Ambulatory care essay

Ambulatory Care Chapter Objectives After completing this chapter, the reader should have an understanding of: • The definition of ambulatory care. • The variety of settings for the delivery of ambulatory care. • The importance of ambulatory care services as a part of the U.

S. health care system. a number of other ways ambulatory care is delivered, and they are described in this chapter. In recent years the number and type of ambulatory or outpatient facilities have increased to allow more patients to receive treatment outside of the more costly acute care hospitals. Because of advances in technology and technique, many of the procedures formerly done in hospitals can now be performed on an outpatient basis.

More familiar ambulatory care facilities, such as hospital outpatient departments and community health centers, have expanded to include surgery centers, diagnostic imaging centers, cardiac catheterization laboratories, and other freestanding facilities. Some facilities are for-profit and are operated by chains, either independently owned or affiliated with a hospital. In other cases, nonprofit health care systems with hospitals have expanded their ambulatory facilities as part of an integrated, cost-efficient way to provide care. When we address health care comprehensively, it is also important to recognize pharmacies, dental care, and “ alternative” care such as chiropractic as fitting into what we categorize as ambulatory care.

We look now at just a few of the major types of ambulatory care. INTRODUCTION Ambulatory care covers a wide range of services for the noninstitutionalized patient and in its most basic description is simply care that does not require an overnight stay by the patient. Office-based

physicians provide the majority of ambulatory care. An estimated 787. 4 million visits were made to doctors’ offices in 1997, or about 3. 0 visits per person (Woodwell, 1999).

More than 50 percent of those visits were made to primary care specialists (family practice, pediatrics, and internal medicine). However, there are 99 100 • CHAPTER 6 MEDICAL PRACTICE Extraordinary changes are taking place in the practice of medicine in the United States. The sheer number of physicians has more than doubled since 1970. Women, who made up only 9. 7 percent of the physician population in 1970, now account for 22 percent of all physicians.

A larger percentage of female (47. 4 percent) than male physicians (31 percent) are in primary care specialties (American Medical Association, 1999). After decades of “ business as usual,” physicians are now faced with a decline of professional autonomy, increased competition among themselves, and changes in the methods of payment for their services. Although much of this change can be attributed to cost containment efforts that seek to provide more efficient, effective medical care, and to the alternative delivery systems that have developed, the growing supply of physicians is also a major factor.

There were 756, 710 physicians in the United States in 1997, or 282 physicians for every 100, 000 people— more physicians than ever before (American Medical Association, 1999). While the focus in the 1960s was concern over a shortage of physicians, current discussions focus on whether

there is an oversupply of physicians (see Table 6–1). The majority of physicians are in office-based patient care (60. 6 percent in 1997).

Not everyone agrees that we have an oversupply, but there is general agreement that there is an imbalance in primary care versus specialty care physicians, and a shortage of physicians practicing in certain geo- graphic areas. Although the sheer numbers of physicians in primary care specialties increased in the 1990s, the overall percentage of physicians in primary care dropped from 36. 5 percent in 1980 to 34. 6 percent in 1997 (American Medical Association, 1999). The increase in the U. S.

physician-population ratio intensifies competition and is one reason why physicians join large group practices or accept salaried positions with hospitals and managed care organizations (Table 6–2). An adequate supply of physicians fosters easy access to care. The level of our knowledge and technology affects the number of physicians needed. New knowledge and new technology permit physicians to do what was previously not possible, and they increase the need for more physicians. Table 6–2 Practice Type for Physicians (Nonfederal), 1997 Employment Status Self-employed, solo Self-employed, group Employee HMO Group practice Private hospital Medical school, academic center State and local government Unknown Independent contractor Percent 25. 9 30.

7 2. 7 11. 1 7. 3 7. 0 9.

6 1. 1 4. 7 Source: Data from the American Medical Association Center for Health Policy Research (Moran, 1998). Table 6–1 Physician Supply for

Selected Years, 1960–1997 Year 1960 1970 1980 1985 1990 1995 1997 Total No.

of Physicians 260, 484 334, 028 467, 679 552, 716 615, 421 736, 279 756, 710Physicians/100, 000 People 142 161 202 228 244 280 282 Total Population/Physician 703 623 494 440 404 359 363 Source: American Medical Association, 1996, 1999. Ambulatory Care • 101 Determination of need is complex and, one might say, elusive. Need is affected by the age characteristics of the population (the elderly having greater needs), by the existing health problems that are recognized by the population as problems, by public decisions about which health services should be covered by insurance or government programs, and by the level of investment that should be made in research and facilities. The need for physicians is also affected by the extent to which physicians are willing to use other health workers, by the population's willingness to accept other practitioners, and by the expectations of the population regarding health care services delivery. Thus, there is no more consensus on the correct number of physicians than there is consensus on the amount of money to spend on health care.

About 40 percent of physicians in 1996 were in the primary care areas of internal medicine (18. 9 percent), family and general practice (12. 3 percent), and pediatrics (8. 5 percent). The majority of U.

S. hysicians are under forty-five years old. More than 20 percent of practicing physicians are women, about 23 percent of physicians are international (foreign) medical graduates, and 62 percent of all physicians are board certified in their specialty. The average annual income for physicians in

1996, after expenses and before taxes, was $199, 000. While over 60 percent of all physicians provide office-based patient care, an increasing number of physicians are hospital based or engaged in other professional activities, such as research, teaching, and administration (American Medical Association, 1998). or transportation.

The hours spent traveling severely limited the number of patients a physician could attend. As transportation and roads improved, physicians were able to travel between patients more quickly; patients were also more able to visit the doctors' offices. Most physicians essentially practiced alone and had little need for hospitals. Medical societies were few and tended to draw only the most elite members of the profession—that is, the ones who had more formal training and who were seeking to upgrade the educational process and the overall quality of medical practice.

