

Office Visits by Women
The National Ambulatory
Medical Care Survey
United States, 1977

Statistics obtained from a national probability sample of office-based physicians are presented on the utilization of ambulatory care by women 15 years and over. Visits are described in terms of patient age, sex, and race, patient condition, and management of the patients' problems. Selected comparisons are made with similar data on visits made by men. Family planning visits by women aged 15-44 years are described according to patient characteristics, reason for visit, and services rendered.

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OFFICE VISITS BY WOMEN

THE NATIONAL AMBULATORY MEDICAL CARE SURVEY

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INTRODUCTION

Background

The need for research on women's health was documented in the proceedings of a conference sponsored by the National Center for Health Services Research in 1975.¹ A wide variety of concerns for women's health issues were discussed. About 79 percent of women in the civilian noninstitutionalized population of the United States saw a physician at least once during 1977,² therefore, basic data concerning physician services used by women are fundamental to research designed to address many of these concerns.

This report presents national estimates of the number and characteristics of visits to office-based, nonfederally employed physicians by women aged 15 years and older during 1977. These statistics represent an objective set of data on physician utilization. This report is not intended to provide answers to the many questions raised about women in the health care system, but in some instances the dispassionate nature of the estimates reveal relationships (or lack of relationships) among variables that are often hypothesized in research projects.

The patently different physiology of women and men affects their use of medical practitioners and thus precludes certain comparisons between them. However, this report does include data for men's visits where comparisons by the patient's sex are a logical consequence of presenting the data for women's visits. For example, if the data show that women tend to

visit physicians proportionately more often for care of one non-sex-related condition than for another, it seems appropriate to consider whether men exhibit a similar health care seeking pattern.

The data were collected in the National Ambulatory Medical Care Survey which is a sample survey conducted yearly by the Division of Health Resources Utilization Statistics of the National Center for Health Statistics. Detailed information regarding the background and methodology of the survey were published in *Vital and Health Statistics*, Series 2, No. 61.³ Summary data for 1977 were published in *Advance Data from Vital and Health Statistics*, No. 48,⁴ and again with greater detail in *Vital and Health Statistics*, Series 13, No. 44.⁵

Data collection and processing for the 1977 National Ambulatory Medical Care Survey were the responsibility of the University of Chicago's National Opinion Research Center. Sample selection was accomplished with the assistance of the American Medical Association and American Osteopathic Association.

Scope of the Survey

The basic sampling unit for the National Ambulatory Medical Care Survey was the physician-patient encounter or visit. The current scope of the NAMCS includes all office visits within the conterminous United States made by ambulatory patients to nonfederally employed office-based physicians as classified by the American Medical Association or the American Osteopathic Association. The NAMCS physician

universe excluded physicians practicing in Alaska and Hawaii and anesthesiologists, pathologists, and radiologists. Visits to physicians principally engaged in teaching, research, or administration; telephone contacts; and visits conducted outside the physician's office were also excluded.

The definitions for office, physician, patient, and visit used to determine eligibility for the National Ambulatory Medical Care Survey are presented in appendix II.

Source and Limitations of the Data

The estimates in this report are based on information obtained from Patient Records (see appendix III) for a sample of visits provided by a national probability sample of office-based physicians. The sample for the 1977 National Ambulatory Medical Care Survey included 3,000 physicians, 507 of whom were not eligible (out of scope) at the time of the survey. Of the 2,493 physicians who were eligible, 1,932 (77.5 percent) actually participated (see appendix I).

Sample physicians listed all office visits during a randomly assigned 7-day reporting period. Information was recorded on the Patient Record, or encounter form, which supplied data on a systematic random sample of 26,553 visits by women aged 15 years and older and 16,137 visits by men of the same age.

Readers are urged to review the appendixes to this report as information provided is necessary for proper understanding and interpretation of the statistics presented. Appendix I contains a general description of the survey methods, the sample design, and the data collection and processing procedures. Methods of estimation and imputation are also presented. The statistics in this report are based on a sample of office visits rather than on all visits and are subject to sampling errors. Therefore, particular attention should be paid to the "Reliability of Estimates" section in appendix I. Charts of relative standard errors and instruction for their use are also given 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, such as the introductory letter, the Patient Record

and Induction Interview forms, are furnished in appendix III.

By means of another program of the NCHS, The Health Interview Survey (HIS) data were collected on the utilization of physician services through a household interview survey. These estimates may differ from those in the National Ambulatory Medical Care Survey because of differences in the collection procedures, population sampled, and definitions. The Health Interview Survey are published in Series 10 of *Vital and Health Statistics*.

PATIENT CHARACTERISTICS

During 1977 an estimated 295 million visits to office-based physicians were made by women aged 15 years and older, which is an average of 3.5 visits per person per year (table 1). About 9 out of 10 visits were made by white women; 1 visit in 10 was made by women of black and other races. The visit rate for white women (3.6) exceeded that for women of all other races (2.7).

This rate increased with the advancing age of the patient. Women aged 65 years and older visited at the highest rate (4.4 visits per person per year). This proportion reflected the high rate of return visits for elderly women with chronic diseases (table 12).

Table A shows that the median visit age^a of white women (37.0 years) was higher than that of black and all other women (33.1 years), but that it did not differ significantly from that of white men (36.7 years).

Women visited at a higher rate than did men aged 15 years and older (the rate for men was 2.3 per person per year); rates were higher for women than for men regardless of age (not shown in table A).

Data on visits by men and other demographic information are found in the 1977 National Ambulatory Medical Care Survey summary.⁵ Demographic data on visits according to

^aMedian *visit* age should not be confused with median *patient* age. The median visit age is based on initial and return visits some of which can be by the same patient. Calculation of median visit age includes visits by patients under age 15 years.

Table A. Median visit age and standard error of the median in years, by sex and race of patient: United States, 1977

Sex and race of patient	Median visit age ¹	Standard error of the median
All visits	36.28	0.38
Female.....	36.42	0.32
White.....	37.00	0.56
Black and all other	33.11	1.12
Male.....	36.09	0.54
White.....	36.73	0.57
Black and all other	30.86	1.40

¹Includes visits by patients under 15 years.

the location of the physician's practice can also be found in the same report.

PATIENT CONDITION

Principal Reason for Visit

Information obtained from item 6 of the Patient Record represents a literal record of the patients' reasons for visiting physicians' offices. These data have been classified and coded according to *A Reason for Visit Classification for Ambulatory Care (RVC)*, which has been published in Series 2 of *Vital and Health Statistics*.⁶ The RVC was not used prior to 1977; the *National Ambulatory Medical Care Survey Symptom Classification*⁷ was used instead to code these data. Therefore previous data on the reasons for women's visits to physicians are not comparable to data in this report.

The RVC uses a modular structure with the basic categorizations of patients' reasons for visits represented by the following seven modules: (1) symptom; (2) disease; (3) diagnostic, screening, and preventive care; (4) treatment; (5) injuries and adverse effects; (6) test results; and (7) administrative.

The RVC⁶ contains a more complete description of the various modules, their development, and application.

The expressed reason for the visit, which in the physician's judgment was most responsible

for the visit, was entered on the Patient Record as the *principal* (first-listed) reason. The physician also listed additional reasons that are not as important as the principal reason.

Women visited physicians for a broad spectrum of reasons. The 57 reasons shown in table 2 accounted for 67 percent of their total visits. Routine prenatal examinations and gynecological examinations primarily account for 10 percent of all reasons. When these visits are added to visits for blood pressure tests (3 percent), general medical examinations (about 3 percent), family planning, not otherwise specified, and contraceptive device (1 percent), and Pap smears (about 1 percent), at least 18 percent of women's visits were shown to be for preventive care. All of the separate reasons in the family planning category are not included in table 2. However, family planning is discussed in greater detail in a later section of this report.

Principal Reason for Visit and Age of the Patient

The order and kind of the principal reasons given for women's visits change when listed by the patient's age. Table 3 shows 20 reasons most frequently expressed by patients in each of the four age groups. Prenatal and postpartum examinations, listed among the leading reasons given by patients aged 15-44 years, are understandably not among the reasons shown for older patients. On the other hand, hypertension and diabetes mellitus are prominent on the list for women aged 45 years and older, but not for those less than age 45.

Hypertension, arthritis, heart examination, general weakness, and shortness of breath are among those reasons given by patients aged 65 years and older and reflect the gerontological conditions generally associated with women.

Request for a blood pressure check ranks first among reasons given by women aged 45 years and older and accounts for 5 percent of all visits by women aged 45-64 and 7 percent of those by women aged 65 and older, which correlates with increased hypertension rates for women of that age.

Gynecological examination is included among the leading reasons for visits for all age

groups. Figure 1 illustrates the annual rate of gynecological examination visits by the patient's age.

A Pap smear ceases to be a leading reason for a visit after age 44 years. In an estimated 3.7 million visits, Pap smear was given as a principal reason for the visit. However more than 30 million visits included a Pap test as a *diagnostic service* (regardless of the patient's reason for visit). The latter visits are discussed in a later section of this report. However, the reason for the visit shows the *intent* of women regarding preventive care. The age curve in figure 2 illustrates the annual visit rate in which Pap smear was one of the reasons for the visit. For this

plot, rates were based on the number of visits in which the test was listed on the survey form either as the principal reason *or* as an additional reason. The latter were included because patients may have also requested a Pap smear during visits for other principal reasons, and those visits are also a rough measure of the patient's intent regarding health care. Visit rates for Pap tests declined after age 34, which corresponds to the decreasing rates of childbearing, and suggests that women tend to neglect this test when gynecological and pregnancy examinations are no longer routine.

Principal Reason for Visit and Race of Patient

The principal reasons for visits by the patient's race are listed in table 4 according to the subgroups of the RVC modules, that is, the seven modules are categorized at the "upper level" of specificity (see reference 6, p. 6). Proportions of visits did not vary appreciably by race except for symptoms referable to the eyes and ears where proportions of visits by white women were significantly higher than those of women of all other races.

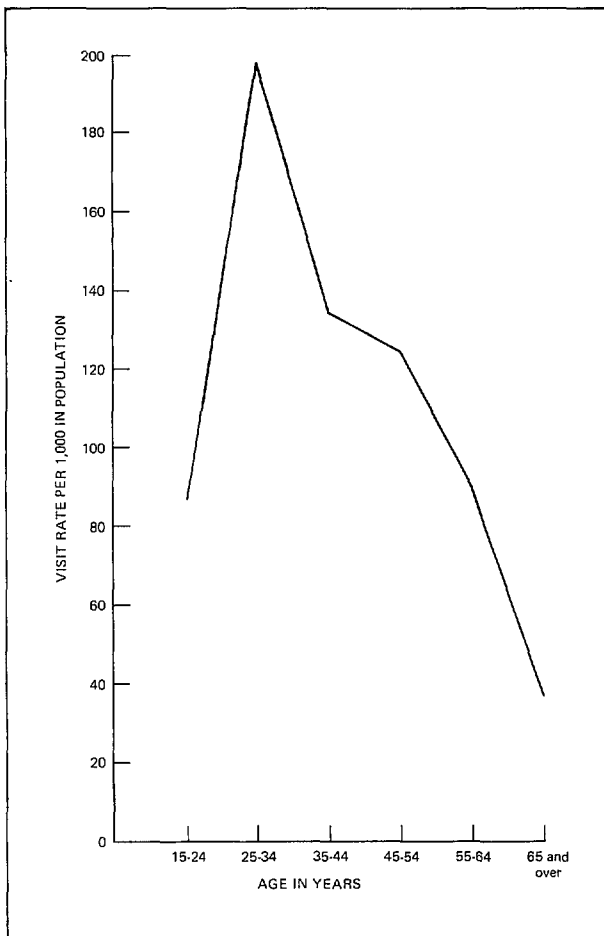


Figure 1. Annual rate of office visits with patient's principal reason for visit gynecological examination, by age of patient: United States, 1977

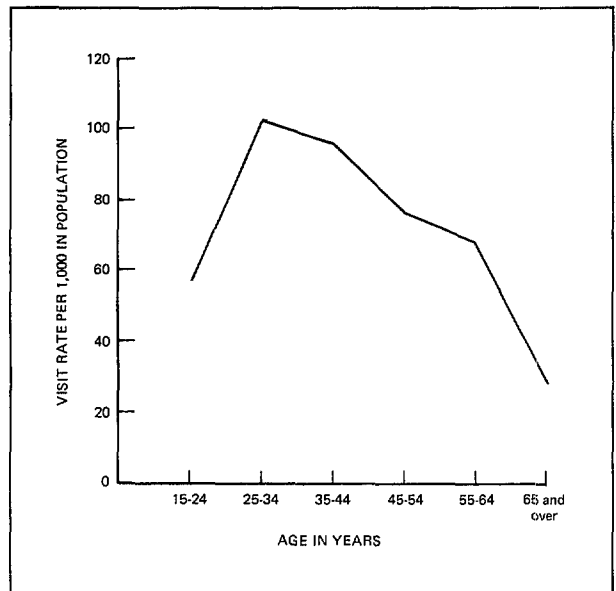


Figure 2. Annual rate of office visits with Pap smear as one of the reasons for visit, by age of patient: United States, 1977

Principal Reason for Visit and Sex of the Patient

The symptom module of the RVC accounted for about 69 percent of all reasons for visits by both sexes aged 15 years and over (table B). Women visited physicians more frequently for diagnostic, screening, and preventive care than men did, chiefly for prenatal and gynecological examinations and for family planning. A larger percent of visits by men were classified in the injuries and adverse effects group than were those by women. Examinations for employment, licenses, and insurance (not shown in table B) contributed to the higher proportion of administrative reasons given by men than by women, a fact that reflects the composition of the work force.

Principal Reason for Visit and Time Since Onset of Complaint or Symptom

One indicator of health care attitudes is the relative amount of time that elapses between the onset of a complaint or symptom and the visit to the physician. However, this period can often be influenced by factors not under the patient's control. Availability of a particular specialist, scheduling, transportation, patient perception of certain symptoms as inevitable, economics, or

other problems may contribute to postponement.

To estimate how long women waited before seeing the physician, new problem visits were separated from return visits. New problem visits were either initial visits or visits by patients that the physician had previously seen for a different problem.

The number of new problem visits (according to the subgroup classification in the symptom module) is itemized by the time since onset of the symptom in table 5. Predictably, patients with acute conditions, chiefly respiratory complaints, were more likely to visit the physician within 1 week of symptom onset than those with other symptoms were.

Table 6 shows the number of visits for selected specific reasons and their proportion according to the time since onset of symptom. This table clearly shows that patients with problems, which are generally acute, such as a head cold, sore throat, and cough, were more likely to visit their physicians within a week than they were to wait longer.

If the new problem visit for a prenatal examination was the patient's first visit for suspected pregnancy, then 69 percent of the women waited at least a month before making a medical visit, which is not unusual. The data also indicate that the time of the first visit since

Table B. Percent distribution of office visits made by patients 15 years and over by principal reason for visit module, according to sex of patient: United States, 1977

Reason for visit module and RVC code ¹	Sex of patient	
	Female	Male
	Percent distribution	
Total	100.0	100.0
Symptom module	69.6	69.0
Disease module	5.1	5.8
Diagnostic, screening and preventive module	15.2	5.9
Treatment module	2.9	2.6
Injuries and adverse effects module	3.7	9.2
Test results module	0.6	0.3
Administrative module	2.1	6.4
Other and uncodable entries	0.8	0.8

¹Reason for visit codes are based on *A Reason for Visit Classification for Ambulatory Care (RVC)*.

onset of pregnancy for 34 percent of the 3.3 million visits was *more* than 3 months. (These and other data are taken from source materials and are not shown in tables or charts.)

Table 7 shows the time since onset of the symptom or complaint by the patient's age. The highest proportions of new problem visits for all ages fell in the time frame of 1-6 days. (Examination of the source data revealed a similar pattern for men's visits.)

Principal Reason for Visit and Physician Specialty

About 40 percent of women's visits to physicians were to general and family practitioners (GFP's), 17 percent were to obstetrician-gynecologists (OBG's), and 13 percent were to internists. These three specialties accounted for about 70 percent of the total number of visits (table 8). White women were more likely to visit psychiatrists than black women and other women were, but additional differences in the utilization of various specialties by women of different races were not statistically significant.

Examination of the data on the most common symptoms and complaints by women to the three most frequently visited specialties is instructive. Data analysis focused on new prob-

lems as an indication of how a woman selects her physician when faced with a new condition. The data in table C provide a contrast between the GFP and internist group and the OBG group. The OBG's treated 41 percent of patients who presented symptoms referable to the genitourinary system. About the same proportion of such symptoms were seen by GFP's and internists. GFP's and internists, who together accounted for the majority of women's visits (about 52 percent), treated 73 percent of women with general symptoms, 69 percent with digestive complaints, and 65 percent with musculoskeletal complaints. Very small percents of visits for these reasons were made to OBG's. Most women went to GFP's or internists for general examinations (80 percent). On the other hand, about two out of three special examinations (chiefly prenatal and gynecological) were conducted in OBG's offices. Family planning was also clearly considered the domain of the OBG by most patients.

Principal Diagnosis

The 58 most common principal diagnoses associated with visits by women aged 15 and older are shown in table 9. These diagnoses accounted for 66 percent of women's visits.

Table C. Number and percent of new problem office visits made by women 15 years and over, by selected principal reasons for visit and selected physician specialties: United States, 1977

Principal reason for visit and RVC code ¹	Number of new problem visits in thousands	Physician specialty	
		General and family practice and internal medicine	Obstetrics and gynecology
		Percent ²	
General symptoms.....S001-S099	8,048	72.8	*5.0
Symptoms referable to the digestive system.....S500-S639	8,050	68.6	8.3
Symptoms referable to the genitourinary system.....S640-S829	12,343	41.9	40.8
Symptoms referable to the musculoskeletal system.....S900-S999	11,300	64.5	*2.8
General examinations.....X100-X199	2,522	79.8	*8.0
Special examinations.....X200-X299	8,709	18.9	67.0
Diagnostic tests.....X300-X399	2,529	79.3	*15.9
Family planning.....X500-X599	2,123	36.6	62.3
Preoperative and postoperative care.....T200-T299	1,159	*30.6	41.9

¹Reason for visit codes are based on *A Reason for Visit Classification for Ambulatory Care (RVC)*.

²Percents will not add to 100.0 because all physician specialties are not shown in the table.

Prenatal care and medical or special examinations constituted 13 percent of the total. At least 13 percent of the patient visits were for disorders unique to women. (Although a one-to-one correlation between reason for the visit and the diagnosis was not expected, a positive connection was found in the data.)

