VITAL HEALTH STATISTICS

Office Visits to Psychiatrists

United States, 1985

Descriptive information on office visits to office-based psychiatrists in 1985 is presented. Trend data for 1975–85 are included. Emphasis is placed on patient diagnoses, factors related to the utilization of medication and psychotherapy, and types of medication utilized. Additional information on visit characteristics is presented, including demographic information, expected source of payment, patient disposition, and visit duration.

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Symbols

- - -	Data not available
. . .	Category not applicable
-	Quantity zero
0.0	Quantity more than zero but less than 0.05
Z	Quantity more than zero but less than 500 where numbers are rounded to thousands
*	Figure does not meet standard of reliability or precision
#	Figure suppressed to comply with confidentiality requirements

Office Visits to Psychiatrists

by Gloria J. Gardocki, Ph.D., Division of Health Care Statistics

Introduction

Purpose

In this report, national information on the characteristics of visits to office-based psychiatrists is presented. The information is based on the 1985 National Ambulatory Medical Care Survey (NAMCS), a sample survey of the medical care provided in the office setting by physicians primarily engaged in office-based practice. Trend analyses based on the 1975–76, 1980–81, and 1985 ambulatory care surveys also are included in this report. A report describing NAMCS information on the visits made to psychiatrists in 1975 and 1976 has been published (NCHS, 1978).

Data source and limitations

NAMCS was conducted annually by the National Center for Health Statistics (NCHS) from 1973 through 1981 and again in 1985. Detailed information on the background and methodology of the survey has been published (NCHS, 1974). In brief, the basic sampling unit for the survey is the physician-patient encounter or visit. The scope of NAMCS includes all office visits within the conterminous United States made by ambulatory patients to nonfederally employed, office-based physicians, excluding anesthesiologists, pathologists, and radiologists. Thus the design of NAMCS excludes all telephone contacts with office-based physicians, all contacts with office-based physicians conducted outside the physician's office, all contacts with physicians in the three specialties mentioned, and all contacts with physicians principally engaged in other professional activities, such as teaching, research, or administration.

The data collected on sample patient visits include patient demographic and medical characteristics (for example, age and significant diagnoses) and information on the conduct of the visits (for example, diagnostic tests ordered or provided and duration of physician-patient contact). The latter information includes prescription and nonprescription therapeutic medications ordered or provided during each visit (that is, drug mentions). Data from individual sample visits were inflated to produce national estimates.

NAMCS data reflect considerable duplication of persons because the unit of measurement used is the patient visit and because the average member of the civilian noninstitutionalized population makes multiple visits each year. This is particularly true for NAMCS data on visits to psychiatrists, since psychiatric patients usually make multiple visits during an episode of illness. For this reason, use of the term "patient" in discussing the characteristics and treatment of the persons who made the visits examined in this report is avoided wherever practicable. When needed for clarity, the term "patient" is used. It refers to the person who made a particular visit, rather than to a person who may receive continuing care by making a number of visits.

The trend data presented in this report include annual averages for 1975–76 and 1980–81, as well as data from the 1985 survey. Each year's NAMCS was conducted using the same definitions of the physician universe and an office visit. The survey designs also were very similar, although two major changes did occur. First, a larger physician sample was utilized for the 1985 survey than for earlier surveys (approximately 5,000, compared with approximately 3,000). Second, the method of stratifying the physician universe according to specialty was changed, along with the attendant sampling fractions. The overall effect of these changes was to increase the precision of estimates. The most obvious differences that appear among the surveys, however, revolve around changes in the Patient Record form and the coding of patients' reasons for visits and diagnoses. Although the 1975 and 1976 surveys were conducted in an identical manner, as were the 1980 and 1981 surveys, numerous changes in the collection and coding of NAMCS data were made over the years. These changes mean that the analysis of longitudinal trends is quite limited. Wherever trend data are presented in this report, the discussion includes an explanation of relevant limitations. For further clarification the reader is urged to consult the detailed information that has been published on each survey (NCHS, 1979a and 1983).

Because of the complexity of the survey design and estimation procedures, appendixes I–III should be reviewed to ensure accurate understanding and interpretation of the statistical estimates presented. Appendix I presents a description of the 1985 survey, including the survey design, data collection and processing procedures, and estimation procedures. Guidelines for judging the precision of estimates also are included in this appendix. Appendix II contains definitions of terms used in the survey. Finally, a facsimile of the Patient Record form—the survey instrument used to report visit information—appears in appendix III.