The practice of medicine began to change significantly as hospital use increased. In the late nineteenth century and early 1900s, the number of hospitals grew rapidly as hospital sanitation improved, hospital infections decreased, and antiseptic surgery was introduced. Urban life that accompanied industrialization (working away from home and having smaller living accommodations) also contributed to the increased use of hospitals, although well-to-do families still preferred treatment in their homes. Around this time and as a result of these developments, " hospitals moved from the periphery to the center of medical practice as well as edical education" (Starr, 1982).

As hospitals became a necessary part of medical practice, medical practitioners increasingly sought access to them, to admit their patients and to continue treatment. Physicians did not become employees of the hospitals, but rather used the hospitals as one of the tools necessary for patient care. Sometimes they established their own hospitals, particularly when they encountered resistance to joining the staffs of existing institutions, which were frequently dominated by the professional elite. Hospitals had no control over the patient’s treatment. This was solely the responsibility of the individual physician. The Development of Medical Practice The practice of medicine brought neither financial wealth nor social prestige in early America.

Medicine was practiced by a wide array of individuals, from those who had studied medicine in Europe to persons with little or no medical training. Most families cared for themselves. Many medical practitioners found it difficult to support themselves solely from medical practice and were forced to resort to a second occupation. Most patients who were treated by physicians remained at home, and their physicians spent many hours traveling to visit them with a horse and buggy Solo Practice Historically, most physicians were in the solo practice of medicine; that is, they practiced alone. Now however, more than half of all physicians work in group practices, and an increasing number of physicians choose 102 • CHAPTER 6 direct employment arrangements (American Medical Association, 1998).

The advantages of solo practice, however, are hard to dispute from an individual standpoint. They include: • Greater autonomy for the physician. • A more personal patient-physician relationship. • Little bureaucracy for both

the patient and the physician. Risks, however, are great for the solo practitioner. Among them are: • Financial risks.

• Investing in facilities and equipment. • Attracting a sufficient patient base. • Administrative responsibilities (hiring staff, contracting insurance, etc.). • Long hours. • Providing scheduled care convenient to patients, usually including evening and weekend hours.

• Covering for emergency care. • Limited access to capital . Difficulty in contracting in a market-driven environment. Group Practice A rapidly growing number of physicians are in group practice—either in a group made up of physicians of the same specialty or in a multispecialty group. Group practice is normally defined as consisting of three or more physicians (two physicians are usually referred to as a partnership) who have organized to practice together, typically sharing offices, personnel, equipment, and other expenses. Groups can, however, be much larger, even numbering in the hundreds (see Table 6–3).

How they are paid varies from fee for service, to salary, to share of the group’s income. The income of group practice physicians tends to be a little higher than that of solo practitioners because of economies achieved by the group from the sharing of support personnel and other resources. Financial risk is also shared, such as the raising of capital and investment in facilities and equipment. The appeal of group practice also comes from other than economic advantages, including: • More peer interaction (ease of consultation and intellectual stimulation).

Table 6–3 The Largest Medical Group Practices (in Terms of Number of Physicians) in the United States in 1998 Group Mayo Clinic Henry Ford Medical Group Emory Medical Care Foundation University of Iowa College of Medicine Cleveland Clinic Foundation University of Wisconsin Medical Foundation, Inc. Group Health Co-Op of Puget Sound Emory Clinic Medical College of Wisconsin Physicians & Clinics UT-MED University of Miami Medical Group Baylor College of Medicine Location Rochester, MN Troy, MI Atlanta, GA Iowa City, IA Cleveland, OH Madison, WI Seattle, WA Atlanta, GA Milwaukee, WI Galveston, TX Miami, FL Houston, TXNo. of Physicians 1, 147 1, 100 1, 020 990 990 886 800 795 750 650 576 570 Source: Moskowitz, 1999. © Faulkner & Gray, Inc. , reprinted with permission.

Ambulatory Care • 103 • More-flexible time (shared emergency coverage, vacation coverage, administrative responsibilities) • Availability of a professional manager (appropriate staffing allowing physicians to relinquish direct concern for the financial aspects of patient care) Group practice, however, is not without its disadvantages. In making the decision to share risks, costs, and administrative responsibilities, the physician also loses some individual autonomy. Group decisions are made regarding office hours, office locations, staffing, and capital investments. Although there are advantages to sharing financial risk, group practice places an additional risk on physicians—legal and ethical risk.

The peer group is expected to be aware of each physician’s medical practice habits and decision-making capabilities, and act as a standardbearer for each member of the practice. If a member of the group is sued for malpractice, other members of the group may be held liable if there is any

indication that the group was aware of the shortcomings of the sued physician. Another difficulty often shared in group practice situations results from the financial structure of the organization. Particularly in multispecialty practices, it is often difficult to formulate an income distribution policy that satisfies all parties. Fee structures, capitation rates, and operational expenses vary greatly with the specialty of the physician. Some specialties require a high use of technology and years of intensive training.

Other specialties rely more on cognitive skills, greater time spent with the patient, and less use of technology. Various models have been developed to address income disbursement. Historically, group practices consisted of independent physician-owners (often called “ partners”) sharing office space and personnel, but each tracking their own income and expenses. This model was somewhat easy to follow in the atmosphere of fee-forservice medicine.

As groups became larger, some practices went to a combination of physician-owners and employed physicians. Physician-owners act as the board of directors and hire additional physicians as the need arises. Hired physicians may be offered a share in ownership after an initial period of employment or may stay on as employees indefinitely. As managed care and capitated payment structures have become more prominent, so too has the employedphysician model. Why would a physician choose to be an employee of a practice rather than a partner or owner? The advantages are many.

Employed physicians need not invest in the organization, and thus they carry limited financial risk. They have more defined working hours, few if any

administrative responsibilities, and little legal risk for actions of other physicians, yet they have access to greater resources of equipment, facilities, and peer interaction. The disadvantages, however, include limited income potential, an atmosphere of greater regulation and review, and limited input into management decisions. The security of an employed position often outweighs the limitations for many new physicians entering practice in today’s uncertain health care environment.