Figure 3 illustrates annual visit rates for prenatal care by age groups. Visit rates for disorders of menstruation and menopausal symptoms are plotted in figure 4. Understandably, visit rates for menopausal symptoms rise with advancing age and those for disorders of menstruation fall. The curves intersect within the group aged 35-44 years.

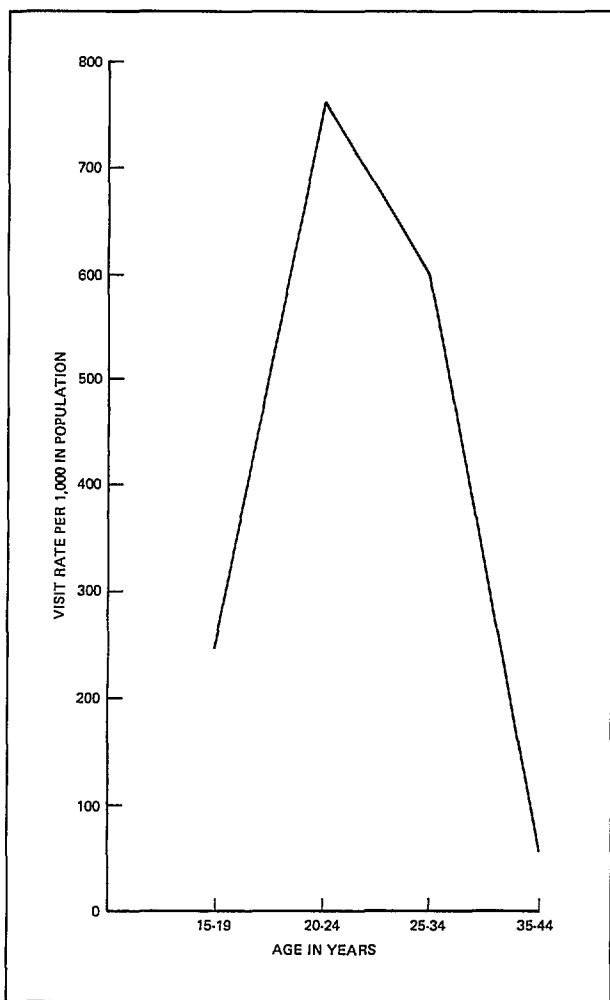


Figure 3. Annual rate of office visits for prenatal care (Y06), by age of patient: United States, 1977

Essential benign hypertension, neuroses, and diabetes mellitus were the three leading morbidity-related diagnoses which accounted for 10 percent of the total visits.^b

Principal Diagnosis and Age of the Patient

Table 10 shows how the predominance of certain diagnoses changed with advancing age as the principal reason for the visit did. Prenatal

^bThe reader is cautioned that the rank order of numbers of visits may be somewhat artificial because many estimates are not statistically different from other near estimates because of sampling variability.

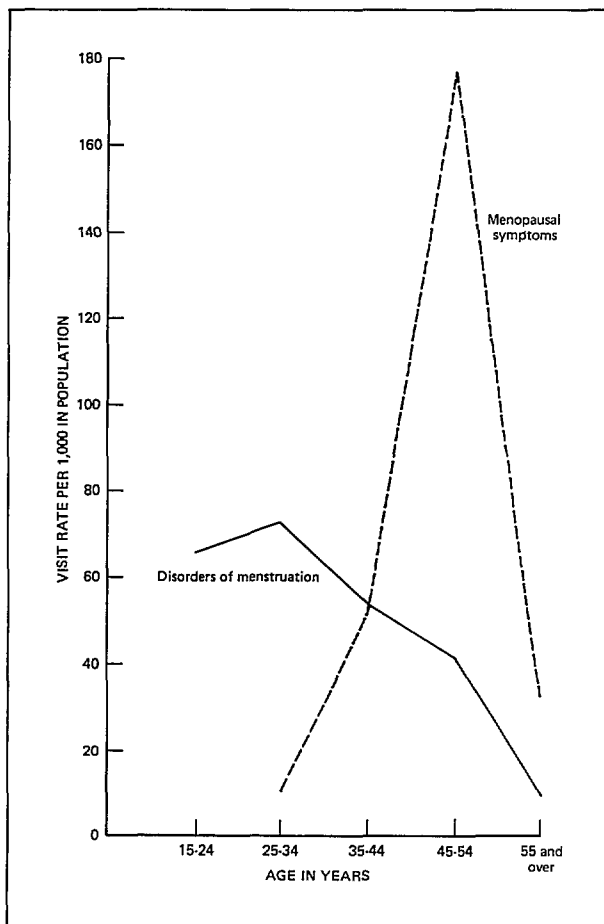


Figure 4. Annual rate of office visits for disorders of menstruation (626) and menopausal symptoms (627), by age of patient: United States, 1977

care accounted for 18 percent of visits in the group aged 15-24 years and declined to 11 percent in the group aged 25-44 years. Visits for hypertension increased from a low of about 1 percent for women aged 25-44 years to a high of 11 percent for those aged 65 years and over.

The importance to women to maintain good health is demonstrated by the fact that medical or special examinations continued to be the second leading diagnosis for visits until age 65 years at which age these examinations placed ninth. At age 65 years, however, visits for chronic conditions, with their relatively high rate of return visits, were more common than those for younger age groups. The most frequent diagnoses for elderly patients included chronic ischemic heart disease and symptomatic heart disease (about 10 percent); osteoarthritis and allied conditions plus arthritis, unspecified (7 percent); cataract and glaucoma (about 3 percent) (table 10).

The need for surgical aftercare persisted throughout all age groups, but was probably caused by dissimilar categories of surgery depending on the age group. Unpublished data from the 1977 Hospital Discharge Survey (HDS), a survey conducted by the Division of Health Resources Utilization Statistics, The National Center for Health Statistics, show that the rates of some surgical procedures varied considerably by age group.⁸ Table D shows that

rates per 10,000 women were higher for women aged 65 years and over than they were for all other age groups for ophthalmological surgery (197.1), vascular and cardiac surgery (129.6), abdominal surgery (288.8), urological surgery (72.8), and orthopedic surgery (278.3). However, women aged 25-44 years had more gynecological surgery (818.7 per 10,000) than other women did. Obstetrical procedures were highest among patients aged 15-34 years (348.1 for each 10,000 in that age group). Rates for breast surgery were not as high and did not vary among age groups as much as the rates for other procedures did. The rates ranged from a low of 19.0 per 10,000 for patients aged 15-24 years to a high of 64.2 for women aged 45-54 years.

Principal Diagnosis and Principal Reason for Visit

The NAMCS data cannot be examined retrospectively and statistically to "predict" a relationship between a reason for a visit and the final diagnosis. However, data on symptoms that can result in diagnoses of varying degrees of gravity, such as "lump or mass of breast" and "vision dysfunction," can be evaluated in terms of the distribution of their visits by diagnosis.

Table E shows that of the 2 million visits in which a lump or mass of breast was the reason for the visit, chronic cystic disease of breast or

Table D. Rate of all-listed operations¹ for female patients discharged from short-stay hospitals, by age of patient and selected surgical categories: United States, 1977

Surgical category and ICDA Code ²	Age of patient					
	15-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65 years and over
	Rate per 10,000 population					
Neurosurgery01-05	5.8	16.1	19.9	6.8	36.5	21.1
Ophthalmology06-14	0.9	8.6	28.8	35.0	68.1	197.1
Vascular and cardiac surgery24-30	7.5	17.2	35.3	60.9	90.5	129.6
Abdominal surgery38-48	92.8	149.4	150.2	174.5	218.4	288.8
Urological surgery54-61	20.8	36.2	49.2	42.5	62.1	72.8
Breast surgery65	19.0	42.2	62.3	64.2	46.6	44.8
Gynecological surgery67-72	259.0	827.0	807.3	558.4	266.3	152.1
Obstetrical procedures74-78	327.9	372.7	91.0	3.8	0.4	-
Orthopedic surgery80-90	82.1	88.5	136.9	185.4	92.4	278.3

¹Calculated from unpublished data collected in the Hospital Discharge Survey, 1977.

²Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States (ICDA)*.

other diseases of the breast was diagnosed in 46 percent with a decision of malignant neoplasm in only 6 percent. Benign neoplasms or those of an unspecified nature were found in about one of three visits.

Table F shows that visits prompted by vision dysfunction (3.9 million) resulted mainly in a diagnosis of refractive error (46 percent). Cataracts accounted for 17 percent, and glaucoma was diagnosed in about 6 percent.

Principal Diagnosis and Race of the Patient

Proportions of visits for selected principal diagnoses are shown in table 11 by race of the patient. White women visited office-based physicians proportionately more often for neuroses and medical or special examinations than other women did. The relative frequency of visits by women of black and other races exceeded that of white women for diabetes mellitus and hypertension. Other differences were not statistically significant.

Prevalence rates for diabetes mellitus and hypertension are also higher among women of black and other races than among white women.^{9,10} A higher prevalence disease rate for a specific group might result in increased visits for medical care for that disease by that group. However, table G shows that the percents of the difference in rates by race were disproportionate, that is, physician visit rates for women other than white were not as high as expected considering the differences in prevalence rates. Although the prevalence rate for women of black and other races for diabetes mellitus was 39 percent higher than that of white women, their visit rate was only 27 percent higher. Similarly, the prevalence rate of hypertension for women of races other than white exceeded that of white women by 82 percent, but their visit rate was only about 1 percent higher. These data indicate that black women and women of other races either are not seeking care for their problems with the same frequency as white women, or are obtaining care in settings other than the office of the private physician. The reason could be a combination of both factors. Data from HIS show that about 9 percent of ambulatory medical care visits by white persons

Table E. Number and percent distribution of office visits made by women 15 years and over with principal reason for visit lump or mass of breast (S805),¹ by principal diagnosis: United States, 1977

Principal diagnosis and ICDA code ²	All visits
	Number in thousands
All diagnoses	2,023
	Percent distribution
Total	100.0
Chronic cystic disease of breast or other disease of breast	610-611 45.8
Neoplasm of unspecified nature of breast	233 24.6
Benign neoplasm of breast	217 *8.0
Malignant neoplasm of breast or other secondary malignant neoplasm ³	174, 198 *5.9
Other diagnoses.....	residual 15.7

¹Reason for visit codes are based on *A Reason for Visit Classification for Ambulatory Care (RVC)*.

²Based on the *Eighth Revision International Classification of Diseases, Adopted for Use in the United States (ICDA)*.

³This diagnosis relates only to those visits where the principal reason for visit was coded "lump or mass of breast." A total of 987,328 visits were estimated where "malignant neoplasm of breast" was the principal diagnosis. Those visits included "lump or mass of breast" plus other reasons.

Table F. Number and percent distribution of office visits made by women 15 years and over with principal reason for visit vision dysfunction (S305),¹ by principal diagnosis: United States, 1977

Principal diagnosis and ICDA code ²	All visits
	Number in thousands
All diagnoses	3,887
	Percent distribution
Total	100.0
Refractive errors	370 45.5
Cataract	374 17.1
Glaucoma.....	375 *5.5
Other diagnoses.....	residual 31.9

¹Reason for visit codes are based on *A Reason for Visit Classification for Ambulatory Care (RVC)*.

²Based on the *Eighth Revision International Classification of Diseases, Adopted for Use in the United States (ICDA)*.

Table G. Prevalence rate by race of patient with percent of difference, and visit rate by race of patient with percent of difference, according to principal diagnoses diabetes mellitus and hypertension: United States, 1977

Principal diagnosis and ICDA code ¹	Rate per 1,000 population ²		Percent of difference
	White	Black and all other	
Diabetes mellitus (250)			
Prevalence rate ³	33.6	46.7	39.0
Visit rate.....	73.4	92.9	26.6
Hypertension (401)			
Prevalence rate ⁴	157.0	286.0	82.2
Visit rate.....	183.2	185.7	1.4

¹Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States (ICDA)*.

²Visit rates are based on data from the 1977 National Ambulatory Medical Care Survey (NAMCS). Prevalence rates from the Health Interview Survey (HIS) and the Health and Nutrition Examination Survey (HANES) are based on prior-year surveys. However, few statistically significant differences in NAMCS visit rates since the inception of the Survey have been observed.

³Based on unpublished data from the 1976 supplement to the HIS. See reference 9.

⁴Based on data on women aged 18-74 years from the HANES. See reference 10.

were to hospital clinics or emergency rooms, whereas 21 percent of visits by members of other races were in a similar setting.¹¹

Principal Diagnosis and Sex of the Patient

Women visited physicians proportionately more often than men did for medical and surgical aftercare which reflects the higher rate of surgery performed on women (120.2 operations per 1,000 women versus 77.8 per 1,000 men).¹² Figure 5 illustrates visit rates for medical and surgical aftercare by patient age. The highest visit rate for women occurred between ages 45 and 64 years; the visit rate for men rose to its highest point at age 65 years and older. Table H shows that men visited the physician proportionately more often than women did for orthopedic aftercare, reflecting a higher rate of orthopedic surgery for men (14.5 per 1,000) than for women (12.4 per 1,000 women).¹² About 81 percent of women's visits

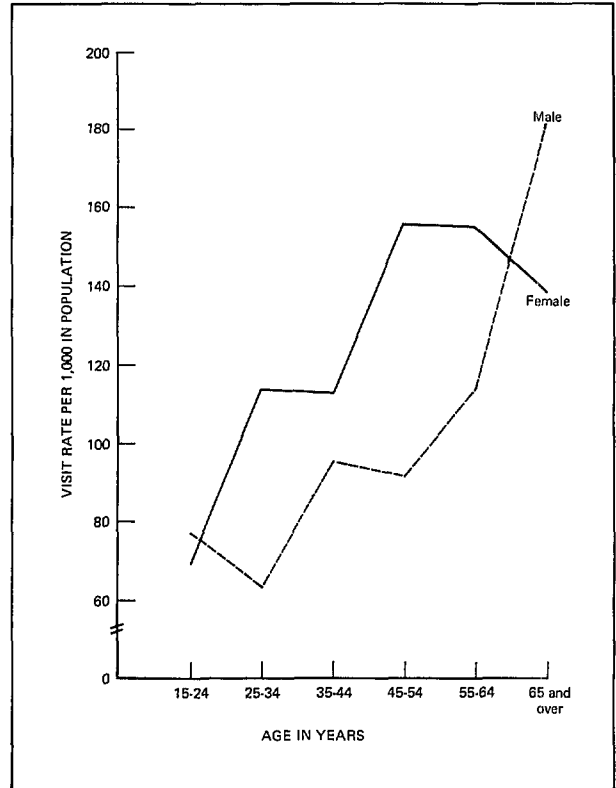


Figure 5. Annual rate of office visits for medical and surgical aftercare (Y10), by age and sex of patient: United States, 1977

Table H. Number and percent distribution of office visits made by patients 15 years and over for medical and surgical aftercare (Y10) by principal 4-digit diagnosis, according to sex of patient: United States, 1977

Principal diagnosis and ICDA code ¹	Sex of patient	
	Female	Male
Number in thousands		
All visits	9,906	7,275
Percent distribution		
Total	100.0	100.0
Orthopedic aftercare..... Y10.4	9.4	16.6
Other surgical aftercare..... Y10.5	81.4	73.7
Other medical aftercare..... Y10.6	6.2	6.3
Other aftercare..... Y10.0, Y10.3, Y10.9	*3.0	*3.3

¹Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States (ICDA)*.

were because of other surgical aftercare compared with about 74 percent of the men's visits.

Figure 6 vividly illustrates the contrast in visit rates for women and men diagnosed with acute upper respiratory infections and acute pharyngitis. Women and men visited the physician at about the same rate when patients were aged 25-34 years and over 54 years, but rates varied considerably at other ages.

Visit rates by sex and age of the patient for diagnoses of diabetes mellitus, obesity, hypertension, and arthritis and rheumatism are plotted in figures 7-10. If the extent of physician utilization reflects attitude towards health care, then NAMCS data for these four conditions provide evidence that women with certain diseases tend to seek health care proportionately more often than men with the same conditions do. Examining visit and prevalence rates for these diagnoses demonstrates that the percent of difference in the visit rates between the two sexes was disproportionately larger than the

corresponding percent of difference in prevalence rates. Table J shows that the prevalence rate for females with diabetes mellitus⁹ was 19 percent greater than that for men, but their visit rate was 27 percent higher. Arthritis and rheumatism caused women to visit the physician at a rate 67 percent higher than that for men although their prevalence rate was only 26 percent higher than that of men.¹³ Even more startling is the extent of visits by women with obesity and hypertension. Although the prevalence of obesity among women was 70 percent higher than among men,¹⁴ their visit rate was over 300 percent higher than that of their male counterparts. The hypertension prevalence rate is the only one shown in table J in which the male prevalence rate¹⁰ exceeds the female prevalence rate, yet the female visit rate is 27 percent higher than that of the corresponding rate for males.

