Documentation

National Ambulatory Medical Care Survey 1979



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Office of Health Research, Statistics, and Technology
National Center for Health Statistics

Hyattsville, Maryland
August 1981

1979 NAMCS MICRO-DATA TAPE DOCUMENTATION

ABSTRACT

This material provides documentation for users of the Micro-Data tapes of the National Ambulatory Medical Care Survey (NAMCS) conducted by the National Center for Health Statistics. Section I, "Description of the National Ambulatory Medical Care Survey," includes information on the history of NAMCS, the scope of the survey, the sample, field activities, data collection procedures, symptom coding procedures, population estimates, and sampling errors. Section II provides technical details of the tape (number of tracks, record length, etc.). Section III provides a detailed description of the contents of each data record by location. Section IV contains marginal data or estimates for each item on the data record in Section III. An appendix defines certain terms used in this document.

TABLE OF CONTENTS

I. DESCRIPTION OF THE NATIONAL AMBULATORY MEDICAL CARE SURVEY

INTRODUCTION.—These Micro-Data Tapes comprise the data collected by the National Ambulatory Medical Care Survey (NAMCS) in 1979, conducted by the National Center for Health Statistics (NCHS). The National Ambulatory Medical Care Survey provides continuous data from samples of patient records selected from a national sample of office-based physicians. These national estimates describe the utilization of ambulatory medical care services in the coterminous United States. In 1979 there were approximately 45,000 patient records sampled from the 1,783 doctors that participated in the survey. For a description of the survey design and data collection procedures, see below. For a more detailed description of the survey design, data collection procedures, and the estimation process see references 1 and 6. A brief statement on sampling errors can be found in the appendix of these documentation.

HISTORY.—To provide more complete and precise information on the utilization of the nation's ambulatory care resources and on the nature and treatment of illness among the population seeking ambulatory care, the NCHS in 1967 began exploring possibilities for surveying morbidity in private physicians' offices. A national technical advisory group was established. Initial discussions resulted in a tentative protocol that called for periodic meetings of a working group comprised of the Director of the NCHS Division of Health Resources Statistics, the Project Officer and staff, the contractor's representatives, and a consultant group from the Johns Hopkins University in Baltimore.

The background and development of methods employed for the NAMCS required exploratory and feasibility studies conducted over a period of 6 years. Literature review and consultation documented needs and potential uses for national ambulatory medical care statistics. Information regarding accepted definitions, uniform terminology, procedural experience, or practical classifications for the problems and conditions encountered in ambulatory care settings was found to be limited. First, data collection forms and procedures were developed and tested by sample physicians in a national field survey, which demonstrated the difficulty of achieving high levels of participation. Refined data collection forms and improved procedures were further tested by a second sample of physicians in an extensive national survey lasting over 2 quarters in 1 year. Results demonstrated the usefulness of professional endorsement, procedural efficiency, and minimal work requirements in achieving physician-participation levels exceeding 80 percent.

Finally, with advice and support from the technical advisory group, the American Medical Association, individual experts, other professional groups, and elements of the Public Health Service, NCHS initiated the National Ambulatory Medical Care Survey in 1973.

SCOPE OF THE SURVEY.--The basic sampling unit for the NAMCS is the physician-patient encounter or visit. Only visits in the offices of nonfederally employed physicians classified by the American Medical Association (AMA) or the American Osteopathic Association (AOA) as "office-based, patient care" were included in the 1979 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 1979 NAMCS were those made by telephone, those made outside of the physician's office, and those made in hospital or institutional settings. It is planned to extend the NAMCS to include these encounters in the future, though some complex methodological and sampling problems must be resolved first.

SAMPLING FRAME AND SIZE OF SAMPLE. The sampling frame for the NAMCS is composed of all physicians contained in the master files maintained by the AMA and AOA as of December 31, 1978, who met the following criteria:

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

Principally engaged in patient care activities;

Nonfederally employed;

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

The 1979 NAMCS sample included 3,023 physicians: 2,902 MD's and 121 doctors of osteopathy. Sample physicians were screened at the time of the survey to assure that they met the above-mentioned criteria; 541 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 2,482 in-scope (eligible) physicians, 1,783 (71.8 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, 256 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 1979 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 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 million residents, and a random number was drawn to determine which PSU came into the sample from each zone.

Table I. Distribution of physicians in the universe[1/] and in the 1979 National Ambulatory Medical Care Survey sample by physician specialty, United States, January-December 1979.

Physician specialty	Universe	Gross Total	Out of Scope	Net Total	Non-Response	Response	Response Rate
All specialties	219,575	3,023	541	2,482	699	1,783	71.8
General and family practice	51,598	690	130	560	166	394	70.4
Medical specialties	64,564	867	148	719	198	521	72.5
Internal medicine	33,754	446	82	364	117	247	67.9
Pediatrics	15,264	213	41	172	32	140	81.4
Other	15,546	208	25	183	49	134	73.2
Surgical specialties	73,825	1,038	119	919	269	650	70.7
General surgery	20,619	281	34	247	76	171	69.2
Obstetrics and gynecology	17,445	247	32	215	59	156	72.6
Other	35,761	510	53	457	134	323	70.7
Other specialties	29,588	428	144	284	66	218	76.8
Psychiatry	15,757	241	45	196	42	154	78.6
Other	13,831	187	99	88	24	64	72.7

[1/] Includes doctors of medicine (M.D.'s) and doctors of osteopathy (D.O.'s).