Some larger group practices follow scheduling patterns that make it difficult for the physician to build a continuing relationship with his or her patients. However, most group practices do try to have each patient followed by a specific physician, particularly in primary care specialties. So, while there is some risk of loss of the physician-patient relationship, often a group practice setting provides many advantages to the patient. The patient can get a wider range of care—a type of one-stop shopping—from one medical practice. The medical record is available to all of the patient’s physicians without duplication of the information.

The patient benefits from improved emergency coverage and, often, a better-informed staff to aid the patient in understanding his or her diagnosis and treatment, as well as the costs, insurance benefits, and financial responsibilities surrounding his or her care. The Controversy over Contract Practices Although contract (employed) and group practices are commonplace today, are growing, and are accepted by organized medicine as appropriate and ethical ways to deliver medical care, many individual practitioners initially resisted what they perceived to be an unwise trend. These trends are represented today by salaried group practices and health

104 • CHAPTER 6 maintenance organizations (HMOs). When they first appeared, they were seen as a threat to other practitioners. The cry of unethical ractice was heard, and the organizations that represented the aggrieved physicians—the state and local medical societies and the AMA—went to battle. The controversies seem at first to be economic—that is, a threat to the incomes of the protesting physicians—but some very real issues lie behind the protests.

To understand the resistance to salaried physician groups, it is important to define contract practice and group practice, and then look at the storms that surrounded their development. Certain industries (e. g. railroads, mining, lumbering, steel) traditionally employed company doctors to do preemployment health examinations, to treat occupational injuries, and in some instances to develop employee medical programs. These physicians were mostly salaried—that is, under contract. Medical societies opposed this type of practice (except when physicians were under contract to serve the military), which they regarded as exploitation because doctors bid against each other for the contracts, thus reducing the price of their services.

The opposition of the medical profession over time discouraged employers from expanding medical services, except in remote areas where physicians were generally unavailable. Another type of contract practice emerged when mutual benefit societies, employee associations, unions, and fraternal orders flourished among immigrants in the early 1900s. These were often social organizations, and sometimes they made life insurance policies available to members. Some also contracted with physicians to provide medical care for their members (and sometimes the members’ dependents) for a fixed yearly

fee per member—thus, a capitation method of payment. These “ benefit societies” thrived in the industrial areas of several states despite the opposition of most physicians.

Although many of these contract physicians felt they were not paid enough for their services, some needed this type of contract, especially if they were younger and trying to establish their practices. Many local medical societies complained about poor-quality care by these contract practitioners, and there may have been some validity to their complaints. The medical societies were also concerned about contract doctors undercutting them economically, doing work for less than they would normally charge on a fee-for-service basis. The AMA, which was as interested in upgrading the medical profession and preserving the independence of doctors as it was in improving medical education, also objected to contract practice.

As Starr (1982) notes, the AMA in 1907 could see “ no economic excuse or justification” for this type of practice, and it objected “ to the unlimited service for limited pay and the ‘ ruinous competition’ it ‘ invariably’ introduced” (p. 08). This type of contract practice declined over time as the supply of physicians decreased and there were enough patients for a physician to earn a living without resorting to contracting. However, it began to rise again with the development of HMOs posing a threat to the traditional form of fee-forservice solo practice, which many physicians still feel serves the best interests of the patient and the physician. Group practice has been a part of the American scene for a long time. The founding of the Mayo Clinic in Rochester, Minnesota, at the end of the nineteenth century is generally

cited as the beginning of organized group practice as we know it today, although there were some antecedents.

Mayo was followed by other groups, among them the famous Ross-Loos Clinic in Los Angeles, which served the city water department employees and others under contract. Some group practices operated on a loose fee-for-service basis as in solo practice, but as the groups became organized, many paid their member physicians a salary, sometimes also a percentage of the net business income or a bonus. MacColl (1966) notes that the quality of care in many of the early groups “ was reasonably good, but there were others which did not reflect much credit on either the organizers or the physicians involved” (p. 12). During the early period of group practice development, the AMA was somewhat ambivalent about it.

Where groups existed, physicians outside the groups often expressed concern about the quality of care the groups provided, as well as concern about the competition from lower fees the groups sometimes charged. Then, in 1932 the Committee on the Costs ofAmbulatory Care • 105 Medical Care, a national committee, issued a report titled Medical Care for the American People. The committee was a prestigious group, chaired by a former AMA president, Dr. Ray Lyman Wilbur, who was at the time in President Hoover’s cabinet as Secretary of the Interior. The committee recommended, albeit with some medical and dental member dissent, that medical care should be provided by organized group practices and that “ the costs of medical care [should] be placed on a group payment basis, through the use of insurance, through the use of taxation, or through the use of both these methods.

This is not meant to preclude the continuation of medical services provided on an individual fee basis for those who prefer the present method" (U. S. Department of Health, Education, and Welfare, 1970, p. 120).

As noted, the report was published in 1932, and it galvanized the opposition of the AMA to both group and salaried practice. In 1933 the AMA declared that groups of physicians in salaried practice were considered unethical (U. S. Department of Health, Education, and Welfare, 1970) when there is solicitation of patients either directly or indirectly . . .

when there is competition and underbidding to secure the contract . . when compensation is inadequate to secure good medical practice . . .

, when there is interference with reasonable competition in a community . . . when free choice of physicians is prevented.

This change on the part of the AMA reflected widespread concern within the profession. The concern was professional as well as economic, although critics all too frequently focus on the economic component, ignoring the professional objections. The AMA's involvement in state and local disputes generally stemmed from questions and issues raised by state and local medical societies. Typically, the latter had a problem for which they needed advice, and they turned to the AMA. The AMA's Judicial Council got involved whenever an aggrieved physician appealed an adverse decision rendered by the state medical society.

A focal point has been the AMA's Principles of Medical Ethics, which serves as a guide to state and local medical societies. This document was

developed by physicians from the states and adopted by local state society representatives in the AMA House of Delegates. The AMA became directly involved in a local issue in the late 1930s and was found guilty of restraint of trade in 1941. The case involved the AMA and the Medical Society of District Columbia (MSDC) in their actions relating to the Group Health Association (GHA) of Washington.