Heart disease tends to afflict more men than women. The visit rate curves in figure 11 reflect

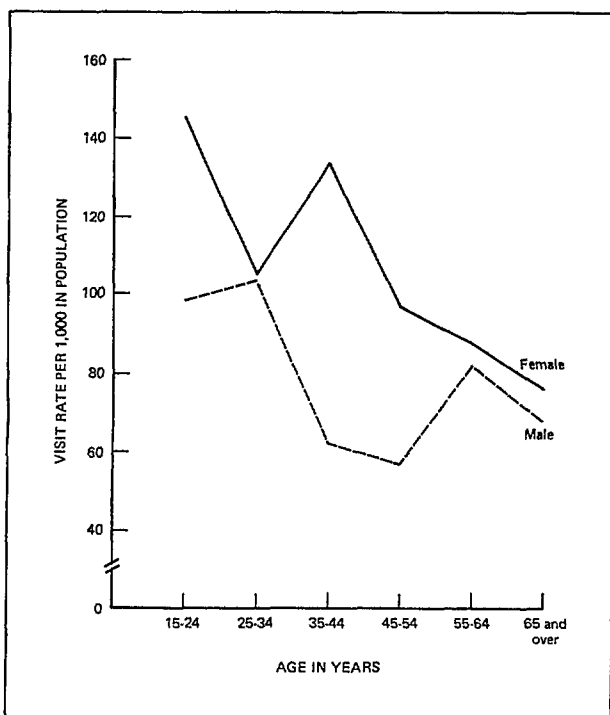


Figure 6. Annual rate of office visits for acute upper respiratory infection of multiple or unspecified sites (462) and acute pharyngitis (465), by age and sex of patient: United States, 1977

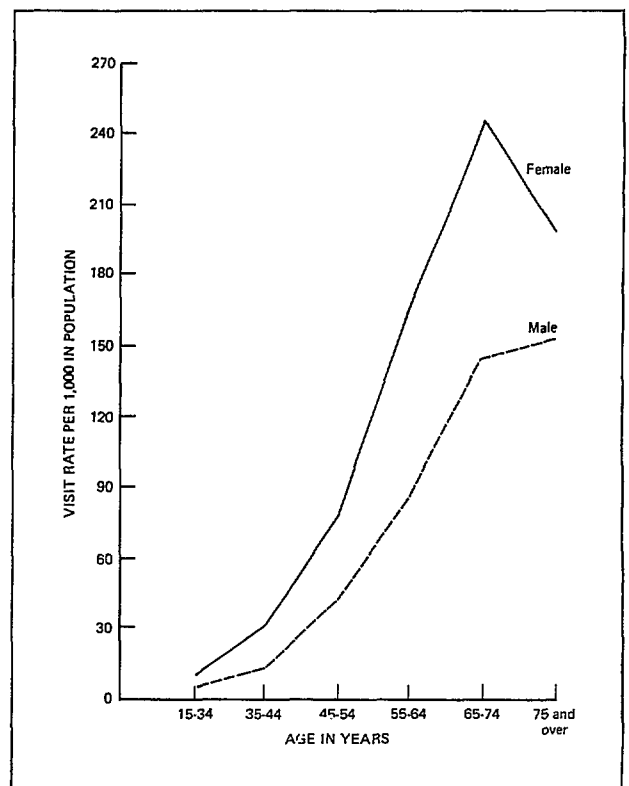


Figure 7. Annual rate of office visits for diabetes mellitus (250), by age and sex of patient: United States, 1977

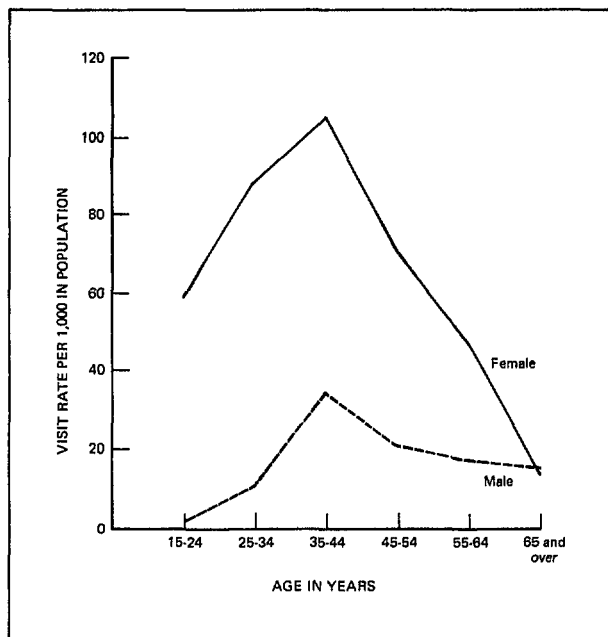


Figure 8. Annual rate of office visits for obesity (277), by age and sex of patient: United States, 1977

this fact because the visit rates for men exceeded those of women. Both curves rise steadily with advancing age. Detailed utilization data on visits for coronary heart disease and symptomatic heart disease can be found in an earlier NCHS publication based on NAMCS data that describes visits for diseases of the circulatory system.¹⁵

Visit rates for neuroses are graphed by age and sex of the patient in figure 12. On the average, women clearly visited the physician more often than men did for this problem. The highest rate for both sexes occurs between age 25 and 34 years. However, the rate for women's visits at that point (161 per 1,000) is almost twice as high as that of men (about 85 per 1,000).

Conflicting reports regarding the validity of interpretation of symptoms presented by women abound. Some researchers theorize that women's symptoms are diagnosed as neuroses or psychoses more often than those symptoms presented by men are.¹⁶ Unpublished data from the Psychological Mental Health Index (PMHI), a portion of the General Well-Being Schedule (GWB) in HANES,¹⁷ show that on the average women responded positively to having symp-

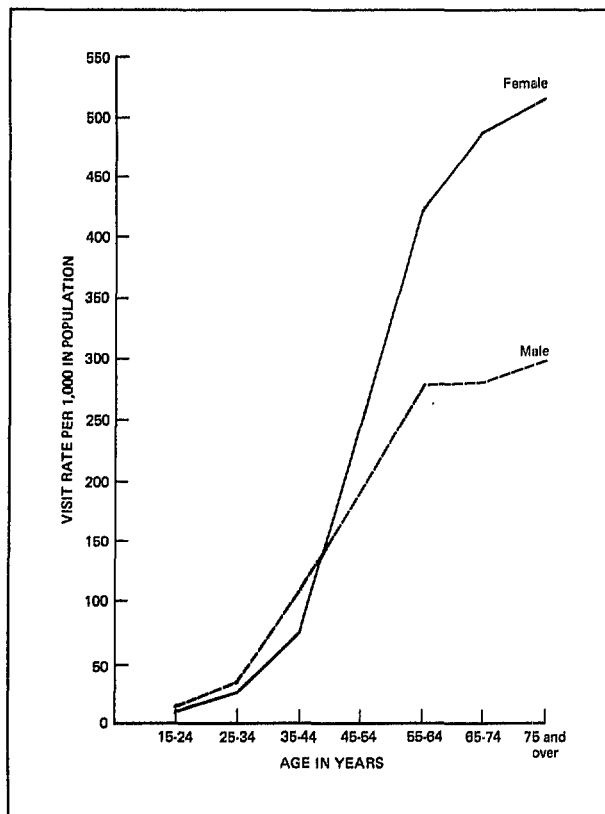


Figure 9. Annual rate of office visits for hypertension (401), by age and sex of patient: United States, 1977

toms of psychological stress more often than men did. The PMHI has been shown to discriminate mental health clinic patients from population samples.¹⁸ Another study supported the capability of the GWB to measure psychological distress.¹⁹ However, some researchers suggest that differences in reporting "neurotic" symptoms may be related to the relative *willingness* of women and men to report such symptoms.¹

The NAMCS data show that proportions of symptoms *expressed by patients*, which were likely to be associated with neuroses or psychoses as diagnosed in visits to office-based physicians, did not vary significantly by sex. These reasons are detailed in table K. The category "general symptoms" may include, for example, tiredness or exhaustion, general weakness, and general ill feeling. Symptoms referable to psychological and mental disorders allude to anxiety and nervousness, depression, anger,

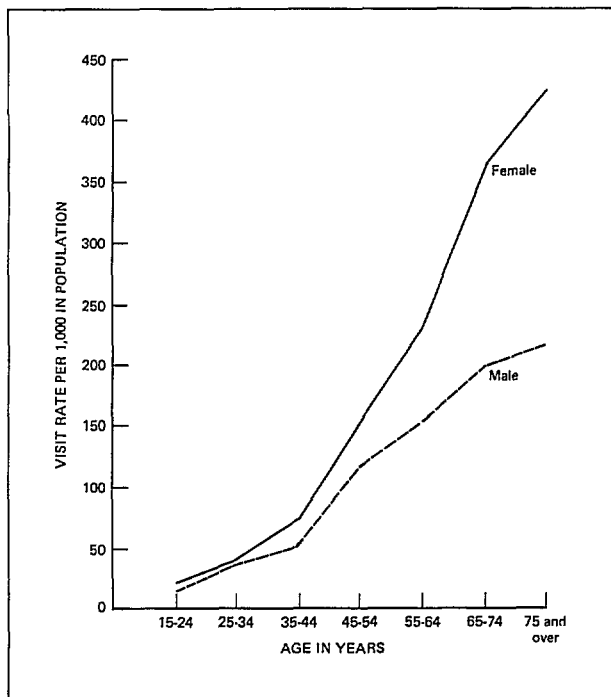


Figure 10. Annual rate of office visits for arthritis and rheumatism (712-715, 717-718), by age and sex of patient: United States, 1977

problems with identity and self-esteem, behavioral disturbances, and so forth. Social problems counseling includes such reasons as marital problems, other problems of family relationship, occupational, and social adjustment problems. Table L presents information regarding the number of visits made by women and men that included the symptoms listed in table K, and the proportionate assignment of those symptoms to the psychoses and neuroses diagnostic groups.²⁰ For example, the 9,150,000 visits made by women with symptoms referable to psychological and mental disorders represented 3 percent of their total visits (table K). Of this group, about 12 percent were diagnosed in the psychoses group and 59 percent in the neuroses group (table L). Men made 5,365,000 visits for the same reason, also representing 3 percent of their total visits (table K). Proportions of the psychoses and neuroses diagnostic groups for men were 14 and 66 percent, respectively. No statistically significant differences were found between women and men, either in the propor-

Table J. Prevalence rate by sex of patient with percent of difference, and visit rate by sex of patient with percent of difference, according to selected principal diagnoses: United States, 1977

Principal diagnosis, ICDA code, ¹ and rate	Rate per 1,000 population ²		Percent of difference
	Male	Female	
Diabetes mellitus (250)			
Prevalence rate ³	29.6	35.2	18.9
Visit rate.....	59.6	75.9	27.3
Obesity (277)			
Prevalence rate ⁴	140.0	237.2	69.9
Visit rate.....	15.5	64.3	314.8
Hypertension (401)			
Prevalence rate ⁵	192.0	171.0	⁶ 12.3
Visit rate.....	127.8	162.4	27.1
Arthritis and rheumatism (712-15, 717-718)			
Prevalence rate ⁷	124.4	156.3	25.6
Visit rate.....	79.2	132.3	67.0

¹Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States (ICDA)*.

²Visit rates are based on data from the 1977 National Ambulatory Medical Care Survey (NAMCS). Prevalence rates from the Health Interview Survey (HIS) and the Health and Nutrition Examination Survey (HANES) are based on prior-year surveys. However, few statistically significant differences in NAMCS visit rates since the inception of the Survey have been observed.

³Based on unpublished data from the 1976 supplement to the HIS. See reference 9.

⁴Based on data from the HANES for persons aged 20-74 years. See reference 14.

⁵Based on data from the HANES for persons aged 18-74 years. See reference 10.

⁶The male prevalence rate exceeds the female prevalence rate.

⁷Calculated from data in the 1976 HIS. See reference 13.

tions of symptoms presented or in the diagnoses rendered.

Principal Diagnosis and Return Visit Rate

The return visit rate is the ratio of return visits to new problem visits. This ratio is an indicator of an attitude toward health care as well as a measure of physician utilization and provides an index of the patient's willingness to return for medical care after a condition has been diagnosed.

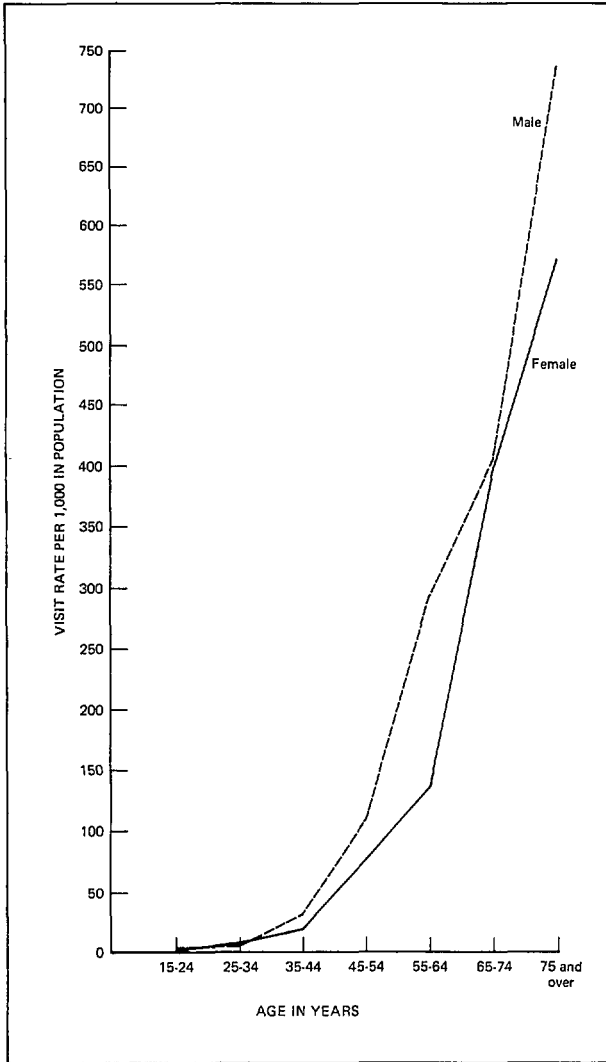


Figure 11. Annual rate of office visits for heart disease (410-413, 427), by age and sex of patient: United States, 1977

Return visit rates well above the average of 1.76 (table 12) tended to be associated with chronic conditions such as diabetes mellitus, chronic ischemic heart disease, hypertension, and hay fever. Except for visits for menopausal symptoms, patients with other female disorders were not likely to make return visits because the return visit ratio for each diagnosis is less than one. On the average, pregnant women made about four return visits for each initial visit for prenatal care.

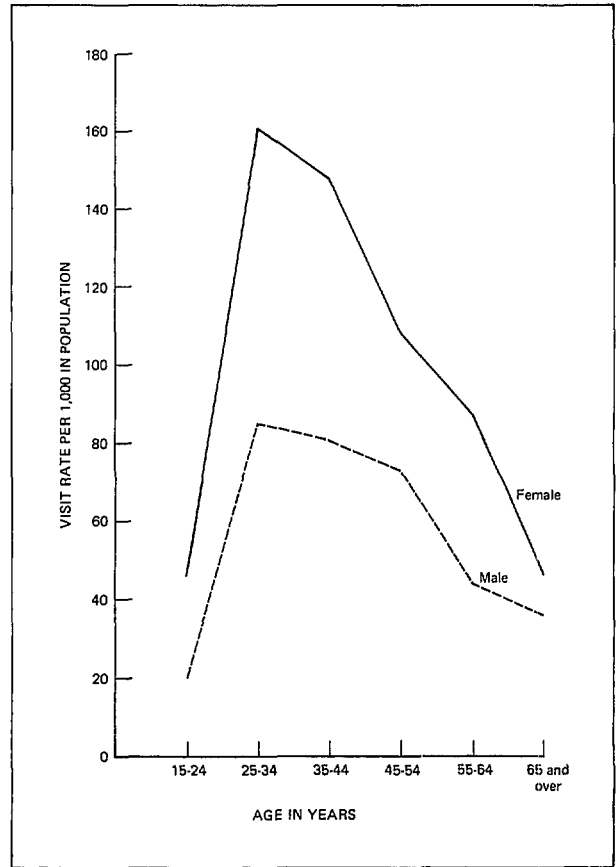


Figure 12. Annual rate of office visits for neuroses (300), by age and sex of patient: United States, 1977

Seriousness of Condition

“Seriousness” refers to the physician’s clinical judgement regarding the extent of the patient’s impairment that might result if care were unavailable. With this criterion, physicians were requested to rate the patient’s condition on a four-point scale ranging from “not serious” to “very serious.” This measure of seriousness is highly subjective, and data should be viewed in this context.

Table 13 shows that in 82 percent of all women’s visits the physician evaluated the condition as not serious or slightly serious with the balance considered serious or very serious. These proportions varied according to the patient’s age. Problems were more likely to be judged serious or very serious when women were aged

Table K. Number and percent of office visits made by patients 15 years and over, by sex of patient and selected principal reasons for visit: United States, 1977

Principal reason for visit and RVC code ¹	Sex of patient			
	Female		Male	
	Number in thousands	Percent of visits ²	Number in thousands	Percent of visits ²
All reasons	294,958	100.0	171,338	100.0
General symptomsS005-S095	21,531	7.3	11,712	6.8
Symptoms referable to psychological and mental disordersS100-S165	9,150	3.1	5,365	3.1
Symptoms referable to the nervous system (excluding sense organs).....S200-S240	12,077	4.1	5,791	3.4
Psychotherapy T410	1,272	0.4	1,011	0.6
Social problems counseling T700-T730	1,468	0.5	1,031	0.6

¹Reason for visit codes are based on *A Reason for Visit Classification for Ambulatory Care (RVC)*.

²Percents will not add to 100.0 because all reasons for visit are not listed.

Table L. Number and percent of office visits made by patients 15 years and over for selected principal reasons for visit, by selected diagnostic groups and sex of patient: United States, 1977

Principal reason for visit, RVC code, ¹ and sex of patient	Reason for visit		Diagnostic group and ICDA code ²	
	Number in thousands	Percent	Psychoses (295-299)	Neuroses (300-309)
			Percent ³	
General symptoms (S005-S095):				
Female.....	21,531	100.0	*0.3	4.3
Male.....	11,712	100.0	*0.4	4.5
Symptoms referable to psychological and mental disorders (S100-S165):				
Female.....	9,150	100.0	11.6	59.4
Male.....	5,365	100.0	13.7	66.1
Symptoms referable to the nervous system (excluding sense organs) (S200-S240):				
Female.....	12,077	100.0	*0.5	12.6
Male.....	5,791	100.0	*0.6	8.0
Psychotherapy (T410):				
Female.....	1,272	100.0	*26.9	64.5
Male.....	1,011	100.0	*18.0	77.5
Social problems counseling (T700-T730):				
Female.....	1,468	100.0	*9.0	75.5
Male.....	1,031	100.0	*10.1	82.0

¹Reason for visit codes are based on *A Reason for Visit Classification for Ambulatory Care (RVC)*.

²Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States (ICDA)*.

³Percents will not add to 100.0 because all diagnostic groups are not listed.

Table M. Return visit rate for women 15 years and over, by seriousness of condition: United States, 1977

Seriousness of condition	Return visit rate ¹
Not serious	1.41
Slightly serious	1.79
Serious.....	3.48
Very serious.....	4.05

¹The return visit rate is the ratio of return visits to new problem visits.

45 years and over, thus reflecting the high proportions of visits made by older women for chronic conditions. The lesser proportions of serious or very serious problems in groups aged 15-24 years and 25-44 years reflect visits associated with the reproductive years that are considered mainly routine and are generally evaluated as not serious.

Table M relates the seriousness of women's problems to their return visit rate. As would be expected, the more serious the condition, the higher was the rate of return.

Seriousness of Condition and Sex of the Patient

Problems were proportionately more often described as slightly serious or not serious than serious or very serious regardless of the sex of the patient. For both women and men this tendency declined with advancing age (table 13). The lesser degree of seriousness for younger women can easily be attributed to the preponderance of routine prenatal visits, although the increased seriousness of the condition for older groups of both sexes is probably because of the onset of chronic problems such as heart disease.