Highlights

- There were 18.0 million visits to office-based psychiatrists in 1985. This was 1 of every 35 physician visits, and 77 visits per 1,000 population.
- More than half of the visits were made by persons 25–44 years of age, and three-fifths were made by females.
- There were no statistically significant changes between 1975–76 and 1985 in the numbers, percents, or rates of visits to psychiatrists for the total population, either sex, or any age group.
- The 1985 regional rates of visits to psychiatrists ranged from 47 visits per 1,000 population in the South to 127 in the Northeast.
- The most common principal diagnosis in 1985 was depression, which was reported for 29.4 percent of the visits. Both the number and percent of visits with a principal diagnosis of depression increased significantly between 1975–76 and 1985 (from 3.0 to 5.3 million visits, and from 19.6 percent to 29.4 percent). Also between 1975–76 and 1985, the proportion of visits with nonpsychiatric principal diagnoses decreased from 14.4 percent to 7.1 percent.
- In 1985, the most common principal diagnoses in the group of depressive disorders were neurotic depression (13.2 percent of all visits to psychiatrists) and major depressive disorder, single episode (9.3 percent). The most common neurotic disorders, excluding neurotic depression, were anxiety states exclusive of generalized anxiety disorder (8.7 percent). Adjustment reaction (9.2 percent of all visits) was the largest component of visits in the residual group of other psychiatric disorders and psychiatric examinations. No other group of principal diagnoses had a statistically significant leading component.
- Females made more visits with a principal diagnosis of depression than males did (3.5 million, compared with 1.8 million).
- The most frequently reported expected sources of payment were self-payment (reported for 57.1 percent of visits), other commercial insurance (29.0 percent), and Blue Cross or Blue Shield (16.1 percent). (Note that these expected sources of payment were not mutually exclusive.)
- Almost three-fourths of all visits were made to solo practitioners.
- Checking patients' blood pressures dropped significantly between 1975–76 and 1985 (from 5.4 percent of visits to 2.3 percent), but ordering or providing one or more clinical laboratory tests remained constant, with 3.3 percent of the visits in 1985 involving these tests.
- Patients were instructed to return at a specified time in 91.4 percent of the visits.
- The median visit duration was 45 minutes. More than half of the visits lasted 41–50 minutes, and almost one-fifth lasted 21–40 minutes.
- The use of medication increased steadily between 1975–76 and 1985. One or more medications were ordered or provided in one-fourth of the 1975–76 visits, one-third of the 1980–81 visits, and almost half of the 1985 visits.
- Medication was ordered or provided most often in the visits made by persons 45 years old and older—62.9 percent. In contrast, it was used in only 40.9 percent of the visits made by persons 25–44 years of age and in 33.1 percent of the visits made by persons under 25 years of age.
- Medication was used primarily as an adjunct to psychotherapy. Psychotherapy alone was used in almost half of the visits, and psychotherapy and medication were both used in another four-tenths of the visits.
- Medication was ordered or provided in six of every seven visits in which the principal diagnosis was a psychosis—more than for any other principal diagnosis.
- Almost half of the visits in which medication was used lasted 0–40 minutes, but only one-seventh of the visits with no medication use were that short.
- There were 14.8 million drug mentions in the 1985 visits to office-based psychiatrists. Of these, 28.8 percent were antidepressants, 28.8 percent were anxiolytics, sedatives, and hypnotics, 16.9 percent were major tranquilizers (that is, antipsychotic medications), and 6.1 percent were antimanic agents.
- The average number of drug mentions per visit rose with patient age, from 0.31 per visit for patients 14 years of age and younger to 1.81 per visit for patients 65 years of age and older.
- The average number of drug mentions per visit also varied with principal diagnosis. Highest were the averages for visits with principal diagnoses of psychoses (1.76 per visit) and depressive disorders (1.02 per visit).

Findings

Demographics

In 1985 there were 18.0 million visits to office-based psychiatrists, or 77 per 1,000 civilian noninstitutionalized population. This was 2.8 percent of all visits to physicians that year. Although the median patient age in visits to psychiatrists of 38.0 is essentially equal to that in visits to all other physicians (38.1), the distribution of visits according to age differs markedly. As table A shows, most of the visits to psychiatrists were made by young and middle-aged adults. Persons 25–44 years of age made more than half of the visits (56.2 percent), and those 45–64 years of age made almost one-fourth of the visits (23.1 percent). All other persons (that is, those under 25 years of age and those over 64 years of age) together accounted for only one-fifth of all visits to psychiatrists.