Opposition to the GHA by the DC Medical Society arose almost immediately after the GHA was organized in 1937. The society notified “ all the physicians in the area that the plan was unethical. The GHA’s salaried physicians were expelled from the Society, and a list of ‘ reputable physicians’ was circulated to all the hospitals for their guidance” (MacColl, 1966, p. 40).

The MSDC and the AMA were subsequently indicted, found guilty, and fined for having conspired to monopolize medical practice. The GHA physicians were later admitted to the society and had no subsequent difficulty over hospital privileges. In other parts of the country, specifically Seattle and San Diego, the local medical societies and not the AMA were the defendants in similar cases, and in each case the medical societies lost in their efforts to block development of group health plans. After the AMA fine in the GHA case, the AMA disengaged from “ further legal entanglement. ” Local societies were left to interpret or misinterpret the code of ethics (MacColl, 1966). The objections to group practice at times took on rather nasty characteristics.

In metropolitan New York, for example, the Health Insurance Plan (HIP) was established in the mid-1940s as a demonstration project for national health

insurance. HIP, the fiscal agent, contracted with medical groups, paying each group so much for each person on its list. How the group divided the money was up to the group. In return for the capitation payment, the group was responsible for providing comprehensive physician services, prevention, and treatment.

For hospital care, most HIP subscribers were at that time covered by Blue Cross. Though the local medical societies might not have been able to keep HIP physicians from joining, they could ostracize them socially. As late as the 1960s, HIP physicians were denied hospital privileges. 106 • CHAPTER 6 The intensity of local medical feeling did not need AMA fuel. HIP, at its inception, had proclaimed itself a demonstration project for a national system, and there were many physicians in New York who were accustomed to government systems before coming to the United States. In addition, the economic pressures on physicians in New York City were considerable because many believed in the 1950s that New York City had an oversupply of medical practitioners.

At every turn, non-HIP physicians challenged HIP physicians. Blue Shield, which was sponsored by the medical profession, used paid salesmen and advertising, but when HIP did this, “ the charge of unethical conduct was raised. Ben E. Landis, one of the HIP physicians, took the matter to the Judicial Council of the AMA, which ruled in his favor, finding that HIP was a legally organized plan and had as much right to advertise as did Blue Shield so long as the personal qualifications of the physicians were not promoted” (MacColl, 1966, p. 139). By the late 1970s in New York, all wounds were

healed, and HIP physicians were fully accepted by medical societies and hospitals.

The AMA’s Judicial Council, in addition to the Landis case, also reversed, on appeal, the earlier expulsion from the Los Angeles County Medical Society of the developers of the Ross-Loos Medical Group. Opposition to contract practice, group practice, and salaried practice has all but disappeared. Organized medicine no longer opposes them, and each of these forms of practice is growing. The change came about partly as a result of effective legal challenges against organized medicine, but perhaps more importantly as a direct result of a recognized physician shortage in the 1950s that would ensure fee-forservice, solo practice physicians an ample number of patients to maintain a good income, regardless of the presence of contract and group practice.

By this time, group practice had also evolved and now was seen by its advocates as a way to regularize their hours, get easy consultation, and afford ownership of expensive technology that they could not justify, economically, by themselves but could justify on a shared basis. All forms of medical practice could thus live together in harmony. Group practices are expanding in size, and increasingly they compete for patients with one another, with solo practitioners, and with hospitalbased physicians. Many groups now contract with managed care plans. Even though they compete with hospital ambulatory clinics, these groups can have considerable influence on hospitals because they control the admission of a significant number of patients to a particular hospital. The 1990s saw groups affiliating

with hospitals to form integrated systems of care in order to survive in a much more competitive environment.

The balance of influence is much harder to identify in a dynamic health care system, which has seen hospitals, physicians, and insurance plans all operating under the same umbrella organizations. Medical Practice Costs and Financing The costs to maintain a medical practice, which in many ways must function as any other business or organization, are considerable. As in most service organizations, the greatest expenses are wages and benefits, including those of physicians, clinical personnel, and office personnel. Additional expenses are incurred for facilities (rent, lease, or real estate), office and medical supplies, medical equipment, liability insurance, and other expenses. Depending on the specialty of the medical practice, malpractice insurance can be one of the largest expenses incurred.

Increasingly, physicians' offices are investing in computer systems, not only for the business function of the practice, but to maintain clinical records. At one time, medicine was the highest-paid profession in the United States. Given the state of the health care environment and the growth in computerization, telecommunications, and Internet industries, medicine may no longer be as attractive a career as it once was. The average physician's net income (after expenses, before taxes) reached $199, 000 in 1996.

Specialists with the highest average earnings were surgeons, radiologists, and obstetrician-gynecologists. Lowest average earnings were found among psychiatrists, general/family practitioners, and pediatricians (American Medical Association, 1998). In a fee-for-service atmosphere, concern over

increased health care costs centered on the possibility of overservice. A number of U.

S. and Canadian economists advance what is called the target income hy-Ambulatory Care • 107 pothesis. This hypothesis contends that physicians set their sights on a given income level, and that they adjust their fees to reach it. When the demand for services is down and threatens attainment of the desired income, physicians raise fees. When fees are decreased (as in the cost containment environment), physicians provide more services, which could be for the purpose of augmenting income rather than for more comprehensive and appropriate medical care.

Supporters of this hypothesis point to the rise in physician incomes despite increased competition for patients and reduced third-party payments per patient encounter. Surgery is often cited in this regard, particularly accusations of unnecessary surgery being performed simply to compensate for decreased fees per procedure. Others argue that the more critical factors in rising physician incomes may be increased demand and productivity resulting from the provision of additional, appropriate diagnostic and therapeutic services as a result of new knowledge and new technology; fear of possible malpractice suits (the practice of defensive medicine); a more educated population seeking medical care with higher expectations for improved outcomes; and a rapidly aging opulation with correspondingly increased morbidity. Managed care has tried to curb overservice through capitated payment mechanisms; however, charges have been made of an overcorrection and fears that some patients might actually be underserved because of the costs involved in providing needed services.