In every age group the problems of men were, on the average, evaluated as serious or very serious proportionately more frequently than those of women were.

PATIENT MANAGEMENT

Diagnostic and Therapeutic Services

The Patient Record contains a checklist of types of diagnostic and therapeutic services.

However, for some services it is not possible to estimate the intensity of the workup (e.g., X-ray) or the extent of therapeutics (e.g., drugs) because the number of tests or prescriptions at each visit are not recorded. The proportions of these services ordered or provided during office visits are shown in table 14 by age of the patient, and in table 15 by race and sex of the patient. Table 16 provides data relating diagnostic services to selected principal reasons for the visit to the physician. Table 17 offers information on therapeutic services rendered with corresponding selected diagnoses.

Diagnostic and Therapeutic Services and Age, Race, and Sex of the Patient

As in most NAMCS visits, the limited history and/or examination was the most widely used diagnostic service. More than half of the visits by patients in all age groups of women included this service (table 14). Blood pressure measurements also were taken during a large proportion of visits made by all age groups. At least one in four visits included one or more clinical laboratory tests. Pap tests were more common for patients aged 25-34 years, which comprised 31 percent of the visits by that age group in comparison with 2-16 percent for other age groups. (These proportions represent visits in which the Pap test was a diagnostic service regardless of the patient's reason for visit.)

Figure 13 shows that Pap tests tend to decline as the patient's age increases. The increasing proportions of blood pressure checks with advancing age are also evident in figure 13.

The prescription of drugs increased from 46 percent of visits by women aged 25-34 years to 68 percent by those aged 75 years and older, but other forms of therapy did not vary appreciably by patient's age (table 14). (As expected proportions of family planning services rendered to patients between ages 15 and 34 years more than doubled those of other age groups.)

Blood pressure was more likely to be measured and drugs were more likely to be ordered during visits by black women and women of other races than during white women's visits (table 15).

Men were more likely than women to have X-rays and EKG's, probably because they have a

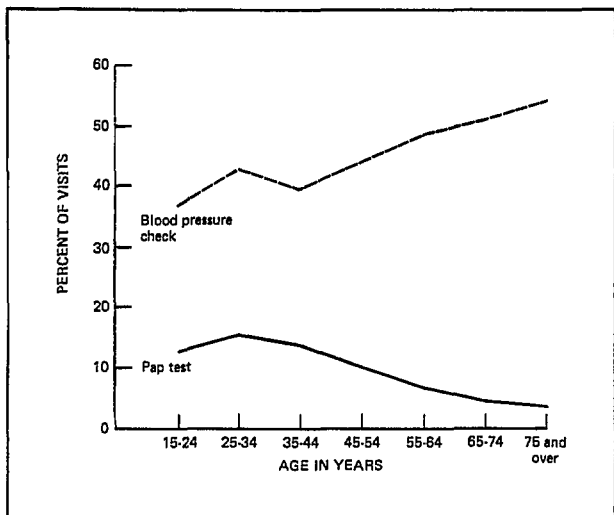


Figure 13. Percent of office visits that included Pap test and blood pressure check, by age of patient: United States, 1977

higher rate of injuries and heart problems. However, visits by women were more likely than those by men to include a clinical laboratory test or a blood pressure check. (Additional data on diagnostic and therapeutic services provided female and male patients visiting a physician for treatment of hypertension and heart disease may be found in an earlier publication "Office Visits for Diseases of the Circulatory System.")¹⁵

Correlating with their higher proportions of visits for injuries and adverse effects, men also had proportionately more physiotherapy and office surgery than women did (table 15).

Diagnostic Services and Patient's Principal Reason for Visit

The relationship of diagnostic services to the patient's principal reason for visit is shown in table 16. Except for depression, vision dysfunction, and symptoms referable to the throat, physicians made higher than average numbers of blood pressure checks when the symptoms listed in table 16 were presented. (Blood pressure checks were made in 34 percent of all NAMCS visits.)⁵ Clinical laboratory tests were highly represented in visits caused by painful urination and vaginal problems. Pap tests were included in 33 percent of visits caused by vaginal discharge and in 43 percent of those where uterine and

vaginal bleeding was the principal reason for visit (table N). X-rays were most commonly used when the reasons shown in table O were presented.

Therapeutic Services and Principal Diagnosis

Table 17 shows that drug therapy ranged from 34 percent of visits for hay fever to over 80 percent for those involving hypertension. At least 50 percent of the visits for neuroses, obesity, diabetes mellitus, chronic ischemic heart disease, asthma, and eczema and other dermatitis included drugs. Patients with menopausal problems visiting a physician were treated with drugs about 78 percent of the time (not shown in table). As expected, about three of five visits by patients with neuroses included psychotherapy. Medical counseling was given to patients with disorders of menstruation (30 percent) and menopausal symptoms (23 percent), as well as to those with the conditions shown in table 17. Hay fever patients received desensitization or immunotherapy during 63

Table N. Percent of office visits made by women 15 years and over that included a Pap test, by selected principal reasons for visit: United States, 1977

Principal reason for visit and RVC code ¹	Total	Percent
Abdominal pain, cramps, and spasms...S550	100.0	14.3
Uterine and vaginal bleeding.....S755	100.0	42.8
Vaginal discharge.....S760	100.0	33.3
Other vaginal symptoms.....S765	100.0	23.2

¹Reason for visit codes are based on *A Reason for Visit Classification for Ambulatory Care (RVC)*.

Table O. Percent of office visits made by women 15 years and over that included X-ray, by selected principal reasons for visit: United States, 1977

Reason for visit and RVC code ¹	Total	Percent
Back symptoms.....S905	100.0	17.1
Low back symptoms.....S910	100.0	19.4
Chest pain and related symptoms (not referable to body system).....S050	100.0	22.6
Cough.....S440	100.0	12.8

¹Reason for visit codes are based on *A Reason for Visit Classification for Ambulatory Care (RVC)*.

percent of their visits. Patients with problems of obesity were given diet counseling in an estimated 68 percent of their visits.

Disposition of Visit

Continuity of care is an important aspect of patient management. The intent of the physician regarding the patient's need for ongoing care is reflected by the disposition of the visit. Most visits concluded with instructions to the patient to return at a specified time (table P). This tendency was more pronounced when women visited than when men did.

Referral

Of the 41 million women making an initial visit to a physician (visits by new patients are shown in table 19), 11.1 million, or 27 percent, were the result of referral by another physician.^c Table 18 shows the distribution of these 11.1

^cThe reader will notice an apparent discrepancy between the number of visits designated as "referred to other physician" (table P) and those referred from another physician (table 18). Largely, this discrepancy is because referrals can be made by physicians not in the scope of the survey or by telephone or by other means.

Table P. Number and percent of office visits made by patients 15 years and over, by sex of patient and disposition of the visit: United States, 1977

Disposition	Sex of patient	
	Female	Male
	Number in thousands	
All visits	294,958	171,338
	Percent ¹	
No followup planned	8.2	11.8
Return at specified time.....	66.2	60.8
Return if needed.....	20.7	21.2
Telephone followup planned.....	2.9	2.7
Referred to other physician	2.5	2.8
Returned to referring physician	0.9	0.9
Admit to hospital.....	2.0	2.3
Other	1.3	1.3

¹Percents will not add to 100.0 because more than one disposition was possible.

million visits according to principal diagnosis. Two groups of conditions were responsible for about 22 percent of referred visits: diseases of the nervous system and sense organs (11 percent) and diseases of the genitourinary system (11 percent).

Duration of Visit

Visit duration, as estimated by the physician, is the amount of time spent in direct encounter with the patient. Although some visits require and consume much of the physician's time, others do not. This fact does not imply, however, that care was not rendered. In the framework of the NAMCS definition, therefore visits could conceivably consume more physician's time because treatment could have been appropriately delegated to the physician's staff. Physicians also devote time to patient care that is not necessarily performed in the presence of the patient, such as evaluating test results, reading X-rays, reviewing histories, and consulting with other physicians. Duration estimates, therefore, are presented mainly for comparative purposes and not as the total time spent in care.

Table 19 shows the proportions of physician visits estimated in discrete time categories by selected patient characteristics and seriousness of the patient's condition. Regardless of the patient's race, age, or status, the majority of visits lasted 15 minutes or less. (Examination of the source data indicated that no significant difference was shown in visit duration by sex of the patient.) No contact was found between the patient and the physician in only a small percent of the visits. A higher proportion of visits made by white women took 31 minutes or longer (about 7 percent) than did those made by black and other women (about 3 percent).

It appears, however, that the duration of the visit was probably more dependent on the status and condition of the patient than on her race or age. New patients were more likely to see the physician for 16 minutes or more than returning patients were. Usually, new patients require more time for history, examination, and other aspects of a workup. The more serious the patient's condition, the higher the proportions of visits were in the categories 16-30 minutes and 31 minutes or more.

Table 11 shows that white women were more likely than black women and women of other races to visit physicians for medical or special examinations and for treatment of neuroses. This, together with the relatively more frequent use of psychotherapy in visits for neuroses, may account for the dominance of visits by white women in the longer time categories.

Table Q lists the mean contact duration of visits according to principal diagnosis. The mean contact duration is the average number of minutes per visit that included contact with the physician. Thus, the duration of contact with only other staff is included in the survey (and is shown under 0 minutes in table 19), but is excluded from the calculation of the mean. Visits involving mental disorders or nervousness

Table Q. Mean contact duration of office visits made by women 15 years and over, by selected principal diagnoses: United States, 1977

Principal diagnosis and ICDA code ¹	Mean contact duration ² (in minutes)
All diagnoses	15.4
Diabetes mellitus.....250	15.2
Obesity277	15.6
Neuroses300	31.1
Personality disorders.....301	47.0
Refractive errors370	22.0
Cataract374	22.6
Glaucoma.....375	14.4
Essential benign hypertension.....401	14.8
Chronic ischemic heart disease412	15.7
Acute pharyngitis.....462	11.0
Acute upper respiratory infection of multiple or unspecified sites.....465	12.2
Hay fever507	13.8
Infective diseases of uterus (except cervix), vagina, and vulva622	16.8
Disorders of menstruation.....626	17.5
Menopausal symptoms.....627	14.9
Other eczema and dermatitis.....692	11.5
Osteoarthritis and allied conditions.....713	17.0
Arthritis, unspecified715	14.7
Nervousness and debility.....790	24.6
Medical or special examinationY00	17.1
Prenatal careY06	10.7
Medical and surgical aftercareY10	12.6

¹Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States (ICDA)*.

²Time spent in face-to-face encounter between physician and patient.

and debility,^d eye conditions (except glaucoma), and medical or special examinations consumed more time on the average than visits for other conditions did. Visits for acute, self-limiting conditions and prenatal care took less than the average time of 15.4 minutes per visit; but the duration of visits for chronic problems, such as hypertension, diabetes mellitus, and heart disease, hovered closely around the average. These data clearly show that the length of the visit was influenced more by the nature of the patient's condition than by demographic variables.

FAMILY PLANNING

Family planning data presented in this report are based on estimates of visits made by women aged 15-44 years. An earlier report published in *Advance Data from Vital and Health Statistics*²¹ included data for patients of both sexes aged 15 years and over. Calculations of rates for that report were based on the corresponding population. Therefore, the two reports are not comparable.

Data on family planning services are also reported from the National Survey of Family Growth (NSFG), which is based on a sample of currently married women aged 15-44 years who have made a family planning visit,²² and by the National Reporting System for Family Planning Services (NRSFPS), which is based on reports by a sample of organized family planning service sites.²³ Because of the differences in the populations sampled, and the differences in the definitions and collection procedures, statistics on family planning visits from these data systems differ.

The RVC delineates commonly presented types of family planning reasons for visiting physicians that are coded on the Patient Record as the principal reason or as an additional reason. Because patients who visit physicians principally for reasons such as general examination, postpartum examination, and gynecological examination often take the opportunity to

^dVisits coded "nervousness and debility" were chiefly described as "depression" by the physician.

discuss or obtain family planning services, this report is based on estimates of visits where family planning was listed on the form as any one of the reasons. By the same logic, visits where family planning was checked as a therapeutic service on item 12 of the Patient Record are also included in the aggregation of family planning visits. However, these visits were counted only once, that is, a visit which indicated that a family planning therapeutic service was given was included only if family planning was not listed as one of the reasons for the visit. Thus, table R shows that family planning was expressed by the patient as a reason for the visit in about half of the 9.7 million total family planning visits—in the other half, patients received a family planning therapeutic service in addition to other medical care, and reasons for the visit other than family planning were given. It is not known whether some patients were reluctant to say that family planning was the reason for their visit or whether the subject, possibly related to the presenting problem, arose during the course of the visit. However, for estimating the extent of utilization of private physicians for family planning services these encounters should be considered “family planning” visits. About half of the time that family planning was a part of a visit, it was a service given during visits for other purposes. (The

principal reasons for such visits are shown in table V.) The patient’s age or sex made no difference in whether family planning was or was not specifically given as a reason because differences in these percents are not statistically significant.

Patient Age and Race

Most family planning visits were made by women aged 20-34 years (78 percent) representing an average of about 288 visits for each 1,000 women of that age in the United States (table S). Patients aged 15-19 years accounted for about 12 percent of the total with a visit rate of about 116 per 1,000. Predictably, visits by patients in their later reproductive years declined considerably.

Proportions of family planning visits by race reflected the composition of all NAMCS visits, with a higher rate of visits by white women than by those of black women and women of other races. The general rate of visits by white women was 33 percent higher than that of all other women; the family planning visit rate was 64 percent higher. However, the small sample of visits by black women and women of other races for family planning tends to minimize what may appear to be very large differences in proportions and rates. Available data sources indicate

Table R. Number of family planning office visits made by women 15-44 years and percent distribution by whether family planning was a stated reason for the visit or a therapeutic service was given, according to age and race of patient: United States, 1977

Age and race of patient	Number in thousands	Family planning visits		
		Total	Reason for visit stated	Therapeutic service given
		Percent distribution		
All family planning visits.....	9,685	100.0	52.1	47.9
<u>Age</u>				
15-19 years.....	1,199	100.0	54.9	45.1
20-34 years.....	7,532	100.0	52.4	47.6
35-44 years.....	954	100.0	46.1	53.9
<u>Race</u>				
White.....	8,788	100.0	51.0	49.0
Black and all other	897	100.0	62.3	37.7

that white patients tend to visit private physicians for family planning services at a higher rate than black patients, but black patients visit organized family planning clinics at a higher rate than white patients do. Of the white female respondents in the NSFG with a family planning visit in the last 3 years, 86 percent reported visiting a private physician in his office; but only 63 percent of the black respondents reported the location as the physician's office.²² On the

other hand, organized family planning clinics that reported to NRSFPS in 1976 showed an enrollment rate of roughly 144 per 1,000 black women aged 15-44 years in the population, compared with only about 44 per 1,000 white women of the same age.²³ The reader should note that the NAMCS *visit rate* includes initial and return visits, but the NRSFPS enrollment rate is based on an unduplicated count of patients.

Table S. Number, percent distribution, and annual visit rate of office visits made by women 15-44 years for family planning, by age and race of the patient: United States, 1977

Age and race of patient	Number in thousands	Percent distribution	Visit rate per 1,000 population
All family planning visits.....	9,685	100.0	200.0
<u>Age</u>			
15-19 years.....	1,199	12.4	116.1
20-34 years.....	7,532	77.8	288.1
35-44 years.....	954	9.9	79.7
<u>Race</u>			
White.....	8,788	90.7	211.8
Black and all other.....	897	9.3	128.9

Physician Specialty

Most family planning visits (73 percent) occurred in the offices of OBG's with an additional 25 percent made to GFP's (table T). When sampling variability is taken into account the patient's age or race did not appear to make a difference in the choice of physician by specialty.

Patient's Reason for Visit

About 96 percent of the 5 million visits by patients who specifically stated they were visiting for family planning or related reasons fell chiefly into three major groups: those who visited for counseling, examinations, and general advice; those who visited for the prescription or renewal of contraceptive medication; and those

Table T. Number and percent distribution of family planning office visits made by women 15-44 years by most visited physician specialty, according to age and race of patient: United States, 1977

Age and race of patient	Number in thousands	Physician specialty			
		Total	General and family practice	Obstetrics and gynecology	All other specialties
All ages.....	9,685	100.0	25.2	72.9	1.9
<u>Age</u>					
15-19 years.....	1,199	100.0	37.5	58.5	*4.0
20-34 years.....	7,532	100.0	22.4	73.6	*4.0
35-44 years.....	954	100.0	*27.2	68.4	*4.4
<u>Race</u>					
White.....	8,788	100.0	23.6	72.2	4.2
Black and all other.....	897	100.0	*35.3	62.2	2.5

who required insertion, removal, or checkup of contraceptive devices (table U). (Predictably, it was observed that teenagers were proportionately more likely to visit the physician for contraceptive medication than they were for a contraceptive device.)

Surgical sterilization and abortion were relatively rare for women visiting private physicians.

Visits made by patients who received a family planning therapeutic service without having directly expressed family planning as one of their reasons for the visit tended to be associated with special examinations. Table V shows the types of examinations given in the 63 percent of these visits. Of these visits, 17 percent were for routine prenatal examinations and 19 percent were for postpartum examinations, indicating that family planning was considered both during pregnancy and following delivery.

Diagnostic and Therapeutic Services

Compared with NAMCS visits for all reasons, patients visiting for family planning received proportionately more Pap tests, blood pressure checks, clinical laboratory tests, and general examinations (table W).

The rate of Pap tests performed during family planning visits in physicians' offices (about 51 percent) was similar to that of the organized family planning clinics measured by NRSFPS.²³ However, blood pressure checks were proportionately more frequent during

clinic visits (about 78 percent) than they were during the physician visits that were estimated in NAMCS (about 61 percent).

Patient age was apparently not a determining factor in the physician's provision of services, because for each service shown in table W the differences in the proportions by age (not shown in table) were not statistically significant.

Table V. Number and percent distribution of office visits made by women 15-44 years that included a family planning therapeutic service but not a family planning reason for visit, by most common principal reason for visit: United States, 1977

Principal reason for visit and RVC code ¹	Number in thousands	Percent distribution
Total.....	4,643	100.0
Gynecological examinationX225	908	19.6
Postpartum examinationX215	880	19.0
Prenatal examination, routineX205	787	17.0
Pap smearX365	*336	7.2
All other reasonsresidual	1,732	37.2

¹Reason for visit codes are based on *A Reason for Visit Classification for Ambulatory Care (RVC)*.