The age differences in the utilization of psychiatrists' services can be seen most clearly in the visit rates. The rates for the group 25–44 years of age (141 per 1,000 population) and the group 45–64 years of age (94) did not differ significantly, but were greater than the rates for those 15–24 years of age (45) and those 65 years old and older (44). Not surprisingly, children 14 years of age and younger had the lowest rate of visits (16).

Visits to psychiatrists also varied significantly with patient sex. In 1985, three-fifths of the visits (59.4 percent) were made by females and only two-fifths by males (40.6 percent). The female rate of 89 visits per 1,000 population was a full third higher than the male rate of 65.

Despite these differences, by far the most striking observation to be made regarding the statistics presented in table A is that there were no significant longitudinal trends at all. The 1975–76 and 1980–81 annual averages and the 1985 annual statistics showed no statistically significant changes over time in the visit frequencies, percent distributions, or rates for the total or for any age or sex group. It should be noted, however, that the relatively small frequencies, by NAMCS standards, resulted in relatively large standard errors. This may have contributed to the negative findings of the statistical tests here, or in some of the other analyses presented in this report.

The 1985 age-specific rates of visits for each sex are shown in figure 1. The difference between the male and female rates is not significant for any of the five age groups. The rise and fall of the rates through the age range, however, is somewhat different for the two sexes. For the males, a sharper peak emerges. The rates for the two youngest age groups do not differ significantly, but are smaller than the rate of 122 visits per 1,000 population for the 25–44 year age group. The rates for the oldest age groups also do not differ significantly and also are smaller than the rate for the

Table A. Number, percent distribution, and rate of visits to office-based psychiatrists by age and sex of patient: United States, 1975–76, 1980–81, and 1985

Age and sex of patient	*1975–76*[1]	*1980–81*[1]	*1985*
	Number in thousands		
All visits	15,308	15,905	17,989
Age			
Under 15 years	1,316	852	821
15–24 years	2,331	1,792	1,730
25–44 years	8,081	8,653	10,114
45–64 years	3,114	3,946	4,149
65 years and over	*466	663	1,175
Sex			
Male	6,105	6,651	7,308
Female	9,203	9,254	10,681
	Percent distribution		
All visits	100.0	100.0	100.0
Age			
Under 15 years	8.6	5.4	4.6
15–24 years	15.2	11.3	9.6
25–44 years	52.8	54.4	56.2
45–64 years	20.3	24.8	23.1
65 years and over	3.0	4.2	6.5
Sex			
Male	39.9	41.8	40.6
Female	60.1	58.2	59.4
	Rate per 1,000 civilian noninstitutionalized population		
All visits	73	71	77
Age			
Under 15 years	25	17	16
15–24 years	60	44	45
25–44 years	153	138	141
45–64 years	72	90	94
65 years and over	*22	27	44
Sex			
Male	61	62	65
Female	85	80	89

[1]Statistics are average annual estimates.