(See more on the costs and financing of health care in Chapters 2 and 3.) As a defense to malpractice claims, physicians have become more careful. They are keeping better records so that they can defend themselves in court. They are improving their communication skills to enhance the physician-patient relationship and to help patients to understand better the risks involved in procedures because there are fewer lawsuits when the physician-patient relationship is good. Physicians may try to reduce the risk of lawsuits by practicing " defensive medicine," ordering more diagnostic tests than may be necessary to confirm a patient's diagnosis but also adding to the rising costs of medical care.

The adoption of standards of care by some specialty groups and medical societies may reduce the number of malpractice actions. For example, the American Society of Anesthesiologists adopted a standard in 1990 that requires its members to use certain devices to measure the level of oxygen in the blood, which it estimates could have prevented serious injury or death in almost one-third of the cases in which anesthesiologists have been accused of malpractice. In Maryland, as another example, obstetriciangynecologists' premiums were reduced about 35 percent when they agreed to follow certain standards of care, such as specific procedures for handling breech deliveries and hypertension during pregnancy. In addition, some states have passed laws to penalize patients who make frivolous claims.

Both hospitals and the government are increasing efforts to identify doctors with a history of malpractice. In 1990 the federal government established a National Practitioner Data Bank to keep track of doctors who have been

successfully sued for malpractice, who have been disciplined for incompetence, and/or who have had hospital privileges revoked. Hospitals are required to access the data bank prior to granting hospital privileges to physicians. Unfortunately, this information is not available to patients when they are choosing a doctor. About half of the states limit the amount or type of damages that can be recovered in malpractice suits.

Still, the average annual malpractice premium for physicians in 1996 was $14, 000. Premiums for specialties such as obstetrics and gynecology (average $35, 200) and surgery ($21, 700), are much higher Malpractice and Professional Liability Medical professional liability (medical malpractice liability) continues to be an important issue. Questions arise regarding whether physicians have overused tests as a defense against possible malpractice charges and whether patients have used charges of malpractice to demand perfection rather than prevent negligence and/or incompetence. Malpractice insurance is a significant expense to medical practitioners.

Premium rates are highest for obstetrician-gynecologists and surgeons, which is a direct reflection of claims filed. 108 • CHAPTER 6 (American Medical Association, 1998). Since 1990, premiums have been somewhat consistent and in some states have dropped. More than half of all doctors in private practice are insured by physicianowned companies, usually state medical societies, which try to keep premiums at a minimum. costs. They believe that one way to control costs is to decrease the use of specialists by encouraging primary care physicians to treat mild illnesses rather than refer patients to expensive specialists.

When specialists and primary care physicians treat patients with comparable illnesses, specialists hospitalize patients more often, write more prescriptions, and order more diagnostic tests (Greenfield et al. 1992). Of course, when an illness is complicated or severe, treatment by specialists is appropriate. Primary care medicine provides the majority of preventive services, such as counseling about healthy lifestyle changes, immunizations, and regularly screening for detection of illnesses before they become serious, all of which are becoming more important in maintaining good health. Managed care organizations use primary care physicians as “ gatekeepers” to prevent the unnecessary use of specialists.

Medical students are being encouraged to enter primary care fields by the increased payment for their services by Medicare and some insurance companies using the Resource Based Relative Value Scale (see Chapter 3 for more details). Before the American College of Surgeons (ACS) was established, and for many years after, the general practitioner did everything, including general surgery. In some communities in the United States, particularly in the more remote areas, family practitioners still provide a wide range of services because of the limited availability of specialists. The American Academy of General Practice, the predecessor of the American Academy of Family Physicians (AAFP), found in a 1969 survey that 39 percent of its members performed major surgery.

Estimates in 1973 were that the percentage was down to 20 to 25 percent (Medical World News, 1973). Though physicians in general or family practice may be doing less major surgery overall, 88 percent of them were reported in 1982 to be performing some ambulatory surgery, which generally consists

of the less complicated surgical procedures (American Medical Association, 1982). With managed care organizations placing emphasis on ambulatory care, and particularly on care delivered by the primary care physician, the percentage of surgical procedures, particularly minor surgery, performed by practitioners other than sur- Primary Care Physicians A primary care physician was defined in 1975 by the Coordinating Council on Medical Education (CCME) as one who provides an individual or family with continuing health surveillance, along with the needed acute and chronic care he or she is qualified to provide and referral service to specialists as appropriate. General practitioners and family practitioners fall within this category, as do pediatricians, internists, and obstetrician-gynecologists, although not everyone would agree about these last three.

The pediatrician typically limits his or her clientele to children and adolescents; the internist typically does not handle some things that a family practitioner might handle, such as obstetrics and pediatric problems. Obstetrics and gynecology has more recently evolved as a primary care specialty for categorical care for obstetric and/or gynecological problems, with female patients going directly to OB-GYN practitioners without referral. The definition of primary care specialties developed by the CCME leaves much to be desired. Other specialties handle a considerable amount of routine primary care that in other settings might be handled by a family practitioner or other health professionals. Prior to the growth of managed care and the gatekeeper concept, many people had the tendency to self-diagnose and self-refer to a specialist— psychiatrist, surgeon, dermatologist,

orthopedist— when, in fact, the family physician or other primary care practitioner might well handle many of the problems.

For example, some patients frequently used ophthalmologists and orthopedic surgeons when optometrists and podiatrists might well have sufficed. Part of the recent emphasis on primary care physicians is economic. The rising costs of health care make the principal payers want a mechanism to control Ambulatory Care • 109 geons is difficult to determine. The American College of Surgeons has long sought to curb surgery by those not specializing in surgery. However, the content of family practice residencies requires some training in a variety of other specialty areas, including surgery. General practice is now an antiquated term that referred to the practice of medicine after one year of internship and no participation in a specialty residency.