Table W. Number and percent of National Ambulatory Medical Care Survey (NAMCS) visits and number and percent of family planning visits made by women 15-44 years, by most common diagnostic and therapeutic services: United States, 1977

Most common diagnostic and therapeutic service	All NAMCS visits	All family planning visits
	Number in thousands	
Total	153,504	9,685
	Percent	
Limited history and/or examination	57.4	49.5
General history and/or examination	21.1	38.4
Pap test.....	13.7	51.1
Clinical laboratory test	26.3	35.0
Blood pressure check.....	39.9	60.6
Drugs (prescription or nonprescription)	48.7	43.3
Diet counseling.....	7.2	7.0
Medical counseling.....	18.9	21.8
Psychotherapy or therapeutic listening	7.5	*4.6

Table U. Number and percent distribution of office visits made by women 15-44 years with a family planning reason for visit, by reason category: United States, 1977

Reason category and RVC code ¹	Number in thousands	Percent distribution
Total	5,042	100.0
Family planning, not otherwise specified.....X500	1,742	34.6
Contraceptive medicationX505	1,565	31.0
Contraceptive device ²X510	1,525	30.3
All other family planning reasonsX515, X520, X525, X530	*210	*4.1

¹Reason for visit codes are based on *A Reason for Visit Classification for Ambulatory Care (RVC)*.

²Includes IUD insertion, removal, or checkup; diaphragm insertion, removal, or checkup.

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Table 1. Number and percent distribution of office visits made by women 15 years and over and number of visits per person per year, by age and race of patient: United States, 1977

Age and race of patient	Number in thousands	Percent distribution	Number of visits per person per year ¹
All visits.....	294,958	100.0	3.5
<u>Age</u>			
15-24 years	56,055	19.0	2.8
25-34 years	60,547	20.5	3.7
35-44 years	36,902	12.5	3.1
45-54 years	42,194	14.3	3.5
55-64 years	42,047	14.3	4.0
65-74 years	35,081	11.9	4.4
75 years and over.....	22,131	7.5	4.4
<u>Race</u>			
White	266,811	90.5	3.6
Black and all other.....	28,146	9.5	2.7

¹Rates are based on estimates of the civilian noninstitutionalized population of the United States for July 1, 1977, furnished by the U.S. Bureau of the Census (see appendix I).

Table 2. Number, percent distribution, and cumulative percent of office visits made by women 15 years and over, by principal reasons for visit in rank order:¹ United States, 1977

Rank	Principal reason for visit and RVC code ²	Number in thousands	Percent distribution	Cumulative percent
	All principal reasons for visit.....	294,958	100.0	100.0
1	Prenatal examination, routine.....X205	19,823	6.7	6.7
2	Gynecological examination.....X225	9,486	3.2	9.9
3	Blood pressure test.....X320	8,886	3.0	12.9
4	Postoperative visit.....T205	8,690	2.9	15.8
5	General medical examination.....X100	8,477	2.9	18.7
6	Symptoms referable to throat.....S455	6,357	2.2	20.9
7	Headache, pain in head.....S210	5,968	2.0	22.9
8	Back symptoms.....S905	5,534	1.9	24.8
9	Abdominal pain, cramps, spasms.....S550	5,493	1.9	26.7
10	Hypertension.....D510	5,128	1.7	28.4
11	Cough.....S440	4,690	1.6	30.0
12	Head cold, upper respiratory infection.....S445	4,358	1.5	31.5
13	Chest pain and related symptoms (not referable to body system).....S050	4,304	1.5	33.0
14	Anxiety and nervousness.....S100	3,924	1.3	34.3
15	Vision dysfunctions.....S305	3,887	1.3	35.6
16	Vertigo—dizziness.....S225	3,834	1.3	36.9
17	Pap smear.....X365	3,732	1.3	38.2
18	Weight gain.....S040	3,621	1.2	39.4
19	Skin rash.....S860	3,509	1.2	40.6
20	Eye examination.....X230	3,050	1.0	41.6
21	Acne or pimples.....S830	3,017	1.0	42.6
22	Diabetes mellitus.....D205	3,012	1.0	43.6
23	Tiredness, exhaustion.....S015	3,011	1.0	44.6
24	Leg symptoms.....S920	2,951	1.0	45.6
25	Depression.....S110	2,945	1.0	46.6
26	Neck symptoms.....S900	2,764	0.9	47.5
27	Earache, or ear infection.....S355	2,403	0.8	48.3
28	Knee symptoms.....S925	2,345	0.8	49.1
29	Shoulder symptoms.....S940	2,334	0.8	49.9
30	Allergy medication.....T100	2,321	0.8	50.7
31	Postpartum examination.....X215	2,310	0.8	51.5
32	Uterine and vaginal bleeding.....S755	2,291	0.8	52.3
33	Low back symptoms.....S910	2,290	0.8	53.1
34	Other vaginal symptoms.....S765	2,284	0.8	53.9
35	Nasal congestion.....S400	2,243	0.8	54.7
36	Vaginal discharge.....S760	2,129	0.7	55.4
37	Injections.....T110	2,126	0.7	56.1
38	Lump or mass of breast.....S805	2,023	0.7	56.8
39	Painful urination.....S650	1,955	0.7	57.5
40	Pain, site not referable to a specific body system.....S055	1,889	0.6	58.1
41	Diet and nutritional counseling.....T600	1,832	0.6	58.7
42	Arthritis.....D900	1,812	0.6	59.3
43	Skin lesion.....S865	1,753	0.6	59.9
44	Foot and toe symptoms.....S935	1,742	0.6	60.5
45	General weakness.....S020	1,734	0.6	61.1
46	Stomach pain, cramps and spasms.....S545	1,601	0.5	61.6
47	Abnormal sensations of the eye.....S320	1,534	0.5	62.1
48	Nausea.....S525	1,493	0.5	62.6
49	Symptoms of unspecified joints.....S970	1,399	0.5	63.1
50	Heart examination.....X235	1,377	0.5	63.6
51	Family planning, not otherwise specified.....X500	1,369	0.5	64.1
52	Contraceptive device.....X510	1,345	0.5	64.6
53	Frequency and urgency of urination.....S645	1,344	0.5	65.1
54	Allergy, not otherwise specified.....S090	1,342	0.5	65.6
55	Hand and finger symptoms.....S960	1,342	0.5	66.1
56	Menopausal symptoms.....S750	1,307	0.4	66.5
57	Psychotherapy.....T410	1,272	0.4	66.9
	All other reasons.....residual	---	33.1	100.0

¹The ordering of reasons for visit is mainly a convenience for listing because many estimates are not statistically different from other near estimates because of sampling variability.

²Reason for visit codes are based on *A Reason for Visit Classification for Ambulatory Care* (RVC).

Table 3. Number and percent distribution of office visits made by women 15 years and over, by age of patient and the 20 most frequent principal reasons for visit: United States, 1977

Age of patient, principal reason for visit, and RVC code ¹	Number in thousands	Percent distribution
All ages.....	294,958	100.0
<u>15-24 years</u>		
Total.....	56,055	100.0
Prenatal examination, routine X205	9,305	16.6
Symptoms referable to throat S455	2,260	4.0
Acne or pimples S830	1,857	3.3
Gynecological examination X225	1,689	3.0
Head cold, upper respiratory infection S445	1,200	2.1
Abdominal pain, cramps, spasms S550	1,157	2.1
Postoperative visit T205	1,144	2.0
Skin rash S860	1,078	1.9
Cough..... S440	1,076	1.9
General medical examination X100	1,015	1.8
Headache, pain in head..... S210	894	1.6
Other vaginal symptoms S765	810	1.4
Postpartum examination X215	788	1.4
Contraceptive medication..... X505	668	1.2
Weight gain..... S040	653	1.2
Earache, or ear infection S355	647	1.2
Pap smear X365	639	1.1
Family planning, not otherwise specified X500	634	1.1
Back symptoms S905	616	1.1
Eye examination X230	603	1.1
Other.....residual	27,322	48.9
<u>25-44 years</u>		
Total.....	97,450	100.0
Prenatal examination, routine X205	10,372	10.6
Gynecological examination X225	4,884	5.0
Postoperative visit T205	3,187	3.3
General medical examination X100	2,545	2.6
Symptoms referable to throat S455	2,364	2.4
Abdominal pain, cramps, spasms S550	2,026	2.1
Headache, pain in head..... S210	1,995	2.0
Pap smear X365	1,856	1.9
Anxiety and nervousness S100	1,824	1.9
Weight gain..... S040	1,756	1.8
Back symptoms S905	1,639	1.7
Depression..... S110	1,547	1.6
Postpartum examination X215	1,499	1.5
Head cold, upper respiratory infection S445	1,495	1.5
Cough..... S440	1,267	1.3
Vaginal discharge..... S760	1,240	1.3
Skin rash S860	1,121	1.2
Allergy medication T100	1,074	1.1
Chest pain and related symptoms (not referable to body system) S050	1,064	1.1
Other vaginal symptoms S765	1,041	1.1
Other.....residual	51,654	53.0

¹Reason for visit codes are based on *A Reason for Visit Classification for Ambulatory Care (RVC)*.

Table 3. Number and percent distribution of office visits made by women 15 years and over, by age of patient and the 20 most frequent principal reasons for visit: United States, 1977—Con.

Age of patient, principal reason for visit, and RVC code ¹	Number in thousands	Percent distribution
<u>45-64 years</u>		
Total.....	84,241	100.0
Blood pressure test..... X320	4,119	4.9
Postoperative visit..... T205	2,993	3.6
General medical examination..... X100	2,722	3.2
Gynecological examination..... X225	2,457	2.9
Hypertension..... D510	2,446	2.9
Back symptoms..... S905	2,235	2.7
Headache, pain in head..... S210	2,028	2.4
Cough..... S440	1,543	1.8
Abdominal pain, cramps, spasms..... S550	1,381	1.6
Vertigo—dizziness..... S225	1,380	1.6
Vision dysfunctions..... S305	1,321	1.6
Chest pain and related symptoms (not referable to body system)..... S050	1,271	1.5
Diabetes mellitus..... D205	1,259	1.5
Anxiety and nervousness..... S100	1,201	1.4
Symptoms referable to throat..... S455	1,150	1.4
Leg symptoms..... S920	1,150	1.4
Tiredness, exhaustion..... S015	1,143	1.4
Weight gain..... S040	1,106	1.3
Injections..... T110	1,075	1.3
Eye examination..... X230	1,058	1.3
Other.....residual	49,203	58.3
<u>65 years and over</u>		
Total.....	57,212	100.0
Blood pressure test..... X320	4,095	7.2
General medical examination..... X100	2,194	3.8
Hypertension..... D510	2,124	3.7
Gynecological examination..... S225	1,639	2.9
Chest pain and related symptoms (not referable to body system)..... S050	1,563	2.7
Diabetes mellitus..... D205	1,454	2.5
Postoperative visit..... T205	1,367	2.4
Vision dysfunctions..... S305	1,363	2.4
Arthritis..... D900	1,066	1.9
Headache, pain in head..... S210	1,051	1.8
Back symptoms..... S905	1,043	1.8
Heart examination..... X235	998	1.7
Abdominal pain, cramps, spasms..... S550	929	1.6
General weakness..... S020	889	1.6
Knee symptoms..... S925	885	1.5
Leg symptoms..... S920	813	1.4
Cough..... S440	804	1.4
Eye examination..... X230	781	1.4
Tiredness, exhaustion..... S015	692	1.2
Shortness of breath..... S415	667	1.2
Other.....residual	30,795	53.9

¹Reason for visit codes are based on *A Reason for Visit Classification for Ambulatory Care* (RVC).

Table 4. Number and percent distribution of office visits made by women 15 years and over by principal reason for visit, according to race of patient: United States, 1977

Principal reason for visit and RVC code ¹	Race of patient	
	White	Black and all other
All principal reasons for visit.....	266,811	28,146
	Percent distribution	
Total.....	100.0	100.0
General symptoms.....S001-S099	7.3	7.2
Symptoms referable to psychological and mental disorders.....S100-S199	3.2	2.2
Symptoms referable to the nervous system (excluding sense organs).....S200-S259	4.1	4.5
Symptoms referable to the cardiovascular and lymphatic systems.....S260-S299	0.6	*0.5
Symptoms referable to the eyes and ears.....S300-S399	4.6	2.6
Symptoms referable to the respiratory system.....S400-S499	7.9	8.4
Symptoms referable to the digestive system.....S500-S639	4.9	5.6
Symptoms referable to the genitourinary system.....S640-S829	7.9	9.9
Symptoms referable to the skin, nails, and hair.....S830-S899	4.7	4.5
Symptoms referable to the musculoskeletal system.....S900-S999	9.2	10.4
Infective and parasitic diseases.....D001-D099	0.3	*0.1
Neoplasms.....D100-D199	0.8	*0.6
Endocrine, nutritional, and metabolic diseases.....D200-D249	1.2	2.1
Diseases of the blood and bloodforming organs.....D250-D299	*0.2	*0.4
Mental disorders.....D300-D349	*0.1	*0.0
Diseases of the nervous system.....D350-D399	0.2	*0.4
Diseases of the eye.....D400-D449	0.5	*0.4
Diseases of the ear.....D450-D499	*0.0	*0.0
Diseases of the circulatory system.....D500-D599	2.3	*3.8
Diseases of the respiratory system.....D600-D649	0.9	*0.8
Diseases of the digestive system.....D650-D699	0.4	*0.2
Diseases of the genitourinary system.....D700-D799	0.8	*0.5
Diseases of the skin and subcutaneous tissue.....D800-D899	0.8	*0.6
Diseases of the musculoskeletal system and connective tissue.....D900-D949	0.7	*1.5
General examinations.....X100-X199	3.0	2.3
Special examinations.....X200-X299	13.0	10.8
Diagnostic tests.....X300-X399	5.0	5.4
Other screening and preventive procedures.....X400-X499	0.3	*0.0
Family planning.....X500-X599	1.3	1.7
Medications.....T100-T199	1.9	*1.0
Preoperative and postoperative care.....T200-T299	3.1	3.3
Specific types of therapy.....T400-T499	0.7	*0.3
Specific therapeutic procedures.....T500-T599	1.0	*0.7
Medical counseling.....T600-T699	0.8	*0.9
Social problems counseling.....T700-T799	0.5	*0.2
Progress visit, not elsewhere classified.....T800-T899	0.6	*0.8
Injury by type and/or location.....J001-J799	2.2	2.1
Injury, not otherwise specified.....J800-J899	0.3	*0.4
Test results module.....R100-R700	0.6	*0.3
Administrative module.....A100-A140	1.0	*1.4
All other reasons ²residual	1.3	*1.3

¹Reason for visit codes are based on *A Reason for Visit Classification for Ambulatory Care* (RVC).

²Includes congenital anomalies (D950-D989), poisoning and adverse effects (J900-J999), and blank and uncodable entries (U990-U999).

Table 5. Number and percent of new problem office visits made by women 15 years and over, by time since onset of complaint or symptom and principal symptom: United States, 1977

Principal symptom and RVC code ¹	Number of new problem visits in thousands	Time since onset of complaint or symptom			
		Less than 1 week	1-3 weeks	1-3 months	More than 3 months
Percent distribution ²					
General symptoms.....S001-S099	8,048	41.9	19.4	13.9	21.7
Symptoms referable to psychological and mental disorders.....S100-S199	1,795	23.1	*21.7	*21.5	30.6
Symptoms referable to the nervous system (excluding sense organs).....S200-S259	4,744	42.6	17.7	16.7	20.2
Symptoms referable to the cardiovascular and lymphatic systems.....S260-S299	615	*49.8	*12.2	*21.4	*13.0
Symptoms referable to the eyes and ears.....S300-S399	7,143	46.3	12.9	13.6	21.5
Symptoms referable to the respiratory system.....S400-S499	12,833	72.6	18.8	5.5	4.7
Symptoms referable to the digestive system.....S500-S639	8,050	47.4	24.5	12.7	14.3
Symptoms referable to the genitourinary system.....S640-S829	12,343	34.8	26.7	19.7	16.2
Symptoms referable to the skin, nails, and hair.....S830-S899	7,516	24.1	17.8	20.7	32.7
Symptoms referable to the musculoskeletal system.....S900-S999	11,300	40.9	24.1	17.5	16.3

¹Reason for visit codes are based on *A Reason for Visit Classification for Ambulatory Care (RVC)*.

²Percents will not add to 100.0 because time since onset of complaint was not applicable to a small percent of visits, e.g., visits for screening and preventive care.

Table 6. Number and percent of new problem office visits made by women 15 years and over, by time since onset of complaint or symptom and specific principal reason for visit: United States, 1977

Specific principal reason for visit and RVC code ¹	Number of new problem visits in thousands	Time since onset of complaint or symptom		
		Less than 1 week	1-3 weeks	1 month or more
Percent ²				
Chest pain and related symptoms (not referable to body system).....S050	1,836	52.6	21.5	24.4
Anxiety and nervousness.....S100	8,822	*25.3	*27.5	*44.9
Headache, pain in head.....S210	2,544	35.2	19.3	41.5
Vision dysfunctions.....S305	1,621	*10.3	*6.0	68.9
Cough.....S440	2,618	70.9	22.5	*6.7
Head cold, upper respiratory infection.....S445	2,873	75.8	19.3	*3.9
Symptoms referable to throat.....S455	4,228	79.8	14.8	*5.0
Abdominal pain, cramps, spasms.....S550	3,151	46.8	27.9	23.6
Uterine and vaginal bleeding.....S755	1,374	*16.2	36.0	46.9
Vaginal discharge.....S760	1,273	*31.7	46.2	*19.5
Other vaginal symptoms.....S765	1,417	48.0	*28.0	*23.5
Lump or mass of breast.....S805	1,131	*31.2	*29.6	*34.3
Back symptoms.....S905	2,056	41.5	28.8	28.7
Prenatal examination, routine ³X205	3,296	*1.3	*2.8	68.8

¹Reason for visit codes are based on *A Reason for Visit Classification for Ambulatory Care (RVC)*.

²Percents will not add to 100.0 because time since onset of complaint was not applicable to a small percent of visits, e.g., visits for screening and preventive care.

³The "time since onset" for 34 percent of these visits was more than 3 months.