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 Asssociation (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 reference 7.

FIELD ACTIVITIES--The first contact with the sample physician is through a letter from the Director, NCHS, which may be accompanied by a letter from one of the 17 national medical associations that endorse the NAMCS providing the physician is a member of one or more of these associations. Examples of these letters are shown in Figures 1 and 2. After the physician has received the introductory letter(s) the interviewer telephones the physician to set up an appointment with him or her to discuss the survey and instruct the doctor on how to complete the forms. The success of the survey depends a great deal on the outcome of this first personal contact with the physician. Therefore, it is very important that the interviewer be trained and well-informed on all aspects of the survey. Rather than include copies of all the interviewer materials in this documentation, copies are available on request. These materials include instructions to interviewers as well as all the forms used in the field by the interviewer in carrying out his or her assignment.

It should be noted that beginning in 1977 a new classification system was used to code reason for visit data. This new system differs from the symptom classification system[3/] used from 1973 through 1976 in that it contains several major revisions and includes a substantially greater amount of detail. Unfortunately, because of these differences the reason for visit data for 1979 are not comparable with reason for visit data from the years prior to 1977. The new system utilizes a modular structure composed of seven modules:

1 - symptom module
2 - disease module
3 - diagnostic, screening, and preventive module
4 - treatment module
5 - injuries and adverse effects module
6 - test results module
7 - administrative module

A maximum of three reasons for visit were coded in sequence.

Diagnostic information in item 8 of the Patient Record was coded according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). A maximum of three diagnoses were coded in sequence.

In addition to the diagnostic codes contained in the ICDA there were 4 unique codes on the tape that were developed by the NAMCS staff:

100000 = blank diagnosis
209970 = diagnosis given as "NONE"
209980 = noncodable diagnosis
209990 = illegible diagnosis
209900 = unsuitable diagnosis

NOTE: The 5-digit diagnosis code is preceded by a prefix '1' or '2'. See notes on Page 19 for an explanation of these prefixes.

It should be noted that all "V" codes will have a zero in the first position of the 5-digit code. 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.

Coding instructions concerning the reasons for visit classsification as well as the ICDA are contained in the NAMCS 1977 Medical Coding Manual.[5/] Copies are available upon request. Call or write to Raymond O. Gagnon, NCHS, Room 2-63, 3700 East-West Highway, Hyattsville, Maryland 20782 (301/436-7132).

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 (Figure 3). 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.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
OFFICE OF HEALTH RESEARCH, STATISTICS AND TECHNOLOGY
HYATTSVILLE, MARYLAND 20782

Date

NATIONAL AMBULATORY
MEDICAL CARE SURVEY

ndorsing Organizations

merican Academy of Dermatology

merican Academy of Family Physicians

merican Academy of Neurology

merican Academy of Orthopaedic Surgeons

merican Academy of Pediatrics

merican Association of Neurological Surgeons

merican College of Emergency Physicians

merican College of Obstetricians and Gynecologists

American College of Physicians

American College of Preventive Medicine

American Osteopathic Association

American Society of Colon and Rectal Surgeons

American Psychiatric Association

merican Society of Internal Medicine

American Society of Plastic and Reconstructive Surgeons, Inc.

American Urological Association

Association of American Medical Colleges

National Medical Association

John Doe, M.D.
1000 Anywhere Street
Sunnyville, Anywhere 99999

Dear Dr. Doe:

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. In particular, your own specialty society has reviewed the NAMCS program and supports this effort (see enclosure). 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

Enclosure

American Psychiatric Association

1700 Eighteenth Street, N.W., Washington, D.C. 20009 • Telephone: (202) 797-4900

Dear Doctor:

You have a heavy schedule and service to your patients must take priority over many desirable things. You receive many questionnaires and fill out many forms. I do urge your participation in the National Ambulatory Medical Care Survey (NAMCS). The National Center for Health Statistics has invested five years in developing this unique study. I believe that it is the most sound and valuable mechanism, developed thus far, for collecting national data on office-based ambulatory practice.

The continued support of the American Psychiatric Association and the support generated among all physicians is indispensable in the inauguration of this research program. There is considerable interest in gaining the information produced -- new, basic information which can prove to be an original, invaluable base for planning and organizing health services, assessing health facility and manpower requirements, for determining desirable modifications in medical education programs, and for providing increased knowledge reflecting the natural history and epidemiology of disease in the ambulatory setting.

Along with other medical organizations, we have been involved in finalizing the NAMCS forms and procedures. I believe you will find the survey design minimizes the amount of record-keeping and time involved, and maximizes the utility of the data collected. In addition, strict confidentiality provisions are to be maintained, with only summary data to be published and made available to the medical profession, to health planners and researchers, and to the public.

I am confident that all will find the information derived will be well worth the extra, individual effort expended by participating physicians like yourself. Again, may I urge your support for the NAMCS by providing the information requested? We can look forward in anticipation of obtaining and utilizing the results of this important research study.

Sincerely yours,

Melvin Sabshin, M.D.
Medical Director

D 710476

PATIENT LOG

As each patient arrives, record name and time of visit on the log below. For the patient entered on line #5, also complete the patient record to the right.

	PATIENT'S NAME	TIME OF VISIT
1		a.m. / p.m.
2		a.m. / p.m.
3		a.m. / p.m.
4		a.m. / p.m.
5		a.m. / p.m.