Today, the Accreditation Council for Graduate Medical Education (ACGME) states that the transitional year (first year of general residency replacing the internship) is not meant to be a complete graduate medical education program for the practice of medicine (ACGME, 1999). The controversy can be seen as a professional debate stressing the importance of strict qualifications for those engaged in surgery or as an attempt on the part of specialists to protect their domain both economically and professionally. incomes are ensured; for others, more orderly personal lives are possible because of fewer emergencies and more regular hours. Most of the factors that affect the location of the primary care physician also influence the specialist’s choice of practice location.

Hospital access, however, may be even more critical for the specialist, in terms of the supportive services that may be necessary for the effective practice of her or his specialty. Studies have also shown that specialists tend to locate in areas close to the place where they did their residency because the new specialist is familiar with the clinicians in the area and tends to know and be comfortable with other specialists for referrals. At the same time, because the new specialist is known by many of the local physicians, the new specialist can anticipate some helpful referrals. Notwithstanding the pull to practice in urban settings, during the past decade the overall increase in the supply of specialists, the spread of technology, and the disadvantages of urban life have influenced the movement of new specialists to outlying areas. The Appeal of Specialization Physicians specialize for many reasons.

People in general have always held specialists in high regard— as physicians who could do things that general physicians could not do and whose special skills warranted a higher fee. Often, the medical school faculty physicians were considered the best of these specialists. There has always been a certain aura that surrounded the physician—a mystique that was even more pronounced for the specialist, who had knowledge and skills that saved lives, eased pain, and improved functioning. The medical student must choose the area of medicine she or he will practice. Many factors may enter this decision process, but because most members of the faculty are specialists, the pressure to respond to one of those specialty role models is ever present.

Specialization has a certain intellectual appeal, which enables the curious to know more and more about the problems that afflict the human being. Because the problems are complex, the curious specialize in order to

understand them. Other factors may enter. A person’s own medical history or that of the family frequently channels a physician’s interest. For some specialties, very highMedical Society Memberships Most physicians find it valuable to belong to the county or city medical society in the area in which they practice and to their state medical society.

Not all physicians elect to join the AMA, for a variety of reasons. Many disagree with the AMA’s policies (although the association probably truly represents the views of its members), others are more interested in their specialty society, and still others are concerned about the rising costs of membership, particularly in view of the many other memberships a physician feels he or she must maintain. Membership in the local and state societies is more vital for the practicing physician. These organizations enable the physician to meet his or her colleagues, to learn about the skills and abilities of other physicians for the purpose of referring patients to him or her, and to facilitate an intellectual interchange among physicians, which has always been a key element in the continued learning process. Medical societies provide an organizational focus for epresentation of medical viewpoints about matters affecting the health of the 110 • CHAPTER 6 population and about other matters of interest or concern to them. In addition, if any government, industry, or other body wishes to communicate something to the medical community, the medical society is perhaps the most effective vehicle.

Finally, membership often enables the physician to receive such financial benefits as group life, health, and malpractice insurance. Physicians often belong to other medical societies, depending on their interests and

specialties. Among the many other societies is the National Medical Association (NMA), an association representing the special interests of African-American physicians (see www. nmanet. org).

There is some ambiguity in the word rural. One federal agency set the definition at a population of 35, 000 or 50, 000. Other agencies have used other, usually lower, figures. For those rural regions of 35, 000 to 50, 000 that have recruited physicians, the reasons for their successes are several: There are more physicians available, and the supply/demand factor operates to secure a more even distribution; the large urban settings are congested and are plagued by high costs and high crime rates; the assets of urban life are not as remote as our road networks improve; the small communities have sought to make their areas attractive to primary care and other physicians by developing for their communities the best hospital facilities their communities can support, and sometimes more than they can support. These small communities, however, do not face the levels of sparse population scattered across a large geographic area that are problematic in a truly rural area.

Inner-city problems are somewhat different. In large cities, the poor have not always used private doctors. Hospital outpatient departments and emergency rooms have served as the primary source of care. As people moved to the suburbs, the physicians went where their paying patients were. The outmigration of physicians and lack of interest from new physicians are a result of the high cost of office and parking spaces, transportation hassles, and crime.

In addition, the cities are far more litigiously inclined, and malpractice insurance rates are generally higher. The movement of physicians out of the cities has become a matter of concern because the poor under Medicaid are entitled to private physician care, but the availability of private physicians is limited. Managed care programs for Medicaid recipients are attempting to provide more comprehensive and continuous care to underserved populations, but the insufficient number of physicians practicing in areas where the Medicaid population resides continues to be a problem. Rural and Inner-City Medical Practice However one chooses to define primary care physicians, rural areas and inner cities have had considerable difficulty in recruiting and retaining them. The lack of appeal of rural practice stems from fear of professional isolation: lack of professional interactions, inaccessibility of hospitals, absence of consultation and continuing medical education opportunities, lack of career opportunities for spouse, and cultural deprivation (no theater, no concerts, no lectures, limited adult education activities, etc.).

The physician today and his or her spouse are urbanites by virtue of their long periods of education and training in urban professional settings, and the adjustment to rural living, though sometimes inviting in moments of idyllic dreaming, has not been successful in most cases. There seems to be greater chance of retention if the physician is originally from a rural area, but no one yet has devised a generally valid formula for the successful establishment of rural practices. Professional as well as personal isolation are factors that are very real. Government-sponsored health plans have adjusted payments to rural physicians and facilities to increase the attractiveness of rural

practices. Medical schools and residency programs have established training centers in rural outreach clinics, and student loan programs have offered loan reductions for services to rural areas. Still, rural areas struggle to maintain health services to what is often a deprived socioeconomic population.

HOSPITAL OUTPATIENT DEPARTMENTS Hospitals offer ambulatory care services in clinics where people with nonurgent medical problems can receive treatment. Clinics are separate from emer- Ambulatory Care • 111 gency department services, but the emergency department often handles nonurgent patients during hours when the clinics are not open. Clinics may be general or specialized (e. g.