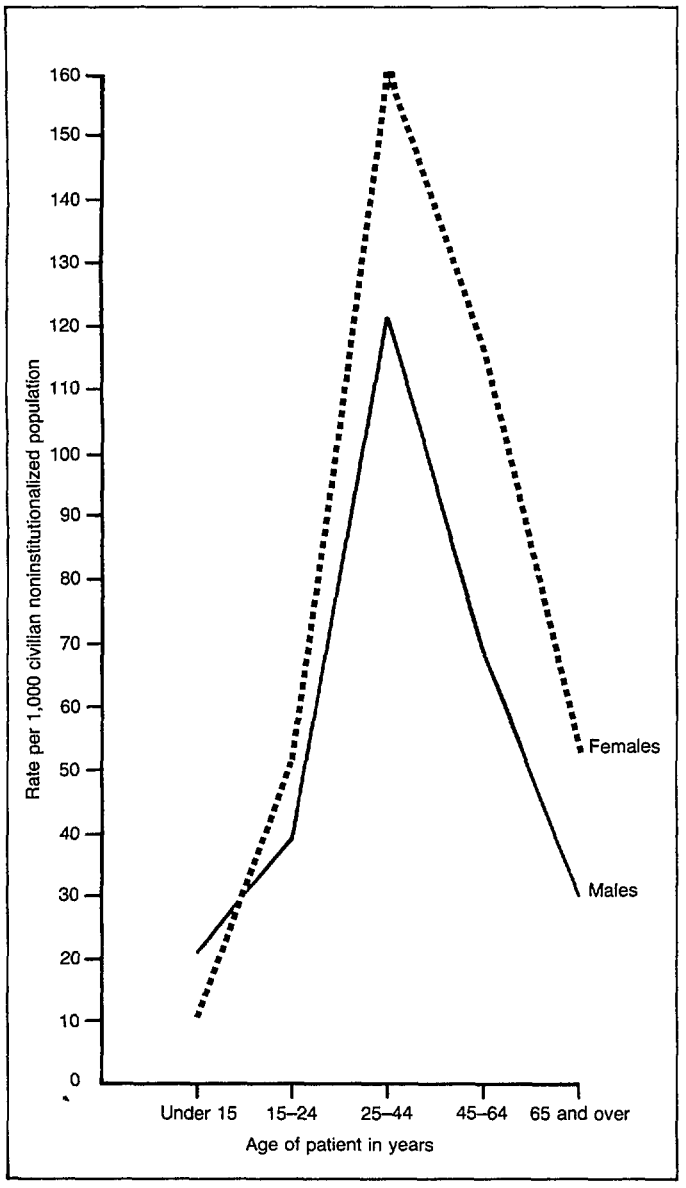

Figure 1. Rate of visits to office-based psychiatrists by sex and age of patient: United States, 1985

middle age group. In contrast, the rates for the females show somewhat more complexity. The rate for girls 14 years of age and younger is significantly smaller than that for young women 15–24 years of age, and both are significantly lower than the rate of 160 per 1,000 population for women 25–44 years of age. The rate of 117 for women 45–64 years of age, however, is not significantly lower. For females, the significant rate drop comes with the group 65 years of age and older.

Information on regional patterns in the use of psychiatrists' services is shown in table B. In 1985, the Northeast had more visits to psychiatrists than any other region—6.3 million, or 35.2 percent of the total. The Northeast's rate of 127 visits per 1,000 population, however, was higher than the rates of only two regions, the Midwest and the South (with rates of 67 and 47, respectively). The rate of 90 visits per

Table B. Number, percent distribution, and rate of visits to office-based psychiatrists by geographic region: United States, 1975–76, 1980–81, and 1985

Geographic region	*1975–76*[1]	*1980–81*[1]	*1985*
	Number in thousands		
All visits	15,308	15,905	17,989
Northeast	5,751	5,313	6,337
Midwest	2,728	2,351	3,945
South	3,690	4,439	3,763
West	3,139	3,802	3,945
	Percent distribution		
All visits	100.0	100.0	100.0
Northeast	37.6	33.4	35.2
Midwest	17.8	14.8	21.9
South	24.1	27.9	20.9
West	20.5	23.9	21.9
	Rate per 1,000 civilian noninstitutionalized population		
All visits	73	71	77
Northeast	118	108	127
Midwest	49	40	67
South	55	61	47
West	86	93	90

[1]Statistics are average annual estimates.

1,000 population in the West did not differ significantly from the Northeast's rate.

Neither the regional frequencies nor the regional rates changed significantly between the 1975–76 and 1985 time periods. A slight shift in the regional percent distribution of visits did appear, however, between 1980–81 and 1985. During that period, the percent of all visits that took place in the Midwest increased (from 14.8 percent to 21.9 percent), and the percent that took place in the South decreased correspondingly (from 27.9 percent to 20.9 percent).

Patients' diagnoses

The distribution of principal diagnoses in visits to psychiatrists in 1975–76, 1980–81, and 1985 is shown in table C. Two different, although related, coding systems were used over the years to organize the diagnoses reported by participating physicians. The *Eighth Revision, International Classification of Diseases, Adapted for Use in the United States* (ICDA) (NCHS, 1967) was used to code the 1975 and 1976 diagnostic data, and the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM) (PHS and HCFA, 1980) was used to code the 1980, 1981, and 1985 diagnostic data. For the analyses in this report, specific diagnostic codes have been aggregated into diagnostic groups. (The exact contents of each diagnostic group under each coding system can be found in appendix II.) Although the ICDA and ICD–9–CM are closely related, they are not identical, so meaningful diagnostic groups that are perfectly comparable could not be constructed. Consequently, trends that appear must be viewed with caution; there is some possibility that they may reflect changes in the coding systems used, rather than changes in the diagnostic patterns displayed by patients.