Record items 1-19 for this patient

CONTINUE LISTING PATIENTS ON NEXT PAGE

D 710476

PATIENT RECORD
NATIONAL AMBULATORY MEDICAL CARE SURVEY

1. DATE OF VISIT — Mo. / Day / Yr.

2. DATE OF BIRTH — Mo. / Day / Yr.

3. SEX
1 ☐ FEMALE
2 ☐ MALE

4. COLOR OR RACE
1 ☐ WHITE
2 ☐ BLACK
3 ☐ ASIAN/PACIFIC ISLANDER
4 ☐ AMERICAN INDIAN/ALASKAN NATIVE

5. ETHNICITY
1 ☐ HISPANIC ORIGIN
2 ☐ NOT HISPANIC

6. WAS PATIENT REFERRED FOR THIS VISIT BY ANOTHER PHYSICIAN?
1 ☐ YES
2 ☐ NO

7. PATIENT'S COMPLAINT(S), SYMPTOM(S), OR OTHER REASON(S) FOR THIS VISIT *[In patient's own words]*
a. MOST IMPORTANT _____
b. OTHER _____

8. MAJOR REASON FOR THIS VISIT *[Check One]*
1 ☐ ACUTE PROBLEM
2 ☐ CHRONIC PROBLEM, ROUTINE
3 ☐ CHRONIC PROBLEM, FLAREUP
4 ☐ POST SURGERY/INJURY
5 ☐ NON-ILLNESS CARE (ROUTINE PRENATAL, GENERAL EXAM, WELL BABY, ETC.)

9. PHYSICIAN'S DIAGNOSES
a. PRINCIPAL DIAGNOSIS/PROBLEM ASSOCIATED WITH ITEM 7a
b. OTHER SIGNIFICANT CURRENT DIAGNOSES

10. HAVE YOU SEEN PATIENT BEFORE?
1 ☐ YES 2 ☐ NO
IF YES, FOR THE CONDITION IN ITEM 9a?
1 ☐ YES 2 ☐ NO

11. DIAGNOSTIC SERVICES THIS VISIT *[Check all ordered or provided]*
1 ☐ NONE
2 ☐ LIMITED HISTORY/EXAM
3 ☐ GENERAL HISTORY/EXAM
4 ☐ PAP TEST
5 ☐ CLINICAL LAB TEST
6 ☐ X-RAY
7 ☐ BLOOD PRESSURE CHECK
8 ☐ EKG
9 ☐ VISION TEST
10 ☐ ENDOSCOPY
11 ☐ MENTAL STATUS EXAM
12 ☐ OTHER (Specify) _____

12. THERAPEUTIC SERVICES THIS VISIT *[Check all ordered or provided]*
1 ☐ NONE
2 ☐ DRUG (PRESCRIPTION)
3 ☐ DRUG (NONPRESCRIPTION)
4 ☐ INJECTION
5 ☐ IMMUNIZATION/DESENSITIZATION
6 ☐ DIET COUNSELING
7 ☐ FAMILY PLANNING
8 ☐ MEDICAL COUNSELING
9 ☐ PHYSIOTHERAPY
10 ☐ OFFICE SURGERY
11 ☐ PSYCHOTHERAPY/THERAPEUTIC LISTENING
12 ☐ OTHER (Specify) _____

13. DISPOSITION THIS VISIT *[Check all that apply]*
1 ☐ NO FOLLOW-UP PLANNED
2 ☐ RETURN AT SPECIFIED TIME
3 ☐ RETURN IF NEEDED, P.R.N.
4 ☐ TELEPHONE FOLLOW-UP PLANNED
5 ☐ REFERRED TO OTHER PHYSICIAN
6 ☐ RETURNED TO REFERRING PHYSICIAN
7 ☐ ADMIT TO HOSPITAL
8 ☐ OTHER (Specify) _____

14. DURATION OF THIS VISIT *[Time actually spent with physician]*
_____ MINUTES

15. IS THE REASON FOR THIS VISIT? *[Check one]*
1 ☐ ACCIDENTAL INJURY (Answer 16-19)
2 ☐ PRODUCT RELATED ILLNESS (Answer 16-19)
3 ☐ NEITHER OF THE ABOVE → STOP
(Go to next patient)

16. DESCRIBE ALL OBJECTS, PRODUCTS, OR SUBSTANCES INVOLVED IN THE ACCIDENT OR PRODUCT RELATED ILLNESS *[Be Specific]*

17. LOCATION OF ACCIDENT OR EXPOSURE TO PRODUCT *[Check One]*
1 ☐ PRIVATE RESIDENCE
2 ☐ ELSEWHERE (Specify) _____
3 ☐ UNKNOWN

18. WAS PATIENT AT WORK, JOB OR BUSINESS WHEN ACCIDENT OR EXPOSURE OCCURRED?
1 ☐ YES
2 ☐ NO
3 ☐ UNKNOWN

19. WAS PATIENT PREVIOUSLY TREATED FOR THIS CONDITION? *[Check all that apply]*
1 ☐ NO
2 ☐ YES - HOSPITAL EMERGENCY ROOM
3 ☐ YES - PRIVATE PHYSICIAN'S OFFICE
4 ☐ YES - PHYSICIAN ELSEWHERE (Specify) _____
5 ☐ YES - PLACE UNKNOWN
6 ☐ UNKNOWN

PHS 6105 D
Rev. 11/78

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
PUBLIC HEALTH SERVICE
NATIONAL CENTER FOR HEALTH STATISTICS

O.M.B. #68-R1498

Data Processing and Medical Coding.--In addition to the 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 7 (patient's reason for visit) of the Patient Record was coded according to a special classification system developed for that purpose.[2]

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.