, in diabetes, oncology, women’s health). Historically, only hospitals with teaching programs or those in areas (usually urban) where patients could not or would not go to doctors’ offices had clinics, and they served mostly those with low incomes. The situation has changed since competition among hospitals has increased and inpatient reimbursement has decreased. Hospitals are establishing and expanding clinics, some of them in the community away from the hospital (freestanding). These clinics also attempt to attract middle-income persons to provide the hospital with additional income and to “ feed” patients to their hospitals for admission.

vendor payments and by government grants. As with so many other government programs, priorities shifted and funding tapered off. In addition to decreased funding, community health centers faced other problems. The demand for services far exceeded their availability because these centers

were the only source of medical care for the poor in many rural areas and in many inner-city neighborhoods.

Many of these centers provide prenatal and obstetric care for low-income women who are considered high risk and who might otherwise not have access to care. Much of the focus of community health centers has turned to primary health care. The centers provide a more limited range of services and refer patients to clinics and hospital centers for more specialized care. Many of these centers have developed with support from one of several federal programs: the National Health Service Corps, the Rural Health Initiative, Health Underserved Rural Areas program, and the Appalachian Regional Commission. Such support augmented local organizational efforts and local building of the facilities. While the original concept of the typical federally supported center often had two family practitioners and one dentist, many centers are now staffed by nurse practitioners and physician assistants who provide primary care.

The supporting services vary from center to center. Some, in very remote areas, have implemented telemedicine to link primary care providers with specialists who are able to “ examine” the patient and provide consultation without physically being in the remote site. Telemedicine is a fairly new concept made possible by advances in technology. Health care providers in remote areas who use telemedicine are equipped with monitors that make it possible to transmit medical information to a “ home base” (emergency room, hospital specialty department, etc.) where consulting physicians receive vital diagnostic information regarding the patient.

In some cases the consultant is able to see the patient on a TV monitor. The consultant is therefore able to assist in or direct the patient’s care. Studies are under way to determine the effectiveness of possible applications of telemedicine in a variety of settings. The long-term survival of community health centers depends on attaining financial resources from COMMUNITY HEALTH CENTERS Community neighborhood health centers began to develop in the late 1960s, with funding initially from the Office of Economic Opportunity and later from the U. S.

Department of Health, Education, and Welfare (HEW). These centers provided primarily comprehensive ambulatory services for a defined population of poor people. The poor had always received large amounts of care from health departments and in hospitals. The larger hospitals, and particularly medical school hospitals, had long histories of care of the poor on both an inpatient and an outpatient basis.

But the outpatient care was often demeaning: There were impersonal, crowded surroundings, and long waits on hard benches. The neighborhood health center was designed to overcome these demeaning features by providing a broad range of primary and secondary ambulatory care services by salaried physicians and other health professionals, by emphasizing prevention, having available a wide range of supporting nonmedical services, and providing these services in the neighborhoods in which the people lived. Important, too, was the concept that the people who were served, the consumers, should be involved in the control of their centers. When possible, the centers were financed on a feefor-service basis by Medicare and Medicaid and other 12 • CHAPTER 6 grants and cooperative ventures with

larger medical centers, and on finding ways to attract and retain quality professional personnel and implement new technologies within limited funding opportunities. costs.

Surgery centers are able to function at lower costs because they incur lower overhead costs than hospitals. Even with the growth of freestanding centers, however, hospitals perform some 84 percent of all outpatient surgery and freestanding surgical centers perform only about 16 percent (Hall & Lawrence, 1998). Freestanding surgery centers are able to compete effectively with hospitals because Medicare now covers many procedures on an outpatient basis only. Surgery centers also affiliate with HMOs and preferred provider organizations (PPOs), thereby competing with hospitals for a certain flow of patients.

Hospitals have responded to the growth of ambulatory surgery centers by establishing their own freestanding centers, by affiliating or going into partnership with some of the freestanding centers, and by aggressively marketing and expanding their own hospital-based outpatient surgical services. Freestanding surgical centers may be independently owned, some by surgeons who are competing with the very hospitals in which they perform their more complicated surgical procedures. Some independently owned facilities are small, single-specialty centers with fewer physicians than those owned by hospitals and corporate chains. The development of ambulatory surgical centers in an area depends on such factors as state regulations, certificate-of-need requirements, competition, and reimbursement policies (Henderson, 1992). AMBULATORY SURGERY

CENTERS Technology and reimbursement patterns have increased the amount of surgery performed on an ambulatory basis.

Hospitals all over the country are experiencing a rise in the number of surgical patients who come into the hospital and go home on the same day, cases that previously required at least an overnight stay in the hospital, if not a two- or threeday stay. In many cases, ambulatory surgery is not optional; third-party payers require that many procedures be done on an outpatient basis. The move to outpatient treatment can significantly affect a hospital’s use of beds and its overall organization. Many surgeons, however, have been accustomed to performing a limited amount of ambulatory surgery in their offices, depending on their facilities, support services, and self-imposed limits. One of the major limits was anesthesia. The surgeon typically provided only surgery requiring a local anesthetic, not a general anesthetic, because board-certified anesthesiologists should administer general anesthesia.

Advances in technology make it possible to perform an increasing number of surgical procedures on an outpatient basis and with general anesthesia. During the 1970s, a number of freestanding—that is, not hospital-based—surgical centers began to develop in several parts of the country. After the American College of Surgeons began to approve freestanding surgical centers in 1981, the number of facilities increased rapidly throughout the country. In 1999 there were over 2, 700 freestanding outpatient surgery centers, up from 2, 400 in 1996. Some 5. 7 million surgical procedures were performed at such centers, up from 4.

3 million in 1996 (Ferreter, 2000). The most common procedures performed at these ambulatory surgical centers are in ophthalmology, gynecology, otolaryngology, orthopedics, and plastic surgery. The rapid growth of ambulatory surgery has been due to a demand by insurance companies and government to provide surgery at lower EMERGENCY CARE When considering emergency treatment, most people still think of the hospital emergency room. However, changes have taken place even in this area of health care delivery on the basis of costs, competition, and quality of care.