Depressive disorders were the most common principal diagnoses in 1985 visits to psychiatrists, accounting for 29.4 percent of the visits. All the other diagnostic groups related to mental disorders accounted for essentially equal proportions—neurotic disorders were listed as the principal diagnosis in 17.6 percent of the visits, psychoses in 16.3 percent, personality disorders in 14.4 percent, and all other psychiatric disorders and psychiatric examinations in 15.2 percent. Principal diagnoses not directly indicative of mental disorders accounted for the smallest proportion of visits, only 7.1 percent.

The 1975–76, 1980–81, and 1985 statistics presented in table C reveal that two significant trends occurred. First, both the number and percent of visits in which the principal diagnosis was a depressive disorder increased between 1975–76 and 1985. Depressive disorders accounted for 5.3 million visits in 1985, or 3 of every 10 visits, but only an average of 3.0 million visits, or 2 of every 10, in 1975 and 1976. Second, the proportion of nonpsychiatric diagnoses decreased from 14.4 percent in 1975–76 to 8.9 percent in 1980–81, then essentially remained constant at 7.1 percent in 1985. Although NAMCS data cannot be used to pinpoint the underlying sources of these changes, several possibilities can be suggested. Modifications of the diagnostic coding system, which were rather extensive for depressive disorders, may have contributed to these statistical changes, despite efforts to make the diagnostic groups comparable over time. Also, because of changes in the knowledge base used in the practice of psychiatry, psychiatrists in 1985 may have assigned mental disorder diagnoses, particularly depression, to cases which they would have classified differently 10 years earlier. Finally, knowledgeability regarding the causes and treatment of depression and/or the definition of mental illness may have increased in the public, spurring a larger number of depressed persons to seek treatment and/or inhibiting persons whose problems do not warrant psychiatric diagnoses from visiting psychiatrists.

A more detailed presentation of the 1985 frequency and percent distributions of the diagnoses included in the diagnostic groups can be seen in table D. Several noteworthy findings emerge from this table. In the group of principal diagnoses that were depressive disorders, neurotic depression and major depressive disorder (single episode) were the most common, accounting for 13.2 percent and 9.3 percent of all visits to psychiatrists, respectively. Second most common were depressive disorders not elsewhere classified (4.9 percent), and least common was major depressive disorder (recurrent episode), which accounted for 2.0 percent. In the neurotic disorder group, which excludes neurotic depression, the largest diagnostic subgroup was anxiety states other than generalized anxiety disorder (8.7 percent of all visits). Generalized anxiety disorder and all other neurotic disorders accounted for essentially equal proportions of psychiatrists' visits (4.0 percent and 4.9 percent, respectively). Finally, a majority of the visits included in the residual category of other psychiatric disorders and psychiatric examinations had the principal diagnosis of adjustment reaction; these visits accounted for 9.2 percent of all visits to psychiatrists in 1985.

The distribution among diagnostic groups of the visits made by each sex in 1985 is presented in table E. Only one significant difference between the visit distributions of males and females was found: Females made significantly more visits for depression than males did (3.5 million compared with 1.8 million). The proportion of visits made by females in which depression was the principal diagnosis, although appearing notably larger than the proportion of visits made by males with that diagnosis, did not differ significantly from it (32.8 percent and 24.4 percent, respectively).

The most common specific principal diagnoses for all visits, each sex, and each age group are shown in table F. It is important to note that, although these specific diagnoses have been rank ordered, differences among the frequencies and percents are not always significant. For all visits, the most common specific diagnoses were neurotic depression, major depressive disorder (single episode), unspecified anxiety state, depressive disorder not elsewhere classified, unspecified adjustment reaction, generalized anxiety disorder, unspecified personality disorder, borderline personality disorder, compulsive personality disorder, and unspecified bipolar affective disorder. Together these 10 diagnoses accounted for approximately half (53.6 percent) of all visits to psychiatrists in 1985.