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, 1979, 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 solely for the purpose of providing denominators for rate computations.

Estimation Procedures.--Statistics produced from the 1979 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 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.

Table II. Estimates of the civilian noninstitutionalized population of the United States,[1] by age, according to race and sex, geographic region, and metropolitan and nonmetropolitan area as of July 1, 1979

Race, sex, geographic region, and metropolitan and nonmetropolitan area	All ages	Age				
		Under 15 years	15-24 years	25-44 years	45-64 years	65+ years
Race and Sex		Number in thousands				
All races	214,393	49,801	39,821	58,259	43,240	23,273
Male	103,448	25,413	19,587	28,191	20,670	9,588
Female	110,945	24,388	20,234	30,068	22,570	13,685
White	185,233	41,091	33,838	50,747	38,523	21,033
Male	89,829	21,023	16,782	24,887	18,505	8,632
Female	95,404	20,068	17,056	25,860	20,018	12,401
All Other	29,160	8,710	5,983	7,512	4,716	2,239
Male	13,619	4,390	2,805	3,304	2,164	956
Female	15,541	4,320	3,178	4,208	2,552	1,283
Geographic region						
Northeast	47,417					
North Central	57,546					
South	70,881					
West	38,649					
Area						
Metropolitan	146,590					
Nonmetropolitan	67,803					

[1]Excludes Alaska and Hawaii

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.

Sampling Errors.--Procedures for calculating sampling errors as well as estimates of standard errors of statistics derived from the NAMCS are described in Appendix I of reference 6, as well as the Appendix of these documentation.

Patient Weight.--The "patient weight" is a vital component in the process of producing national estimates from sample data and its use should be clearly understood by all micro-data tape users. The statistics contained on the micro-data tape reflect data concerning only a sample of patient visits--and not a complete count of all the visits that occurred in the United States. The "patient weight" is an inflation factor assigned to each patient record. By aggregating the "patient weights" an estimated complete count or national estimate can be obtained.

Questions.--Questions concerning data in the tapes should be directed to Ambulatory Care Statistics Branch, Division of Health Resources Utilization Statistics, National Center for Health Statistics, Room 263, 3700 East-West Highway, Hyattsville, Maryland 20782. The telephone number is 301/436-7132.

References[1/]

NCHS published statistics from the NAMCS in Series 13 of VITAL AND HEALTH STATISTICS, PHS No. 1000, Public Health Service, Washington, U.S. Government Printing Office.

1.--National Center for Health Statistics: National Ambulatory Medical Care Survey: Background and Methodology, United States, VITAL AND HEALTH STATISTICS. Series 2-No. 61. DHEW Pub. No (HRA) 74-1335. Health Resources Administration. Washington. U.S. Government Printing Office. March 1974.

2.--National Center for Health Statistics: A Reason for Visit Classification for Ambulatory Care, United States. VITAL AND HEALTH STATISTICS. Series 2-No. 78. DHEW Pub. No. (PHS) 79-1352. Public Health Service. Hyattsville, Maryland. U.S. Government Printing Office, February 1979.

3.--National Center for Health Statistics: The National Ambulatory Medical Care Survey: Symptom Classification, United States, VITAL AND HEALTH STATISTICS. Series 2-No. 63. DHEW Pub. No. (HRA) 74-1337. Health Resources Administration. Washington. U.S. Government Printing Office, May 1974.

4.--National Center for Health Statistics: Ninth Revision International Classification of Diseases, Adapted for Use in the United States (ICDA). PHS Pub. No 1693. Public Health Service. Washington. U.S. Government Printing Office, 1967.

5.--National Ambulatory Medical Care Survey: 1977 Medical Coding Manual.

6.--National Center for Health Statistics: 1979 Summary: National Ambulatory Medical Care Survey, United States. Advance Data from Vital and Health Statistics, No 66. DHEW Publication No. (PHS) 81-1250. Public Health Service. Hyattsville, Maryland

7.--Induction Interview Form. National Ambulatory Medical Care Survey. National Opinion Research Center. University of Chicago. OMB No. 068-572106.

[1/] Information concerning other reports to be written on 1979 data may be obtained from the Ambulatory Care Statistics Branch.

II. Technical Description of Tapes

Date Set Name:	NAMC1979
Number of Reels	1
Number of Recording Tracks:	9
Density (bpi):	1600
Language	EBEDIC
Parity:	ODD
Record Length:	99
Blocksize:	9900
Number of Records:	45,351
Computer Compatibility:	IBM 360 or 370

III. TAPE RECORD FORMAT

This section consists of a detailed breakdown of each tape record, providing a brief description of each item of data included in the records. The data are arranged sequentially according to their physical location on the tape record. Unless otherwise stated in the "Item description" column, the data are derived from the patient record (page 9). The AMA and the induction interview (reference 7) are alternate sources of data, while the computer generates other items by recoding selected data items.