Many communities have tried to provide care to the uninsured in more suitable settings, recognizing that emergency rooms are overburdened with treatment requests that could better be served in a primary care setting. Managed care companies try to address this issue by requiring that the primary care provider (gatekeeper) be the initial contact even in emergent cases, mandating that primary care physicians provide twenty-four–hour contact optionsAmbulatory Care • 113 for their patients. The emergency care described in the sections that follow is just a sampling of the care that is available, and it may vary greatly in local communities. vided care and return home on the same day. Those requiring additional care are either admitted to an inpatient service of the facility or referred to another appropriate facility.

Hospital Emergency Departments The emergency room (ER) or emergency department (ED) is still the most familiar setting for emergency care and is the most appropriate for most acute and all life-threatening medical situations. The hospital ER has at its disposal all of the resources of equipment and specialty care provided by the hospital. It also has the

referral mechanisms in place for care not available in-house. Although each hospital may have its own method for staffing the ER, most hospitals today either directly employ physicians trained and certified in emergency medicine (a new and growing specialty area of medicine) or contract with emergency medical groups for continuous coverage. In very specialized areas of care, area physicians may be on call to provide care rather than such care being available inhouse. Although most hospitals do have emergency rooms or emergency departments, there is no general mandate to have an ER.

However, if a hospital does have an emergency department, it must treat all patients who present for care, regardless of ability to pay. The mandate to treat is defined as a requirement to stabilize the patient. A 1986 federal “ antidumping law” states that hospitals cannot inquire about patients’ insurance status before providing emergency care (“ Patient Dumping,” 1999). The statute often places ERs in a difficult situation because many managed care organizations refuse to pay for emergency care without prior authorization.

An ER also places stress on the hospital’s financial status because most acute trauma cases are very expensive to treat and many patients requiring such treatment are uninsured or underinsured and unable to pay for this very expensive care. ERs also face financial stress in that they are often used as a primary source of care by patients who have no regular source of care because they have no, or very inadequate, insurance. The emergency room is considered an outpatient service of the hospital. Patients most often are pro- Freestanding Emergency Centers Freestanding emergency centers

(urgi-care centers) provide episodic emergency care twenty-four hours a day for non-life-threatening problems.

It is estimated that there are over 5, 000 such centers in the nation. They provide primary care on a “ walk-in” or appointment basis, as well as more acute care. Sometimes they are storefront operations located in large shopping malls, but more often they are fully equipped clinics that provide a wide range of care for non-life-threatening situations. Like the ambulatory surgical centers, they provide the opportunity for physicians and forprofit organizations to compete with hospitals and office-based physicians for patients. They provide a treatment option to the use of hospital emergency departments and other practitioners whose location or appointment systems are inconvenient for patients.

Unlike medical clinics provided by hospital outreach programs, urgi-care centers are often a cash-and-carry operation, requiring payment at the time of service (cash, check, or credit card) and not billing insurances. Patients are given proper documentation to submit to any insurance plans they may have for reimbursement after payment is made to the center. Ambulance Services Ambulance services are provided by a variety of agencies. Depending on the community, services may be provided by police and fire departments, hospitals, volunteer groups, and private ambulance companies.

Considerable effort has been made in recent years to train ambulance crews in dealing with the kinds of emergencies they are likely to encounter and in connecting ambulance services via sophisticated communications equipment

to emergency facilities to provide care swiftly to the patient at the point of contact. Many communities have paramedic teams and emergency medical technicians (EMTs) as part of their ambulance services who are able, in 114 • CHAPTER 6 communication with the hospital emergency room staff, to provide treatment prior to the patient’s arrival in the emergency room. On the other hand, ambulance services can also provide routine transport for patients being transferred from the hospital to more appropriate sites of care, such as a rehabilitation center, nursing home, or home care. Transport can also be arranged for a bedbound patient from home to physician visits or other ambulatory care.

Costs and reimbursement policies for ambulance services vary by insurance company and reason for transport and can be a financial burden to patients required to pay out of pocket. Some community ambulance companies provide free services to individuals who become annual “ members” of the ambulance service by making an annual contribution to the ambulance corps. desired. However, some tests are very complicated and require rather costly equipment.

For these tests, as well as some of the simpler tests, the physician may have an arrangement with the nearby hospital or may use a freestanding clinical laboratory run by a pathologist or by a registered medical technologist. Sometimes the physician sends the patient to the lab; sometimes the physician sends the specimen to the lab. In rural settings, doctors may have to mail the specimen to a lab, or the lab may arrange for periodic pickup of specimens. Although there is state licensing of clinical laboratories and federal monitoring of those labs that work across state lines, there has been

concern over the years about the quality of laboratory analyses. Periodically, studies are completed that call into question the accuracy of clinical lab results.

This is, of course, a serious matter because a physician treats a patient on the basis of lab reports. The Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88)—changes to the Clinical Laboratory Improvement Act of 1967—brought much-needed regulation to laboratories to ensure the quality of test results. CLIA ’88 brought standards to freestanding and office-based laboratories similar to those imposed on hospitals and reference laboratories by CLIA ’67. Laboratories must be registered, must be open to periodic inspection, must perform proficiency testing, and must follow staffing guidelines in order to be paid by government programs for their services. These requirements have helped to improve the quality of laboratory findings, which ultimately lead to higher-quality treatment planning. Although not foolproof, CLIA ’88 is a move in the right direction (Health Care Financing Administration, 1998).

FAMILY PLANNING CENTERS Family planning centers were first established in 1970 when Congress passed Title X of the Public Health Service Act, which provided federal funding for establishing family planning services on the local level. Depending on the state and geographic area, local health departments, hospital agencies, or voluntary agencies established the centers, which typically provided gynecological examinations, breast or cervical cancer screening, contraceptive information and supplies, and other services related to reproductive health care. Many centers have expanded

their services to include genetic screening; routine child health screening; and sexually transmi