The statistics presented for each sex and for each age group show all the specific diagnoses named as the principal diagnosis often enough to attain statistical reliability. Particular

Table C. Number and percent distribution of visits to office-based psychiatrists by principal diagnosis: United States, 1975–76, 1980–81, and 1985

Principal diagnosis[2]	1975–76[1]		1980–81[1]		1985	
	Number in thousands	Percent distribution	Number in thousands	Percent distribution	Number in thousands	Percent distribution
All visits	15,308	100.0	15,905	100.0	17,989	100.0
Psychoses (including affective psychoses, except major depressive disorder)	2,497	16.3	2,471	15.5	2,928	16.3
Depressive disorders (including major depressive disorder)	2,994	19.6	4,266	26.8	5,287	29.4
Neurotic disorders (excluding neurotic depression)	3,597	23.5	3,264	20.5	3,165	17.6
Personality disorders	2,059	13.4	2,477	15.6	2,587	14.4
Other psychiatric disorders and psychiatric examinations	1,960	12.8	2,019	12.7	2,743	15.2
All other principal diagnoses	2,201	14.4	1,408	8.9	1,279	7.1

[1]Statistics are average annual estimates.
[2]In the 1975 and 1976 surveys, based on *Eighth Revision, International Classification of Diseases, Adapted for Use in the United States* (ICDA). In the 1980, 1981, and 1985 surveys, based on *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM).

Table D. Number and percent distribution of visits to office-based psychiatrists by detailed principal diagnosis: United States, 1985

Principal diagnosis and ICD–9–CM code[1]	*Number in thousands*	*Percent distribution*
All visits	17,989	100.0
Psychoses (including affective psychoses, except major depressive disorder) . 290–295, 296.0, 296.1, 296.4–296.9, 297–299	2,928	16.3
Paranoid type schizophrenia . 295.3	467	2.6
Other schizophrenic disorders . 295.0–295.2, 295.4–295.9	983	5.5
Bipolar affective disorders . 296.4–296.7	673	3.7
Other affective psychoses (excluding major depressive disorder) . 296.0, 296.1, 296.8, 296.9	425	2.4
Other psychoses . 290–294, 297–299	379	2.1
Depressive disorders (including major depressive disorder) . 296.2, 296.3, 300.4, 311	5,287	29.4
Major depressive disorder, single episode . 296.2	1,665	9.3
Major depressive disorder, recurrent episode . 296.3	355	2.0
Neurotic depression . 300.4	2,383	13.2
Depressive disorder, not elsewhere classified . 311	884	4.9
Neurotic disorders (excluding neurotic depression) . 300.0–300.3, 300.5–300.9	3,165	17.6
Generalized anxiety disorder . 300.02	712	4.0
Other anxiety states . 300.00, 300.01, 300.09	1,567	8.7
Other neurotic disorders . 300.1–300.3, 300.5–300.9	887	4.9
Personality disorders . 301	2,587	14.4
Compulsive personality disorder . 301.4	473	2.6
Borderline personality disorder . 301.83	535	3.0
Other personality disorders . 301.0–301.3, 301.5–301.7, 301.81, 301.82, 301.84, 301.89, 301.9	1,579	8.8
Other psychiatric disorders and psychiatric examinations . 302–310, 312–316, V67.3, V70.1, V70.2, V79.0, V79.1	2,743	15.2
Adjustment reaction . 309	1,658	9.2
Remaining psychiatric disorders and examinations . 302–308, 310, 312–316, V67.3, V70.1, V70.2, V79.0, V79.1	1,085	6.0
All other diagnoses . Residual	1,279	7.1

[1]Based on *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM).

Table E. Number and percent distribution of visits to office-based psychiatrists by principal diagnosis, according to sex of patient: United States, 1985

Principal diagnosis[1]	*Both sexes*	*Male*	*Female*	*Both sexes*	*Male*	*Female*
	Number in thousands			Percent distribution		
All visits	17,989	7,308	10,681	100.0	100.0	100.0
Psychoses (including affective psychoses, except major depressive disorder)	2,928	1,246	1,682	16.3	17.0	15.8
Depressive disorders (including major depressive disorder)	5,287	1,781	3,506	29.4	24.4	32.8
Neurotic disorders (excluding neurotic depression)	3,165	1,309	1,857	17.6	17.9	17.4
Personality disorders	2,587	1,238	1,350	14.4	16.9	12.6
Other psychiatric disorders and psychiatric examinations	2,743	1,203	1,541	15.2	16.5	14.4
All other diagnoses	1,279	533	746	7.1	7.3	7.0

[1]Based on *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM).

diagnoses appear in these listings with remarkable consistency. For each sex and for the three middle age groups (25–34 years, 35–44 years, and 45–64 years), neurotic depression was always the most common principal diagnosis. Major depressive disorder (single episode) and unspecified anxiety state, not always in that order, were the next most common diagnoses for each sex and age group with at least two or three diagnoses that reached the level of statistical reliability. No single specific principal diagnosis was made often enough to be considered reliable in the youngest and oldest age groups.