Item No.	Field Length	Tape Location	Item Description and Codes
1	4	1-4	Date of visit
1.1	2	1-2	Month of visit 01-12: January-December
1.2	2	3-4	Year of visit Last 2 digits of year
2	4	5-8	Date of birth
2.1	2	5-6	Month of birth 01-12: January-December
2.2	2	7-8	Year of birth Last 2 digits of year
3	1	9	Sex 1=Female 2=Male
4	1	10	Race 1=White 2=Black 3=Asian/Pacific Islander 4=American Indian/Alaskan Native
5	1	11	Ethnicity 1=Hispanic Origin 2=Not hispanic
6	1	12	Patient Referred by Another Physician 1=Yes 2=No
7	15	13-27	Patient Reason for Visit (See Page 19)
7.1	5	13-17	Most important problem #1
7.2	5	18-22	Most important problem #2 (if any reported)
7.3	5	23-27	Other problem

Item No.	Field Length	Tape Location	Item Description and Codes
8	1	28	Major reason for this visit 1=Acute problem 2=Chronic problem, routine 3=Chronic problem, flareup 4=post surgery/post injury 5=non-illness care (routine prenatal, general exam, well baby, etc.)
9	18	29-46	Physician's principal diagnosis (See notes on Page 19.)
9.1	6	29-34	First diagnosis associated with item 6a
9.2	6	35-40	Second Diagnosis associated with item 6a (if any
9.3	6	41-46	Other significant current diagnosis reported)
10	2	47-48	Ever seen patient before
10.1	1	47	1=yes 2=no
10.2	1	48	If yes, for the condition in item 8a? 0=blank 1=yes 2=no
11	12	49-60	Diagnostic services this visit
11.1	1	49	None (1=yes and 0=no)
11.2	1	50	Limited history/exam "
11.3	1	51	General history/exam "
11.4	1	52	Pap test "
11.5	1	53	Clinical lab. test "
11.6	1	54	X-ray "
11.7	1	55	Blood pressure check "
11.8	1	56	EKG "
11.9	1	57	Vision test "
11.10	1	58	Endoscopy "
11.11	1	59	Mental status exam "
11.12	1	60	Other "
12	12	61-72	Therapeutic services this visit
12.1	1	61	None (1=yes and 0=no)
12.2	1	62	Drug (prescription) "
12.3	1	63	Drug (nonprescription) "
12.4	1	64	Injection "
12.5	1	65	Immunization/desensitization "
12.6	1	66	Diet Counseling "
12.7	1	67	Family planning "
12.8	1	68	Medical counseling "
12.9	1	69	Physiotherapy "
12.10	1	70	Office surgery "
12.11	1	71	Psychotherapy/therapeutic listening "
12.12	1	72	Other "

Item No.	Field Length	Tape Location	Item Description and Codes
13	8	73-80	Disposition of visit
13.1	1	73	No follow-up planned (1=yes and 0=no)
13.2	1	74	Return at specified time "
13.3	1	75	Return if needed "
13.4	1	76	Telephone follow-up "
13.5	1	77	Referral "
13.6	1	78	Return to referring physician "
13.7	1	79	Admit to hospital "
13.8	1	80	Other "
14	3	81-83	Duration of visit in minutes (000-999)
15	10	84-93	Patient Weight A right justified, alphanumeric integer developed by the NAMCS staff for the purpose of producing national estimates from sample estimates. See notes on page 12 of these documentation.
16	1	94	Geographic Region (Based on actual location of physician's practice.) 1=Northeast 2=North Central 3=South 4=West
17	1	95	Metropolitan/Nonmetropolitan (Based on actual location in conjunction with the definition of the Bureau of the Census and the U.S. Office of Management and Budget. 01=Standard Metropolitan Statistical Area (SMSA) 02=Non-SMSA
18	3	96-98	Physician Specialty (Derived from Induction Interview - reference 7) NOTE: See "List of Designated Specialty Codes" on page 18 of these documentation.
19	1	99	Type of practice (Derived from Induction Interview-see reference 7) 1=solo 2=partnership 3=group 4=other

List of Designated Specialty Codes

AM	Aerospace Medicine
A	Allergy
*AN	Anesthesiology
BE	Broncho-Esophagology
CD	Cardiovascular Diseases
D	Dermatology
DIA	Diabetes
END	Endocrinology
FP	Family Practice
GE	Gastroenterology
GP	General Practice
GPM	General Preventive Medicine
GER	Geriatrics
GYN	Gynecology
HEM	Hematology
HYP	Hypnosis
ID	Infectious Diseases
IM	Internal Medicine
LAR	Laryngology
LM	Legal Medicine
ND	Neoplastic Diseases
NEP	Nephrology
N	Neurology
CHN	Neurology, Child
*NM	Nuclear Medicine
NTR	Nutrition
OBS	Obstetrics
OBG	Obstetrics and Gynecology
OM	Occupational Medicine
OPH	Ophthalmology
OT	Otology
OTO	Otorhinolaryngology
*PTH	Pathology
*CLP	Pathology, Clinical
*FOP	Pathology, Forensic
PD	Pediatrics
PDA	Pediatrics, Allergy
PDC	Pediatrics, Cardiology
PA	Pharmacology, Clinical
PM	Physical Medicine and Rehabilitation
P	Psychiatry
CHP	Psychiatry, Child
PYA	Psychoanalysis
PYM	Psychosomatic Medicine
PH	Public Health
PUD	Pulmonary Diseases
*R	Radiology
*DR	Radiology, Diagnostic
*PDR	Radiology, Pediatric
*TR	Radiology, Therapeutic
RHU	Rheumatology
RHI	Rhinology
ABS	Surgery, Abdominal
CDS	Surgery, Cardiovascular
CRS	Surgery, Colon and Rectal
GS	Surgery, General
HS	Surgery, Hand
HNS	Surgery, Head and Neck
NS	Surgery, Neurological
ORS	Surgery, Orthopedic
PDS	Surgery, Pediatric
PS	Surgery, Plastic
TS	Surgery, Thoracic
TRS	Surgery, Traumatic
U	Surgery, Urological

In addition to the above specialties the following designations are also used:

OS	Other, i.e., physician designated a specialty other than those appearing above.
US	Unspecified, i.e., physician did not specify a specialty.
EM	Emergency Medicine

* Excluded from NAMCS by definition.