Table 7. Number and percent distribution of new problem office visits made by women 15 years and over by time since onset of complaint or symptom, according to age of patient: United States, 1977

Age of patient	Number of new problem visits in thousands	Time since onset of complaint or symptom						
		Total	Less than 1 day	1-6 days	1-3 weeks	1-3 months	More than 3 months	Not applicable ¹
Percent distribution								
15-24 years.....	26,766	100.0	6.4	31.9	16.2	13.4	14.2	17.9
25-34 years.....	24,654	100.0	5.1	28.1	16.1	16.1	17.2	17.4
35-44 years.....	14,220	100.0	5.2	33.6	16.3	12.1	17.1	15.8
45-54 years.....	14,707	100.0	4.3	30.9	19.6	15.7	19.0	10.6
55-64 years.....	12,498	100.0	4.8	34.6	18.2	15.0	16.7	10.8
65-74 years.....	8,790	100.0	4.5	28.6	24.6	12.7	21.1	8.6
75 years and over.....	5,181	100.0	5.5	35.3	17.6	11.7	22.2	8.3

¹Refers chiefly to visits not involving a symptom or complaint, e.g., annual examination.

Table 8. Number and percent distribution of office visits made by women 15 years and over by most visited physician specialty, according to race of patient: United States, 1977

Physician specialty	Number in thousands	Race of patient		
		All races	White	Black and all other
Percent distribution				
All visits.....	294,958	100.0	100.0	100.0
General and family practice.....	116,967	39.7	39.3	43.0
Obstetrics and gynecology.....	48,629	16.5	16.4	17.4
Internal medicine.....	37,487	12.7	12.7	12.5
General surgery.....	19,575	6.6	6.6	6.8
Ophthalmology.....	14,341	4.9	5.0	3.6
Dermatology.....	9,222	3.1	3.2	2.6
Psychiatry.....	9,159	3.1	3.3	1.4
Orthopedic surgery.....	8,157	2.8	2.8	2.7
Otolaryngology.....	7,030	2.4	2.4	2.1
Urological surgery.....	4,271	1.5	1.5	1.4
Cardiovascular diseases.....	3,039	1.0	1.1	0.6
Neurology.....	1,394	0.5	0.5	0.3
All other specialties.....	15,687	5.3	5.2	5.6

Table 9. Number, percent distribution, and cumulative percent of office visits made by women 15 years and over, by principal diagnoses in rank order: United States, 1977

Rank	Principal diagnosis and ICDA code ¹	Number in thousands	Percent distribution	Cumulative percent
	All diagnoses.....	294,958	100.0	100.0
1	Prenatal care..... Y06	20,714	7.0	7.0
2	Medical or special examination..... Y00	17,125	5.8	12.8
3	Essential benign hypertension.....401	15,419	5.2	18.0
4	Medical and surgical aftercare..... Y10	9,906	3.4	21.4
5	Neuroses.....300	8,157	2.8	24.2
6	Diabetes mellitus.....250	6,378	2.2	26.4
7	Acute upper respiratory infection of multiple or unspecified sites.....465	6,036	2.0	28.4
8	Chronic ischemic heart disease.....412	5,711	1.9	30.3
9	Obesity.....277	5,399	1.8	32.1
10	Hay fever.....507	5,131	1.7	33.8
11	Other eczema and dermatitis.....692	4,339	1.5	35.3
12	Refractive errors.....370	4,246	1.4	36.7
13	Diseases of sebaceous glands.....706	4,087	1.4	38.1
14	Osteoarthritis and allied conditions.....713	3,957	1.3	39.4
15	Disorders of menstruation.....626	3,869	1.3	40.7
16	Menopausal symptoms.....627	3,678	1.2	41.9
17	Acute pharyngitis.....462	3,293	1.1	42.0
18	Infective diseases of uterus (except cervix), vagina, and vulva.....622	3,192	1.1	43.1
19	Arthritis, unspecified.....715	3,126	1.1	44.2
20	Cystitis.....595	3,001	1.0	45.2
21	Synovitis, bursitis, and tenosynovitis.....731	2,505	0.8	46.0
22	Sprains and strains of other unspecified parts of back.....847	2,501	0.8	46.8
23	Chronic sinusitis.....503	2,485	0.8	47.6
24	Bronchitis, unqualified.....490	2,393	0.8	48.4
25	Other nonarticular rheumatism.....717	2,339	0.8	49.2
26	Nervousness and debility.....790	2,326	0.8	50.0
27	Observation without need for further care.....793	2,294	0.8	50.8
28	Postpartum observation..... Y07	2,197	0.7	51.5
29	Other diseases of urinary tract.....599	2,142	0.7	52.2
30	Asthma.....493	1,948	0.7	52.9
31	Otitis media.....381	1,833	0.6	53.5
32	Symptomatic heart disease.....427	1,831	0.6	54.1
33	Other viral diseases.....079	1,758	0.6	54.7
34	Diarrheal disease.....009	1,609	0.5	55.2
35	Chronic cystic disease of breast.....610	1,602	0.5	55.7
36	Other diseases of eye.....378	1,576	0.5	56.2
37	Rheumatoid arthritis and allied conditions.....712	1,571	0.5	56.7
38	Vertebrogenic pain syndrome.....728	1,501	0.5	57.2
39	Fitting of prosthetic device..... Y12	1,468	0.5	57.7
40	Myxedema.....244	1,459	0.5	58.2
41	Moniliasis.....112	1,458	0.5	58.7
42	Cataract.....374	1,453	0.5	59.2
43	Certain symptoms referable to nervous system and special senses.....780	1,451	0.5	59.7
44	Laboratory examination..... Y03	1,392	0.5	60.2
45	Glaucoma.....375	1,348	0.5	60.7
46	Other diseases of ear and mastoid process.....387	1,329	0.5	61.2
47	Personality disorders.....301	1,289	0.4	61.6
48	Stricture of urethra.....598	1,253	0.4	62.0
49	Influenza, unqualified.....470	1,245	0.4	62.4
50	Functional disorders of intestines.....564	1,176	0.4	62.8
51	Other and unspecified anemias.....285	1,176	0.4	63.2
52	Gastritis and duodenitis.....535	1,150	0.4	63.6
53	Sprains and strains of sacroiliac region.....846	1,148	0.4	64.0
54	Acute tonsillitis.....463	1,128	0.4	64.4
55	Infective diseases of cervix uteri.....620	1,114	0.4	64.8
56	Other and unspecified forms of neuralgia and neuritis.....355	1,101	0.4	65.2
57	Schizophrenia.....295	1,101	0.4	65.6
58	Symptoms referable to abdomen and lower gastrointestinal tract.....785	1,032	0.3	65.9
	All other diagnoses.....residual	---	34.1	100.0

¹Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States* (ICDA).

Table 10. Number and percent distribution of office visits made by women 15 years and over, by age of patient and the 20 most frequent principal diagnoses: United States, 1977

Age of patient, principal diagnosis, and ICDA code ¹	Number in thousands	Percent distribution
All ages.....	294,958	100.0
<u>15-24 years</u>		
Total.....	56,055	100.0
Prenatal care..... Y06	9,951	17.8
Medical or special examination..... Y00	5,106	9.1
Diseases of sebaceous glands..... Y06	2,140	3.8
Acute upper respiratory infection of multiple or unspecified sites..... Y06	1,635	2.9
Medical and surgical aftercare..... Y10	1,380	2.5
Disorders of menstruation..... Y20	1,324	2.4
Acute pharyngitis..... Y06	1,289	2.3
Hay fever..... Y06	1,206	2.2
Obesity..... Y06	1,180	2.1
Refractive errors..... Y06	1,053	1.9
Infective diseases of uterus (except cervix), vagina, and vulva..... Y20	1,019	1.8
Other eczema and dermatitis..... Y06	994	1.8
Neuroses..... Y06	923	1.6
Other person without complaint or illness ² Y09	864	1.5
Postpartum observation..... Y07	764	1.4
Acute tonsillitis..... Y06	637	1.1
Other viral diseases..... Y06	610	1.1
Otitis media..... Y06	563	1.0
Cystitis..... Y06	552	1.0
Diseases of parametrium and pelvis peritoneum..... Y20	535	1.0
Other..... residual	22,330	39.8
<u>25-44 years</u>		
Total.....	97,450	100.0
Prenatal care..... Y06	10,626	10.9
Medical or special examination..... Y00	7,629	7.8
Neuroses..... Y06	4,412	4.5
Medical and surgical aftercare..... Y10	3,223	3.3
Obesity..... Y06	2,707	2.8
Acute upper respiratory infection of multiple or unspecified sites..... Y06	2,233	2.3
Hay fever..... Y06	2,156	2.2
Disorders of menstruation..... Y20	1,834	1.9
Other eczema and dermatitis..... Y06	1,585	1.6
Diseases of sebaceous glands..... Y06	1,422	1.5
Postpartum observation..... Y07	1,411	1.4
Essential benign hypertension..... Y20	1,340	1.4
Infective diseases of uterus (except cervix), vagina, and vulva..... Y20	1,324	1.4
Refractive errors..... Y06	1,154	1.2
Sprains, strains of other and unspecified parts of back..... Y06	1,128	1.2
Acute pharyngitis..... Y06	1,090	1.1
Cystitis..... Y06	1,079	1.1
Other person without complaint or illness ³ Y09	1,038	1.1
Bronchitis, unqualified..... Y06	926	1.0
Personality disorders..... Y06	881	0.9
Other..... residual	48,252	49.5

See footnotes at end of table.

Table 10. Number and percent distribution of office visits made by women 15 years and over, by age of patient and the 20 most frequent principal diagnoses: United States, 1977—Con.

Age of patient, principal diagnosis, and ICDA code ¹	Number in thousands	Percent distribution
45-64 years		
Total.....	84,241	100.0
Essential benign hypertension.....401	7,421	8.8
Medical or special examination.....Y00	3,518	4.2
Medical and surgical aftercare.....Y10	3,504	4.2
Menopausal symptoms.....627	2,764	3.3
Diabetes mellitus.....250	2,677	3.2
Neuroses.....300	2,208	2.6
Refractive errors.....370	1,601	1.9
Acute upper respiratory infection of multiple or unspecified sites.....465	1,513	1.8
Osteoarthritis and allied conditions.....713	1,470	1.7
Obesity.....277	1,338	1.6
Chronic ischemic heart disease.....412	1,293	1.5
Other eczema and dermatitis.....692	1,289	1.5
Hay fever.....507	1,221	1.4
Arthritis, unspecified.....715	1,030	1.2
Synovitis, bursitis, and tenosynovitis.....731	1,014	1.2
Other nonarticular rheumatism.....717	954	1.1
Nervousness and debility ⁴790	953	1.1
Chronic sinusitis.....503	870	1.0
Cystitis.....595	823	1.0
Asthma.....493	790	0.9
Other.....residual	45,990	54.6
65 years and over		
Total.....	57,212	100.0
Essential benign hypertension.....401	6,517	11.4
Chronic ischemic heart disease.....412	4,306	7.5
Diabetes mellitus.....250	2,957	5.2
Osteoarthritis and allied conditions.....713	2,338	4.1
Medical and surgical aftercare.....Y10	1,799	3.1
Arthritis, unspecified.....715	1,703	3.0
Symptomatic heart disease.....427	1,244	2.2
Cataract.....374	1,062	1.9
Medical or special examination.....Y00	873	1.5
Glaucoma.....375	839	1.5
Other diseases of eye.....378	814	1.4
Acute upper respiratory infection of multiple or unspecified sites.....465	655	1.1
Neuroses.....300	614	1.1
Hay fever.....507	549	1.0
Cystitis.....595	547	1.0
Diverticula of intestine.....562	534	0.9
Other and unspecified anemias.....285	501	0.9
Rheumatoid arthritis and allied conditions.....712	491	0.9
Synovitis, bursitis, and tenosynovitis.....731	475	0.8
Other eczema and dermatitis.....692	471	0.8
Other.....residual	27,923	48.8

¹Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States* (ICDA).

²In 67 percent of these visits, the reason for visit was family planning.

³In 70 percent of these visits, the reason for visit was family planning.

⁴About 55 percent of these diagnoses were depression (790.2).

Table 11. Number and percent of office visits made by women 15 years and over, by race of patient and selected principal diagnoses: United States, 1977

Principal diagnosis and ICDA code ¹	Race of patient		
	All races	White	Black and all other
	Number		
All visits.....	294,958	266,811	28,146
	Percent ²		
Diabetes mellitus.....250	2.2	2.0	3.5
Obesity277	1.8	1.8	2.2
Neuroses300	2.8	2.9	1.8
Refractive errors370	1.4	1.5	1.0
Essential benign hypertension401	5.2	5.0	7.0
Chronic ischemic heart disease412	1.9	1.9	2.5
Acute pharyngitis.....462	1.1	1.2	*0.8
Acute upper respiratory infection of multiple or unspecified sites.....465	2.0	2.0	2.1
Hay fever507	1.7	1.8	*1.0
Cystitis.....595	1.0	1.0	*1.0
Infective diseases of uterus (except cervix), vagina, and vulva.....622	1.1	1.0	1.8
Disorders of menstruation.....626	1.3	1.3	1.7
Menopausal symptoms.....627	1.3	1.3	*1.0
Other eczema and dermatitis.....692	1.5	1.5	*1.4
Diseases of sebaceous glands706	1.4	1.4	*1.1
Osteoarthritis and allied conditions.....713	1.3	1.3	1.6
Arthritis, unspecified715	1.1	1.0	1.8
Nervousness and debility790	0.8	0.8	*0.5
Medical or special examinationY00	5.8	6.0	4.2
Prenatal careY06	7.0	7.1	6.3
Medical and surgical aftercareY10	3.4	3.3	4.1

¹Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States (ICDA)*.

²Percents will not add to 100.0 because all diagnoses are not listed in the table.

Table 12. Return visit rate of women 15 years and over, by selected principal diagnoses: United States, 1977

Principal diagnosis and ICDA code ¹	Return visit rate ²
All diagnoses.....	1.76
Diabetes mellitus	7.69
Obesity	3.05
Neuroses	3.60
Essential benign hypertension.....	9.38
Chronic ischemic heart disease.....	12.40
Acute pharyngitis	0.48
Acute upper respiratory infection of multiple or unspecified sites.....	0.60
Hay fever	5.31
Cystitis	0.85
Infective diseases of uterus (except cervix), vagina, and vulva.....	0.76
Disorders of menstruation	0.74
Menopausal symptoms.....	3.67
Other eczema and dermatitis	1.55
Osteoarthritis and allied conditions	3.89
Arthritis, unspecified	3.57
Prenatal care.....	3.95

¹Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States (ICDA)*.

²The return visit rate is the ratio of return visits to new problem visits. Where the rate is less than 1.0, new problem visits exceeded return visits.

Table 13. Number and percent distribution of office visits made by patients 15 years and over by seriousness of the problem, according to age and sex of patient: United States, 1977

Age and sex of patient	Number of visits in thousands	Total	Serious or very serious	Slightly serious or not serious
All visits	466,296	100.0	18.3	81.7
All ages:				
Female	294,958	100.0	18.1	81.9
Male	171,339	100.0	24.4	85.6
15-24 years:				
Female	56,055	100.0	8.4	91.7
Male	29,706	100.0	14.5	85.0
24-44 years:				
Female	97,450	100.0	14.0	86.0
Male	48,880	100.0	17.9	82.1
45-64 years:				
Female	84,241	100.0	20.7	79.3
Male	57,922	100.0	27.9	72.1
65 years and over:				
Female	57,212	100.0	30.8	69.2
Male	34,831	100.0	36.2	63.8

Table 14. Number and percent of office visits made by women 15 years and over, by age of patient and diagnostic and therapeutic services ordered or provided: United States, 1977

Diagnostic and therapeutic services	Age of patient							
	All ages	15-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75 years and over
	Number in thousands							
All visits	294,958	56,055	60,547	36,902	42,194	42,047	35,081	22,131
	Percent							
<u>Diagnostic service</u>								
Limited history and/or examination	57.5	59.1	58.4	53.4	54.3	57.0	59.4	62.4
General history and/or examination	20.9	21.2	20.3	22.4	23.1	20.9	19.1	18.8
Pap test	10.3	12.0	30.7	16.4	14.1	9.7	4.9	2.1
Clinical laboratory test	24.4	27.9	27.9	21.4	20.3	22.9	23.8	22.0
X-ray	7.1	4.4	5.4	7.0	8.5	9.0	9.8	8.1
Electrocardiogram	2.8	*0.4	1.1	2.1	3.6	4.4	5.6	5.3
Vision test	3.7	3.7	2.1	2.4	4.0	4.6	5.2	6.1
Endoscopy	1.5	1.0	1.4	1.3	1.7	2.0	1.8	*1.7
Blood pressure check	43.9	37.3	42.9	38.9	43.3	47.7	51.3	53.7
Other diagnostic services	4.5	4.5	4.1	4.7	4.2	5.1	4.8	4.2
None	11.3	11.5	12.7	14.9	12.3	10.0	8.0	6.2
<u>Therapeutic service</u>								
Immunization or desensitization	3.5	3.8	4.0	3.8	3.7	3.4	3.0	2.1
Drugs (prescription or nonprescription)	55.2	49.3	46.0	52.2	58.6	61.2	64.2	68.4
Diet counseling	7.6	7.1	7.5	7.0	7.8	9.1	8.4	6.2
Family planning	2.6	5.5	5.7	1.6	*0.5	*0.0	*0.0	*0.0
Medical counseling	20.9	18.0	20.3	18.3	21.5	22.1	23.4	27.1
Physiotherapy	3.2	2.6	3.1	3.9	3.6	3.3	3.5	2.2
Office surgery	7.1	7.0	6.9	7.9	6.7	7.9	6.5	6.1
Psychotherapy or therapeutic listening	6.4	5.3	8.1	9.8	8.0	5.3	3.2	3.4
Other therapeutic services	2.8	2.7	2.2	2.7	3.7	2.7	2.9	2.9
None	20.0	24.2	24.2	20.1	17.2	17.3	16.1	15.2

¹Percents will not add to 100.0 because more than 1 diagnostic or therapeutic service may have been ordered or provided.