IV. 1979 MARGINALS

Any cell with an estimate of 348,000 visits or less has a relative standard error of 30-percent or more; therefore, it is considered an unreliable statistic, according to the standards of reliability of the National Center for Health Statistics.

For tabulations involving principal diagnoses (coded according to the ICD-9-CM[4/] the following characteristics exist:

1 - The prefix "1" preceding the 3-digit diagnostic codes represents diagnoses 001-999, e.g. '1381'='381'=otitis media.

2 - The prefix "2" preceding the 3-digit diagnostic codes represents V code diagnoses V01-V82, e.g., '2010'='V10'=medical or surgical aftercare. In other words, eliminate the prefix "2" and change the first "0" to V.

3 - The diagnostic code '2099'=V99=the sum of the following: diagnosis given as "none", noncodable diagnosis, illegible diagnosis; and unsuitable diagnosis (see page 6 of these documentation).

For tabulations involving principal reasons for visit (coded according to A Reason for Visit Classification for Ambulatory Care (RVC)[2/]), the digits 1 through 8 preceding the 3-digit RVC codes represent the various modules of the RVC according to the following:

"1" = symptom module, e.g., '1010'=S010=fever

"2" = disease module, e.g., '2205'=D205=diabetes mellitus

"3" = diagnostic, screening, and preventive module, e.g., '3100'= X100 = general medical exam

"4" = treatment module, e.g., '4110'=T110=injections

"5" = injuries and adverse effects module, '5020'=J020=fracture and dislocation of leg

"6" = test results module, e.g., '6100' = R100 = results of blood glucose test

"7" = administrative module, e.g., '7100' = A100 = physical examination required for employment

"8" = Uncodeable entries, e.g., '8997' = U997 = entry of "none" or no complaint

"0" = special code=blank

KEY

ROW 01 = Unweighted frequency

ROW 02 = Weighted frequency*

ROW 03 = Column percent

ROW 04 = Row percent

* See notes on "patient weight" on page 12 of these documentation.

	ALL	UNDER15	15-24	25-44	45-64	65+
PATIENT AGE	45351	7821	6417	12950	10772	7391
	556313431	101352298	82289782	151713912	128594299	92363140
	100.00	100.00	100.00	100.00	100.00	100.00
	100.00	18.22	14.79	27.27	23.12	16.60

	ALL	F	M
PATIENT SEX	45351	27089	18262
	556313431	337095808	219217623
	100.00	100.00	100.00
	100.00	60.59	39.41

	ALL	WHITE	BLACK	ASIAN ILANDER	INDIAN ALASKAN
RACE	45351	41211	3610	442	88
	556313431	502526839	46789200	5559524	1037868
	100.00	100.00	100.00	100.00	100.00
	100.00	90.40	8.41	1.00	0.19

	ALL	HISPAN	NOT HISPAN
ETHNICITY	45351	2007	43344
	556313431	26730560	529582871
	100.00	100.00	100.00
	100.00	4.80	95.20

	ALL	YES	NO
PATIENT REFERRAL STATUS	45351	2169	43182
	556313431	22413164	533900267
	100.00	100.00	100.00
	100.00	4.03	95.97

	ALL	SYMPTOM MODULE	DISEASE MODULE	DIAG SCREEN PREVEN	TREAT-MENT MODULE	INJURY ADVERSE EFFECTS
GEN RFV-7	45351	25209	3390	7802	5439	1663
MODULES	556313431	308588203	42748059	101202716	58711746	22472563
	100.00	100.00	100.00	100.00	100.00	100.00
	100.00	55.47	7.68	18.19	10.55	4.04

	TEST RESULTS MODULE	ADMIN MODULE	UNCODE-ABLE
	254	673	731
	3366612	9154070	8568184
	100.00	100.00	100.00
	0.61	1.65	1.54

	ALL	ACUTE PROB	CHRONIC PROB ROUTINE	CHRONIC PROB FLAREUP	POST SURGERY INJURY	NON ILLNESS CARE
MAJOR REASON FOR VISIT	45351	15367	14038	4181	4456	7309
	556313431	200011667	160603104	48310006	51240630	96148024
	100.00	100.00	100.00	100.00	100.00	100.00
	100.00	35.95	28.87	8.68	9.21	17.28

	ALL	INF-PAR DIS	NEOPLSM	ENDO NUTR MET	MENTAL DISORDR	DIS NERV SYSTEM
MAJOR ICDA CLASSES	45351	1407	1312	1774	3964	3963
	556313431	19710523	14205120	22855954	24579636	50559649
	100.00	100.00	100.00	100.00	100.00	100.00
	100.00	3.54	2.55	4.11	4.42	9.09

	DIS CIRC SYSTEM	DIS RESP SYSTEM	DIS DIGEST SYSTEM	DIS GENITO SYSTEM	SKIN DIS	DIS MUSKETL SYSTEM
	3999	5415	2081	3014	2011	2837
	45606605	73433128	24711109	36632101	29131571	37004262
	100.00	100.00	100.00	100.00	100.00	100.00
	8.92	13.20	4.44	6.58	5.24	6.65

	SYMPTOM	ACCENT	SPECL COND	OTHER	DX NONE	DX UNK
	1461	3934	6783	653	218	525
	17251162	51782107	87903377	8160532	2606688	6179508
	100.00	100.00	100.00	100.00	100.00	100.00
	3.10	9.31	15.80	1.47	0.47	1.11

STATUS OF VISIT	ALL	NEW PT	OLD PT NEWPROB	OLD PT OLDPROB
	45351	7520	9339	28492
	556313431	88135652	125647282	342530497
	100.00	100.00	100.00	100.00
	100.00	15.84	22.55	61.57

DIAG SERVICES	ALL	NONE	LIMITED EXAM	GEN EXAM	PAP TEST	CLIN LAB TEST
	45351	5585	27460	7718	2167	10182
	556313431	56622265	350636532	93358322	27414443	129187284
	100.00	100.00	100.00	100.00	100.00	100.00
	100.00	10.18	63.03	16.78	4.93	23.22

	X-RAY	BLOOD PRES CK	EKG	VISION TEST	ENDOS COPY
	3654	15279	1364	2533	567
	45845882	200501180	15223437	33450547	7334935
	100.00	100.00	100.00	100.00	100.00
	8.24	36.04	2.74	6.01	1.32

	MENTAL STATUS EXAM	OTHER DIAG
		1634
	1235	19615526
	8261427	100.00
	100.00	3.53
	1.49	

THER SERVICES	ALL	NONE	DRUGS PRESCRP	DRUGS NON PRESCRP	INJECTN	IMMUNIZ DESEN
	45351	8934	20119	1964	3500	2111
	556313431	110020596	260331651	24740434	53326995	28848513
	100.00	100.00	100.00	100.00	100.00	100.00
	100.00	19.78	46.80	4.45	9.59	5.19

	DIET COUNSEL	FAMILY PLAN	MED COUNSEL	PHYSIOT	OFFICE SURG
	2633	581	10306	1261	3218
	33154290	7943016	123681992	17083568	40989168
	100.00	100.00	100.00	100.00	100.00
	5.96	1.43	22.23	3.07	7.37

	PSYCHOT THER LISTEN	OTHER THER
	4072	1493
	24719419	19215448
	100.00	100.00
	4.44	3.45

	ALL	NO FOLLOW	RETURN SPEC TIME	RETURN IF NEEDED	TEL FOLLOW	REFER
DISPOSITION	45351	4941	28335	9103	1935	1152
	556313431	64685735	344029271	114068968	21194361	13797032
	100.00	100.00	100.00	100.00	100.00	100.00
	100.00	11.63	61.84	20.50	3.81	2.48

	RETURN	ADMIT HOSP	OTHER
	405	1028	382
	3561480	11431485	3763991
	100.00	100.00	100.00
	0.64	2.05	0.68

	ALL	ZERO	1-5	6-10	11-15	16-30
DURATION OF VISIT	45351	1445	4515	11762	12103	10660
	556313431	18996897	67609996	169216946	149291263	118171454
	100.00	100.00	100.00	100.00	100.00	100.00
	100.00	3.41	12.15	30.42	26.84	21.24

	31-60	60+
	4555	311
	30511706	2515179
	100.00	100.00
	5.48	0.45

	ALL	MD	DO
MD VS DO	45351	43202	2149
	556313431	524585490	31727941
	100.00	100.00	100.00
	100.00	94.30	5.70

	ALL	SOLO	PARTNER	GROUP
TYPE OF PRAC	45351	26614	8695	10042
	556313431	315389513	114786808	126137110
	100.00	100.00	100.00	100.00
	100.00	56.69	20.63	22.67

	ALL	METRO	NON METRO
METRO NONMETRO	45351	34933	10418
	556313431	408567465	147745966
	100.00	100.00	100.00
	100.00	73.44	26.56

	ALL	NE	NC	S	W
GEOG REGION	45351	12064	10033	14273	8981
	556313431	133695965	129979331	178529804	114108331
	100.00	100.00	100.00	100.00	100.00
	100.00	24.03	23.36	32.09	20.51

ALL

ALL SPECIALTIES	A	CD	D	GE	GP
45351	430	837	911	457	12005
556313431	7626006	7485641	17535535	3547912	190193914
100.00	100.00	100.00	100.00	100.00	100.00
100.00	1.37	1.35	3.15	0.64	34.19

GYN	HEM	IM	N	OBG	OH
74	47	5933	358	3929	22
709404	480156	66908253	1874144	50113908	448822
100.00	100.00	100.00	100.00	100.00	100.00
0.13	0.09	12.03	0.34	9.01	0.08

OPH	OTO	PD	PDA	PDC	PM
2347	750	4500	257	71	161
30433232	9864436	53536069	3616878	972793	1985812
100.00	100.00	100.00	100.00	100.00	100.00
5.48	1.77	9.62	0.65	0.17	0.36

P	CHP	PUD	CRS	GS	NS
3158	308	338	105	3476	366
15748262	1344250	2399995	671182	33740031	3113984
100.00	100.00	100.00	100.00	100.00	100.00
2.83	0.24	0.43	0.12	6.06	0.56

ORS	PS	TS	U	OS	US
2227	357	77	1115	258	464
31080695	3592906	486110	9600989	2392137	4667374
100.00	100.00	100.00	100.00	100.00	100.00
5.59	0.65	0.09	1.73	0.43	0.84

EM
13
92001
100.00
0.02

1979 NAMCS MICRO-DATA TAPE DOCUMENTATION

APPENDIX

Sample Errors and Rounding of Numbers

The standard error is primarily a measure of the sampling variability that occurs by chance because only a sample, rather than the entire universe, is surveyed. The relative standard error of an estimate is obtained by dividing the standard error of the estimate by the estimate itself and is expressed as a percentage of the estimate. Relative standard errors of selected aggregate statistics are shown in tables I and II. The standard errors for estimated percentages of visits are shown in tables III and IV.