Table 15. Number and percent of office visits made by patients 15 years and over, by race of female, sex of patient, and diagnostic and therapeutic services ordered or provided: United States, 1977

Diagnostic and therapeutic service	Race of female		Sex of patient	
	White	Black and all other	Female	Male
	Number in thousands			
All visits	266,811	28,146	294,958	171,339
	Percent			
<u>Diagnostic service</u>				
Limited history and/or examination	57.0	62.8	57.5	57.7
General history and/or examination	20.9	21.2	20.2	18.9
Pap test	10.5	8.5	10.3	...
Clinical laboratory test	24.3	24.7	24.4	19.2
X-ray	7.2	6.5	7.1	11.2
Electrocardiogram	2.8	2.0	2.8	5.2
Vision test	3.8	2.9	3.7	4.8
Endoscopy	1.5	*1.2	1.5	1.4
Blood pressure check	43.0	52.3	43.9	33.4
Other diagnostic services	4.6	3.6	4.5	4.9
None	11.7	7.2	11.3	13.1
<u>Therapeutic service</u>				
Immunization or desensitization	3.7	2.3	3.5	4.5
Drugs (prescription or nonprescription)	54.2	64.6	55.2	53.2
Diet counseling	7.7	7.3	7.6	6.4
Family planning	2.6	2.4	2.6	*0.2
Medical counseling	21.2	18.1	20.9	20.9
Physiotherapy	3.2	3.2	3.2	4.8
Office surgery	7.3	5.0	7.1	10.4
Psychotherapy or therapeutic listening	6.6	4.5	6.4	5.9
Other therapeutic services	2.9	1.9	2.8	3.1
None	20.4	16.4	20.0	18.9

¹Percents will not add to 100.0 because more than 1 diagnostic or therapeutic service may have been ordered or provided.

Table 16. Number and percent of office visits made by women 15 years and over, by selected diagnostic services and selected principal reasons for visit: United States, 1977

Principal reason for visit and RVC code ¹	Number in thousands	Diagnostic service			
		Limited history and/or examination	General history and/or examination	Clinical laboratory test	Blood pressure check
		Percent ²			
Tiredness, exhaustionS015	3,011	58.6	21.3	36.9	56.6
Chest pain and related symptoms (not related to body system)S050	4,304	63.0	25.4	23.7	62.8
Anxiety and nervousnessS100	3,924	41.5	18.7	*11.2	44.0
DepressionS110	2,945	16.5	*7.7	*3.2	15.8
Headache, pain in headS210	5,968	59.6	25.2	15.7	56.0
Vision dysfunctionsS305	3,887	49.2	27.2	1.0	*4.9
CoughS440	4,690	68.9	22.3	13.1	44.7
Head cold, upper respiratory infectionS445	4,358	69.2	17.0	10.5	45.2
Symptoms referable to throatS455	6,357	78.1	14.5	18.9	30.8
Abdominal pain, cramps, spasmsS550	5,493	56.9	31.6	33.6	46.6
Painful urinationS650	1,955	65.3	*16.9	81.1	39.6
Menopausal symptomsS750	1,307	50.5	*21.2	*16.4	62.3
Uterine and vaginal bleedingS755	2,291	55.1	37.8	29.0	62.8
Vaginal dischargeS760	2,129	64.6	27.9	50.2	44.2
Other vaginal symptomsS765	2,284	67.9	*19.2	48.6	36.9
Back symptomsS905	5,534	60.4	20.7	17.1	38.0
Low back symptomsS910	2,290	61.2	*17.6	*18.9	39.6

¹Reason for visit codes are based on *A Reason for Visit Classification for Ambulatory Care (RVC)*.

²Percents will not add to 100.0 because more than 1 service may have been ordered or provided.

Table 17. Number and percent of office visits made by women 15 years and over, by selected therapeutic services ordered or provided and selected principal diagnoses: United States, 1977

Principal diagnosis and ICDA code ¹	Number in thousands	Therapeutic service				
		Drugs (prescription or nonprescription)	Diet counseling	Medical counseling	Immunization or desensitization	Psychotherapy or therapeutic listening
		Percent ²				
Essential benign hypertension401	15,419	81.1	16.5	24.4	...	3.1
Diabetes mellitus250	6,378	65.4	36.5	32.8	...	*2.2
Chronic ischemic heart disease412	5,711	77.8	11.7	36.8	...	*2.9
Obesity277	5,399	67.6	68.2	19.8	...	13.2
Neuroses300	8,157	52.5	*4.6	13.6	...	61.4
Hay fever507	5,131	34.2	*2.8	11.0	63.0	*0.9
Asthma493	1,948	60.9	*1.1	27.2	39.7	*2.7
Other eczema and dermatitis692	4,339	70.6	*1.4	10.6	23.7	*0.5

¹Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States, 1965*.

²Percents will not add to 100.0 because more than 1 service may have been ordered or provided, and all services are not listed in the table.

Table 18. Number and percent distribution of new female patients 15 years and over referred from another physician, by principal diagnosis: United States, 1977

Principal diagnosis and ICDA code ¹	Number of new patients in thousands	Percent distribution
All principal diagnoses.....	11,138	100.0
Neoplasms.....140-239	963	8.7
Endocrine, nutritional, and metabolic diseases.....240-279	444	4.0
Mental disorders.....290-315	489	4.4
Diseases of the nervous system and sense organs.....320-389	1,262	11.3
Diseases of the circulatory system.....390-458	690	6.2
Diseases of the respiratory system.....460-519	521	4.7
Diseases of the digestive system.....520-577	519	4.7
Diseases of the genitourinary system.....580-629	1,263	11.3
Diseases of the skin and subcutaneous tissue.....680-709	878	7.9
Diseases of the musculoskeletal system.....710-738	860	7.7
Symptoms and ill-defined conditions.....780-796	994	8.9
Accidents, poisoning, and violence.....800-990	945	8.5
Special conditions and examinations without sickness.....Y00-Y13	839	7.5
Other diagnoses ²residual	472	4.2

¹Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States* (ICDA).

²Includes infective and parasitic diseases (000-136); diagnosis of "none;" blank, noncodable, and illegible diagnoses; and other diagnoses.

Table 19. Number and percent distribution of office visits made by women 15 years and over by duration of visit, according to selected patient characteristics and seriousness of condition: United States, 1977

Patient characteristic and seriousness of condition	Number in thousands	Duration of visit					
		Total	0 minutes ¹	1-10 minutes	11-15 minutes	16-30 minutes	31 minutes or more
<u>Race</u>		Percent distribution					
White.....	266,811	100.0	2.4	41.2	27.2	22.6	6.6
Black and all other	28,146	100.0	*0.8	45.5	28.7	21.7	3.3
<u>Age</u>							
15-24 years.....	56,055	100.0	1.2	51.3	23.7	19.0	4.8
25-34 years.....	60,547	100.0	1.7	44.7	25.8	20.3	7.5
35-44 years.....	36,902	100.0	3.1	37.9	28.0	21.7	9.4
45-54 years.....	42,194	100.0	3.2	37.2	27.8	24.8	7.0
55-64 years.....	42,047	100.0	2.6	38.4	28.8	24.5	5.6
65 years and over	57,212	100.0	2.4	37.0	30.5	25.7	4.4
<u>Status</u>							
New patient.....	41,068	100.0	*0.5	25.8	27.9	33.4	12.5
Old patient, new problem.....	65,748	100.0	*0.6	43.0	30.4	22.9	3.2
Old patient, old problem	188,141	100.0	3.2	44.6	26.1	20.0	6.0
<u>Seriousness of condition</u>							
Not serious.....	152,618	100.0	2.2	47.0	27.1	19.8	3.9
Slightly serious.....	88,934	100.0	2.3	41.5	27.4	23.3	5.5
Serious	44,035	100.0	1.8	27.9	28.8	28.2	13.2
Very serious	9,370	100.0	*3.3	19.7	22.8	33.7	20.5

¹Indicates no direct encounter between patient and physician.

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APPENDIX I

TECHNICAL NOTES^c

This report is based on data collected in the 1977 National Ambulatory Medical Care Survey (NAMCS), an annual sample survey of office-based physicians conducted by the Division of Health Resources Utilization Statistics of the National Center for Health Statistics.

Statistical Design

Scope of the survey.—The target population of 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, or radiology. Telephone contacts and nonoffice visits are excluded.

Sample design.—The NAMCS utilizes a multistage probability design that involves 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) of the University of Chicago, the organization responsible for NAMCS field and data processing operations under contract to the National Center for Health Statistics. 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.

The second stage consisted of a probability sample of practicing physicians selected from the master files maintained by the American Medical Association (AMA) and the American Osteopathic Association (AOA) who met the following criteria:

Office-based, as defined by 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 1977 NAMCS physician universe included 188,690 doctors of medicine and 10,010 doctors of osteopathy (see table I).

Within each PSU, all eligible physicians were arranged by nine specialty groups: general and family medicine, internal medicine, pediatrics, other medical specialties, general surgery, obstetrics and gynecology, other surgical specialties, psychiatry, and all 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 1977 NAMCS physician sample included 3,000 physicians. Sample physicians were screened at the time of the survey to ensure that they met the aforementioned criteria; 507 physicians did not meet all the criteria and were therefore ruled out of scope (ineligible) for the study. The most common reasons for being out

^cPrepared by Thomas McLemore, M.S.P.H., Division of Health Resources Utilization Statistics.

Table I. Distribution of physicians in the universe¹ and in the 1977 National Ambulatory Medical Care Survey sample and response rates, by physician specialty

Physician specialty	Universe	Gross total	Out of scope	Net total	Non-respondents	Respondents	Response rate
All specialties	198,700	3,000	507	2,493	561	1,932	77.5
General and family practice	52,432	740	140	600	162	438	73.0
Medical specialties.....	54,011	826	132	694	169	525	75.6
Internal medicine	28,109	430	65	365	99	266	72.9
Pediatrics	13,260	203	34	169	34	135	79.9
Other medical specialties.....	12,642	193	33	160	36	124	77.5
Surgical specialties	68,901	1,062	112	950	187	763	80.3
General surgery	20,067	302	41	261	44	217	83.1
Obstetrics and gynecology	15,937	249	21	228	54	174	76.3
Other surgical specialties.....	32,897	511	50	461	89	372	80.7
Other specialties.....	23,356	372	123	249	43	206	82.7
Psychiatry	13,747	221	47	174	32	142	81.6
Other specialties.....	9,609	151	76	75	11	64	85.3

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

of scope were that the physician was retired, deceased, or employed in teaching, research or administration. Of the 2,493 in-scope (eligible) physicians, 1,932 (77.5 percent) participated in the study. Of the participating physicians, 265 physicians saw no patients during their assigned reporting period because of vacations, illnesses, or other reasons for being temporarily not in practice. The physicians sample size and response data by physician specialty are shown in table I.

The final stage was the selection of patient visits within the annual practices of the 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. The method by which the sampling rate was determined is described later in this appendix and in the Induction Interview Form in appendix III. During 1977, 51,044 useable Patient Record forms were completed by physicians participating in NAMCS.

Data Collection and Processing

Field procedures.—Both mail and telephone contacts were used to enlist sample physicians for NAMCS. Physicians received introductory letters from NCHS (see appendix III) and 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 physician to explain briefly the study and arrange an appointment for a personal interview. A physician who did not respond initially was generally recontacted via a telephone call or special explanatory letter requesting him to reconsider participation in the study.

During the personal interview the field representative determined the physician's eligibility, ascertained his cooperation, delivered survey materials with verbal and printed instructions, and assigned a predetermined Monday-Sunday reporting period. A short interview concerning basic practice characteristics, such as type of practice and expected number of office visits, was conducted. 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 questions that might have arisen and to ensure that procedures were going smoothly. At the end of the survey week, the participating physician mailed the finished survey materials to the interviewer, who edited the forms for completeness before transmitting them for central data processing. Problems of missing or incomplete data were resolved at this stage 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 NAMCS. After the end of the survey year, each sample physician was sent a thank-you letter from NCHS along with one of the survey's statistical reports.

Data collection.—The actual data collection for 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 visits for which data were to be recorded. A perforation between the patient names and patient visit characteristics permitted the physician to remove and retain the patient names, thus protecting the confidentiality of the patients.

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 Record forms were completed during the assigned reporting week. Physicians expecting 10 or fewer visits each day recorded data for all visits, 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 approximately 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 recorded 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 items.

Information contained in item 6 (patient's problem or reason for visit) of the Patient Record was coded according to *A Reason for Visit Classification for Ambulatory Care*.⁶ Diagnostic information (item 8 of the Patient Record) was coded according to the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States*.²⁰ A maximum of three entries were coded from each of these items. Quality control in the medical coding operation involved a two-way independent verification procedure with 100-percent verification. Coding differences were adjudicated at the National Center for Health Statistics.

Information from the Induction Interview and Patient Record forms was keypunched, with 100-percent verification, and converted to computer tape. At this point, extensive computer consistency and edit checks were performed. Incomplete items were imputed by assigning a value from a Patient Record with similar characteristics; physician specialty and broad diagnostic categories were used as the basis for these imputations.

Estimation Procedures

Statistics from the 1977 National Ambulatory Medical Care Survey were derived by a multistage estimation procedure, which produces essentially unbiased national estimates and has three basic components: (1) inflation by reciprocals of the probabilities of selection, (2) adjustment for nonresponse, and (3) a ratio adjustment to fixed totals. Each component is described briefly.

Inflation by reciprocals of sampling probabilities.—Since the survey utilized a three-stage sample design, there were three probabilities of

NOTE: A list of references follows the text.

selection: (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 within 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, physicians were judged similar if they had the same specialty designation and practiced 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 of which the numerator was the number of physicians in the universe in each physician specialty group and the denominator the estimated number of physicians in that particular specialty group. The numerator was based on figures obtained from the AMA-BOA 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 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 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. The standard error, as calculated in this report, also reflects part of the variation that 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 percent of the estimate. For this report, an asterisk (*) precedes 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 published.^{24,25}

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.

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:

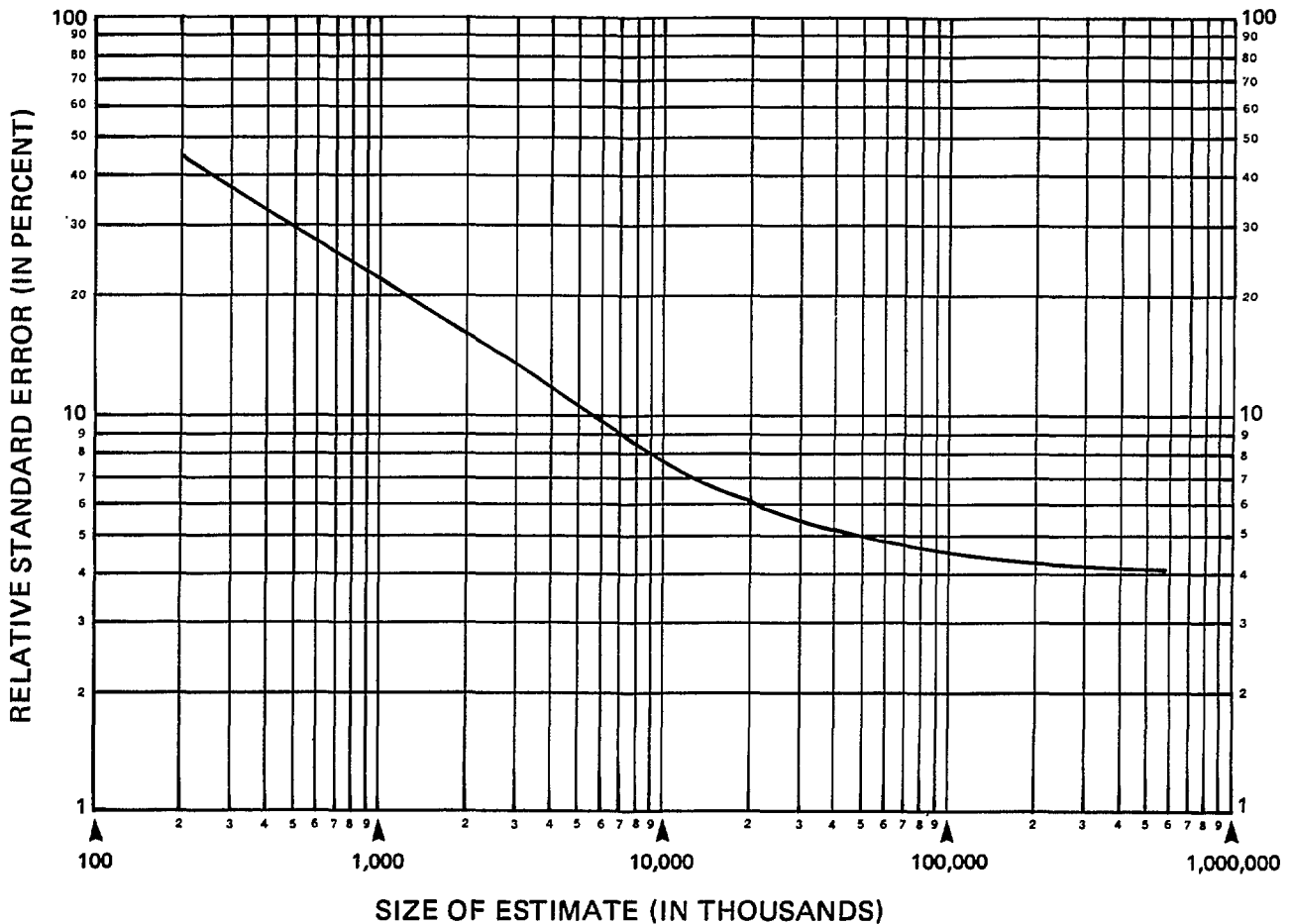
$$RSE(x) = \sqrt{0.00160725 + \frac{41.31046}{x}} \cdot 100$$

where x is the aggregate of interest in thousands.

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

NOTE: A list of references follows the text.