Table I. Approximate relative standard errors of estimated number of office visits based on all physician specialties: NAMCS, 1979

Estimated number of office visits in thousands	Relative standard error in percent
500	25.1
1,000	17.9
2,000	12.9
5,000	8.6
10,000	6.6
20,000	5.3
50,000	4.3
100,000	3.9
500,000	3.6

Example of use of table: An aggregate of 75,000,000 visits has a relative standard error of 4.1 percent or a standard error of 3,075,000 visits (4.1 percent of 75,000,0000).

Table II. Approximate relative standard errors of estimated number of office visits based on an individual physician specialty: NAMCS, 1979

Estimated number of office visits in thousands	Relative standard error in percent
500	27.6
1,000	20.1
2,000	15.0
5,000	10.8
10,000	9.0
20,000	8.0
50,000	7.3
100,000	7.0
200,000	6.9

Example of use of table: An aggregate of 15,000,000 visits has a relative standard error of 8.3 percent or a standard error of 1,245,000 visits (8.3 percent of 15,000,000).

Table III. Approximate standard errors of percent of estimated numbers of office visits based on all physician, specialties: NAMCS, 1979

Base of percent (number of office visits in thousands)	Estimated percent					
	1 or 99	5 or 95	10 or 90	20 or 80	30 or 70	50
	Standard error in percentage points					
500	2.5	5.4	7.5	10.0	11.4	12.4
1,000	1.8	3.8	5.3	7.0	8.1	8.8
2,000	1.2	2.7	3.7	5.0	5.7	6.2
5,000	0.8	1.7	2.4	3.1	3.6	3.9
10,000	0.6	1.2	1.7	2.2	2.5	2.8
20,000	0.4	0.9	1.2	1.6	1.8	2.0
50,000	0.2	0.5	0.7	1.0	1.1	1.2
100,000	0.2	0.4	0.5	0.7	0.8	0.9
500,000	0.1	0.2	0.2	0.3	0.4	0.4

Example of use of table: An estimate of 30 percent based on an aggregate of 15,000,000 visits has a standard error of 2.1 percent or a relative standard error of 7.0 percent (2.1 percent ÷ 30 percent).

Table IV. Approximate standard errors of percent of estimated numbers of office visits based on an individual physician specialty: NAMCS, 1979

Base of percent (number of office visits in thousands)	Estimated Percent					
	1 or 99	5 or 95	10 or 90	20 or 80	30 or 70	50
	Standard error in percentage points					
500	2.7	5.8	8.0	10.7	12.3	13.4
1,000	1.7	4.1	5.7	7.6	8.7	9.5
2,000	1.3	2.9	4.0	5.4	6.1	6.7
5,000	0.8	1.8	2.5	3.4	3.9	4.2
10,000	0.6	1.3	1.8	2.4	2.7	3.0
20,000	0.4	0.9	1.3	1.7	1.9	2.1
50,000	0.3	0.6	0.8	1.1	1.2	1.3
100,000	0.2	0.4	0.6	0.8	0.9	0.9
200,000	0.1	0.3	0.4	0.5	0.6	0.7

Example of use of table: An estimate of 90 percent based on an aggregate of 7,500,000 visits has a standard error of 2.1 percent, or a relative standard error of 2.3 percent (2.1 percent ÷ 90 percent).

APPENDIX

Definitions of Certain Terms Used in this Document.

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.

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

Ambulatory patient.--An individual presenting for personal health services, neither bedridden nor currently admitted to any health care institution on the premises.

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 doctor has a *private* office (which fits definition of "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 any 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.

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 VA, 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).

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 AMA or AOA.

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:

Region	States Included
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, and the Bureau of the Census.

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.

1979 NAMCS USER QUESTIONNAIRE

In order to improve the NCHS Micro-Data Tape Release program, we would appreciate your assistance in regard to the following questionnaire.

Name: _____
Title: _____
Organization: _____
Address: _____
_____
Date of tape purchase: _____
Type of organization (university, insurance, etc.): _____

1. Have you used this tape? (If not, please indicate why.)

2. Did you have any computer problems using the data?

3. Did you have any analytic problems with the data?

4. What output was produced using the tape?

5. How was this output used?

6. How was the overall quality of the documentation?

7. Did you find the explanation of the survey helpful? Was it clear, concise, etc.?

8. Was the description of the tape record format easy to use? Were the item descriptions understandable? Did you find any errors?

9. Do you have any other comments or complaints?

Return this questionnaire to the address on back. Please feel free to include additional comments. Thank you very much for your assistance.

fold here

ASSOCIATE DIRECTOR
DIVISION OF OPERATIONS
NATIONAL CENTER FOR HEALTH STATISTICS
3700 EAST-WEST HIGHWAY
HYATTSVILLE, MD 20782

fold here