Figure I. Approximate relative standard errors for estimated numbers of office visits, 1977 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 7.6 percent (read from scale at left side of chart) or a standard error of 760,000 office visits (7.6 percent of 10 million visits).

resulting value for the denominator from the resulting value for the numerator, and extract the square root. This calculation has been made for several percents and bases and is presented in figure II. Alternatively, the formula

$$RSE(p) = \sqrt{\frac{41.31046(1-p)}{p \cdot x}} \cdot 100$$

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

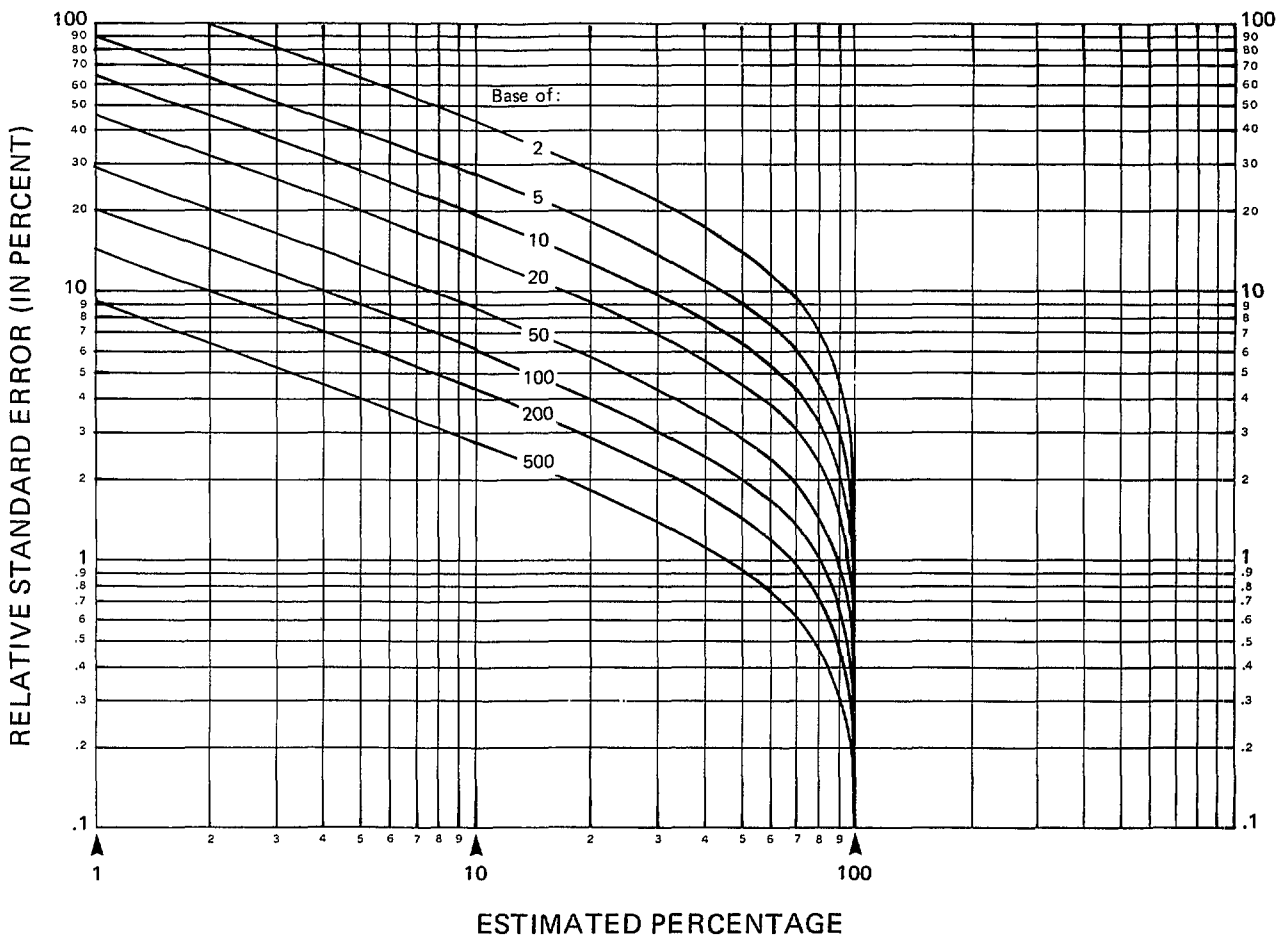
Estimates of rates where the numerator is not a subclass of the denominator.—Approximate relative standard errors for rates in which

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.

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 represents the standard error quite accurately for the difference between separate

Figure II. Approximate relative standard errors for percentages of estimated numbers of office visits, 1977 National Ambulatory Medical Care Survey

(Base of percentage shown on curves in millions)



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 12.9 percent (read from scale at left of chart) or a standard error of 2.6 percentage points (12.9 percent of 20 percent).

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, they were kept to a minimum by procedures built into the survey operation. Careful attention and extensive pretesting were given to the phrasing of the questions and the terms (and their definitions) employed in order to eliminate ambiguities and

encourage uniformity of reporting. The steps taken to reduce nonresponse bias are discussed in the sections on field procedures and data collection. Quality control procedures and consistency and edit checks, discussed in the data processing section, reduced errors in data coding and processing.

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 are statistically significant. Terms such as "similar" or "no difference" mean that no statistical significance exists between the estimates being compared. A lack of comment regarding the difference between any two estimates does not mean that the difference was tested and found to be not significant.

Population Figures

The base population used in computing annual visit rates is presented in table II. The figures are based on provisional estimates for the civilian noninstitutionalized population of the United States as of July 1, 1977, provided by the U.S. Bureau of the Census. Because NAMCS included data for only the conterminous 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 official and are presented here solely to provide denominators for rate computations.

Systematic Bias

There have been no attempts to determine systematic bias on the data reported here. There are several factors, however, which the user of these data should understand, that indicate that these data underrepresent the total number of office visits to office-based physicians. Some of the factors are:

1. The sampling frame for the 1977 NAMCS included all nonfederally employed, "office-based, patient care" physicians on the AMA-AOA master files. There are certainly physicians not so classified who, at the time of survey, would have met the criteria for that

Table II. Estimates of the civilian noninstitutionalized population of the United States,¹ by age, race, and sex: United States, July 1, 1977

[Used in the calculation of rates for this report]

Race and sex	All ages	Age							
		Under 15 years	15-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75 years and over
		Number in thousands							
All races.....	210,843	51,186	39,425	31,947	22,946	23,075	20,065	14,217	7,983
Male.....	101,745	26,110	19,350	15,499	11,021	11,126	9,471	6,178	2,991
Female.....	109,098	25,076	20,075	16,448	11,925	11,950	10,594	8,039	4,992
White	182,781	42,495	33,648	27,878	20,059	20,469	18,129	12,836	7,267
Male.....	88,607	21,734	16,639	13,703	9,754	9,926	8,582	5,567	2,701
Female.....	94,174	20,761	17,010	14,175	10,305	10,543	9,546	7,269	4,565
Black.....	24,970	7,761	5,262	3,458	2,467	2,311	1,767	1,280	664
Male.....	11,610	3,911	2,465	1,512	1,060	1,038	807	556	259
Female.....	13,360	3,850	2,797	1,945	1,407	1,273	959	724	405
All other races.....	3,093	930	514	611	420	295	170	100	52
Male.....	1,529	464	246	284	207	161	82	55	31
Female.....	1,564	466	268	328	213	135	88	46	21

¹Excludes Alaska and Hawaii.

classification. Visits to these physicians are not represented here.

2. Physicians who participated in NAMCS did a thorough and conscientious job in keeping the Patient Log; however, the

probability that a patient visit 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 also introduces an unknown bias into the data.



APPENDIX II

DEFINITION OF TERMS

Terms Relating to the Survey

Office(s).—Premises identified by the physician as locations for his ambulatory practice. The 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.—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.—Classified as either:

In scope: All patients seen by the physician or a 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 are considered in scope.] The following types of patients are considered out of scope:

Patients seen by the physician in an institution (including outpatient clinics of hospitals) for whom the institution has the primary responsibility 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.

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 on observation and/or prior knowledge of the patient. "Other" was restricted to Oriental people, American Indians, and persons of other nonwhite, non-Negro races.

Was patient referred for this visit by another physician?—Referrals are any visits that are made because of the advice or direction of a physician other than the one being visited. The interest is in referrals for the current visit and not in referrals for any prior visit.

Patient's complaint(s), symptom(s), or other reason(s) for this visit (in patient's own words).—The patient's principal problem, complaint, symptom, or other reason for this 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.

Time since onset of complaint/symptom in item 6a.—Physicians were instructed to check the category corresponding to the length of time since the known beginning of the patient's most important problem. "Not applicable" was used when the reason for visit was not a complaint or symptom (e.g., annual and well-baby examinations). For postoperative visits, "onset" refers to the length of time since the surgery. For routine prenatal visits, onset refers to the length of time since conception. For a flareup of a chronic condition (e.g., arthritis), onset refers to the length of time since the flareup, not the onset of the original condition.

Principal diagnoses.—The physician's diagnosis of the patient's principal problem, complaint, or symptom. 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.

Seriousness of problem in item 8a.—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 the physician's clinical judgment as to the extent of the impairment that might result if no care were given.

Diagnostic services this visit.—Physicians were instructed to check any of the following services that were ordered or provided during the current visit:

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

Pap test: Papanicolaou test, self-explanatory.

Clinical lab 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 (excludes Pap test).

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

EKG: Electrocardiogram, self-explanatory.

Vision test: Visual acuity test.

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

Blood pressure check: Self-explanatory.

Other: All other diagnostic services ordered or provided that are not included in the preceding categories.

Therapeutic services this visit.—Physicians were instructed to check any of the following services that were ordered or provided during the current visit:

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

Drugs (prescription/nonprescription): Drugs, vitamins, hormones, ointments, suppositories, or other medications ordered or provided, except injections and immunizations. Includes both prescription and nonprescription (over-the-counter) medication.

Diet counseling: Instructions, recommendations, or advice regarding diet or dietary habits.

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

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

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.

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, dilations, and excisions.

Psychotherapy/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 ordered or provided which are not included in the preceding categories.

Disposition this visit.—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.

Return at specified time: 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 considered it necessary.

Telephone followup planned: Patient was instructed to telephone the physician on a particular day to report on his progress, or if the need arose.

Referred to other physician: Patient was instructed to consult or seek care from another physician. 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 who referred him.

Admit to hospital: Patient was instructed that further care or treatment would 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 this visit.—Time the physician spent with the patient, not including the time the patient spent waiting to see the physician, time the patient spent receiving care from someone other than the physician without the pres-

ence of the physician, and time spent reviewing records, tests results, etc. In the event a patient was cared for by a member of the physician's staff but did not see the physician during the visit, the duration of visit was recorded as zero.



APPENDIX III

SURVEY INSTRUMENTS

Introductory Letter From Director, National Center for Health Statistics



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
NATIONAL CENTER FOR HEALTH STATISTICS
HYATTSVILLE, MARYLAND 20782

NATIONAL AMBULATORY
MEDICAL CARE SURVEY

Endorsing Organizations

American Academy
of Dermatology

American Academy of
Family Physicians

American Academy
of Neurology

American Academy of
Orthopaedic Surgeons

American Academy
of Pediatrics

American Association of
Neurological Surgeons

American College of
Obstetricians and
Gynecologists

American College
of Physicians

American College of
Preventive Medicine

American Osteopathic
Association

American Proctologic
Society

American Psychiatric
Association

American Society of
Internal Medicine

American Society of
Plastic and Reconstructive
Surgeons, Inc.

American Urologic
Association

Association of American
Medical Colleges

National Medical
Association

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

PATIENT LOG		ASSURANCE OF CONFIDENTIALITY—All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey and will not be disclosed or released to other persons or used for any other purpose.						
		PATIENT RECORD NATIONAL AMBULATORY MEDICAL CARE SURVEY						
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		1. DATE OF VISIT ___/___/___ <i>Mo / Day / Yr</i>	2. DATE OF BIRTH ___/___/___ <i>Mo / Day / Yr</i>	3. SEX 1 <input type="checkbox"/> FEMALE 2 <input type="checkbox"/> MALE	4. COLOR OR RACE 1 <input type="checkbox"/> WHITE 2 <input type="checkbox"/> NEGRO/BLACK 3 <input type="checkbox"/> OTHER 4 <input type="checkbox"/> UNKNOWN	5. WAS PATIENT REFERRED FOR THIS VISIT BY ANOTHER PHYSICIAN? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	6. PATIENT'S COMPLAINT(S), SYMPTOM(S), OR OTHER REASON(S) FOR THIS VISIT <i>(In patient's own words)</i> a. MOST IMPORTANT _____ b. OTHER _____	
PATIENT'S NAME	TIME OF VISIT	7. TIME SINCE ONSET OF COMPLAINT/SYMPTOM IN ITEM 6a <i>(Check one)</i> 1 <input type="checkbox"/> LESS THAN 1 DAY 2 <input type="checkbox"/> 1-6 DAYS 3 <input type="checkbox"/> 1-3 WEEKS 4 <input type="checkbox"/> 1-3 MONTHS 5 <input type="checkbox"/> MORE THAN 3 MONTHS 6 <input type="checkbox"/> NOT APPLICABLE	8. PHYSICIAN'S DIAGNOSES a. PRINCIPAL DIAGNOSIS/PROBLEM ASSOCIATED WITH ITEM 6a _____ b. OTHER SIGNIFICANT CURRENT DIAGNOSES _____		9. HAVE YOU SEEN PATIENT BEFORE? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, FOR THE CONDITION IN ITEM 8a? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	10. SERIOUSNESS OF CONDITION IN ITEM 8a <i>(Check one)</i> 1 <input type="checkbox"/> VERY SERIOUS 2 <input type="checkbox"/> SERIOUS 3 <input type="checkbox"/> SLIGHTLY SERIOUS 4 <input type="checkbox"/> NOT SERIOUS		
1	a.m. p.m.							
2	a.m. p.m.							
3	a.m. p.m.							
4	a.m. p.m.							
5 Record items 1-14 for this patient ↓ CONTINUE LISTING PATIENTS ON NEXT PAGE		11. DIAGNOSTIC SERVICES THIS VISIT <i>(Check all ordered or provided)</i> 1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> LIMITED EXAM/HISTORY 3 <input type="checkbox"/> GENERAL EXAM/HISTORY 4 <input type="checkbox"/> PAP TEST 5 <input type="checkbox"/> CLINICAL LAB TEST 6 <input type="checkbox"/> X-RAY 7 <input type="checkbox"/> EKG 8 <input type="checkbox"/> VISION TEST 9 <input type="checkbox"/> ENDOSCOPY 10 <input type="checkbox"/> BLOOD PRESSURE CHECK 11 <input type="checkbox"/> OTHER <i>(Specify)</i> _____	12. THERAPEUTIC SERVICES THIS VISIT <i>(Check all ordered or provided)</i> 1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> IMMUNIZATION/DESENSITIZATION 3 <input type="checkbox"/> DRUGS (PRESCRIPTION/NONPRESCRIPTION) 4 <input type="checkbox"/> DIET COUNSELING 5 <input type="checkbox"/> FAMILY PLANNING 6 <input type="checkbox"/> MEDICAL COUNSELING 7 <input type="checkbox"/> PHYSIOTHERAPY 8 <input type="checkbox"/> OFFICE SURGERY 9 <input type="checkbox"/> PSYCHOTHERAPY/THERAPEUTIC LISTENING 10 <input type="checkbox"/> OTHER <i>(Specify)</i> _____	13. DISPOSITION THIS VISIT <i>(Check all that apply)</i> 1 <input type="checkbox"/> NO FOLLOW-UP PLANNED 2 <input type="checkbox"/> RETURN AT SPECIFIED TIME 3 <input type="checkbox"/> RETURN IF NEEDED, P.R.N. 4 <input type="checkbox"/> TELEPHONE FOLLOW-UP PLANNED 5 <input type="checkbox"/> REFERRED TO OTHER PHYSICIAN 6 <input type="checkbox"/> RETURNED TO REFERRING PHYSICIAN 7 <input type="checkbox"/> ADMIT TO HOSPITAL 8 <input type="checkbox"/> OTHER <i>(Specify)</i> _____	14. DURATION OF THIS VISIT <i>(Time actually spent with physician)</i> _____ MINUTES			

Induction Interview Form

BEGIN DECK 3

CONFIDENTIAL*
NORC-4233

Form Approved
OMB No. 68R1498

FOR OFFICE USE ONLY:

(BATCH NO.)

--	--

5-6/

(LOG NO.)

--	--	--	--

7-10/

NATIONAL AMBULATORY MEDICAL CARE SURVEY
INDUCTION INTERVIEW

BEFORE STARTING INTERVIEW

1. ENTER PHYSICIAN I.D. NUMBER IN BOX TO RIGHT.
2. ENTER DATES OF ASSIGNED REPORTING WEEK IN Q. 2, P. 2.

(Phys. ID Number)

--	--	--	--

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)

--	--	--

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-A.	ENTER TOTAL FROM Q. 4-B. _____ DAYS						
		1	2	3	4	5	6	7
A--Patient Record is to be completed for <u>ALL</u> patients listed on Log. 14-16/	<div style="border: 1px solid black; width: 60px; height: 20px; margin: 0 auto;"></div> 1- 12 PATIENTS	A	A	A	A	A	A	A
	13- 25 "	B	A	A	A	A	A	A
B--Patient Record is to be completed for every <u>SECOND</u> patient listed on Log.	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
C--Patient Record is to be completed for every <u>THIRD</u> patient listed on Log.	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
	119-131 "	D	D	C	C	B	B	B
	132-145 "	D	D	D	C	C	B	B
*D--Patient Record is to be completed for every <u>FIFTH</u> patient listed on Log.	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 patient record forms completed.
	Letter	Number				
A					 	17-21/ 22-24/
B						
C						
D						

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: Number patient record forms completed
	Letter	Number				
						25-29/ 30-32/ 33-37/ 38-40/ 41-45/ 46-48/

8. During the survey week (REPEAT EXACT DATES), will anyone be available to help you in filling out these records (at each IN-SCOPE location)?

Yes (ASK A) . . . X
No Y

A. IF YES: Who would that be?

RECORD NAME, POSITION AND LOCATION.

Table with 3 columns: NAME, POSITION, LOCATION. Multiple blank rows for data entry.

PERSONALLY BRIEF EACH PERSON LISTED ABOVE.

EMPHASIZE THAT EVERY PATIENT VISIT DURING THE ENTIRE WEEK IS TO BE RECORDED ON THE LOG EXCEPT "ADMINISTRATIVE PURPOSE ONLY."

9. Do you have a solo practice, or are you associated with other physicians in a partnership, in a group practice, or in some other way?

Solo (GO TO Q. 10) . . . 1 49/
Partnership . . (ASK A-C) . . . 2
Group (ASK A-C) . . . 3
<--- Other (SPECIFY AND ASK A-C) . . 4

IF PARTNERSHIP, GROUP, OR OTHER:

A. Is this a prepaid group practice? Yes . . (ASK [1]) . . . 1 50/
No 2

[1] IF YES TO A: What per cent of patients are prepaid? _____ per cent 51-53/

B. How many other physicians are associated with you? NUMBER OF PHYSICIANS: _____ 54-56/

C. What are the specialties of the other physicians associated with you? (How many of these are there?)

Table with 2 columns: Specialty, Number of Physicians. Rows (1) through (5) for listing specialties and counts.

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

--	--	--	--	--	--

(Month) (Day) (Year)

COMMENTS:

INTERVIEWER NUMBER

--	--	--	--	--

INTERVIEWER'S SIGNATURE

FOR OFFICE USE ONLY:

No. of Patients Seen:

--	--	--

59-61/

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