The final aspect of diagnoses to be considered is the question of secondary diagnoses. In the 1985 visits to psychiatrists, 6.4 million secondary diagnoses were reported, an average of 0.36 per visit. As figure 2 shows, the least common diagnostic group was psychoses, as only 4.9 percent of these diagnoses were so classified. The remaining diagnostic groups accounted for proportions ranging from 13.0 percent to 28.7 percent, with no noteworthy pattern emerging.

Visit characteristics

The 1985 NAMCS included, for the first time, a question on the sources from which payment for physician visits was to be expected. Participating physicians were asked to indicate on a checklist which of the nationally most common payment sources was expected to pay all or part of the charges incurred during each sample visit. The accuracy of these reports thus depends on the extent of physicians' knowledge regarding the precise status of patients' insurance coverage, as well as on completeness of reporting. For this reason, NAMCS

Table F. Number and percent distribution of the most common specific principal diagnoses in visits to office-based psychiatrists by sex and age of patient: United States, 1985

Principal diagnosis and ICD–9–CM code,[1] *and sex and age of patient*	*Number in thousands*	*Percent distribution*
Both sexes		
All visits	17,989	100.0
Neurotic depression . . . 300.4	2,383	13.2
Major depressive disorder, single episode . . . 296.2	1,589	8.8
Anxiety state, unspecified . . . 300.00	1,220	6.8
Depressive disorder, not elsewhere classified . . . 311	884	4.9
Unspecified adjustment reaction . . . 309.9	799	4.4
Generalized anxiety disorder . . . 300.02	712	4.0
Unspecified personality disorder . . . 301.9	607	3.4
Borderline personality disorder . . . 301.83	535	3.0
Compulsive personality disorder . . . 301.4	473	2.6
Bipolar affective disorder, unspecified . . . 296.7	436	2.4
All other principal diagnoses . . . Residual	8,352	46.4
Male		
All visits	7,308	100.0
Neurotic depression . . . 300.4	846	11.6
Anxiety state, unspecified . . . 300.00	481	6.6
Major depressive disorder, single episode . . . 296.2	465	6.4
Depressive disorder, not elsewhere classified . . . 311	353	4.8
All other principal diagnoses . . . Residual	5,164	70.7
Female		
All visits	10,681	100.0
Neurotic depression . . . 300.4	1,537	14.4
Major depressive disorder, single episode . . . 296.2	1,123	10.5
Anxiety state, unspecified . . . 300.00	739	6.9
Unspecified adjustment reaction . . . 309.9	560	5.2
Depressive disorder, not elsewhere classified . . . 311	532	5.0
Borderline personality disorder . . . 301.83	383	3.6
Generalized anxiety disorder . . . 300.02	376	3.5
All other principal diagnoses . . . Residual	5,431	50.8
Under 25 years of age[2]		
All visits	2,552	100.0
25–34 years of age		
All visits	4,640	100.0
Neurotic depression . . . 300.4	563	12.1
All other principal diagnoses . . . Residual	4,077	87.9
35–44 years of age		
All visits	5,473	100.0
Neurotic depression . . . 300.4	807	14.7
Major depressive disorder, single episode . . . 296.2	428	7.8
Anxiety state, unspecified . . . 300.00	412	7.5
Generalized anxiety disorder . . . 300.02	367	6.7
All other principal diagnoses . . . Residual	3,460	63.2
45–64 years of age		
All visits	4,149	100.0
Neurotic depression . . . 300.4	589	14.2
Major depressive disorder, single episode . . . 296.2	501	12.1
All other principal diagnoses . . . Residual	3,059	73.7
65 years of age and over[2]		
All visits	1,175	100.0

[1]Based on *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM).
[2]For this age group, no specific diagnosis had a frequency large enough to meet the NCHS standard of statistical reliability.

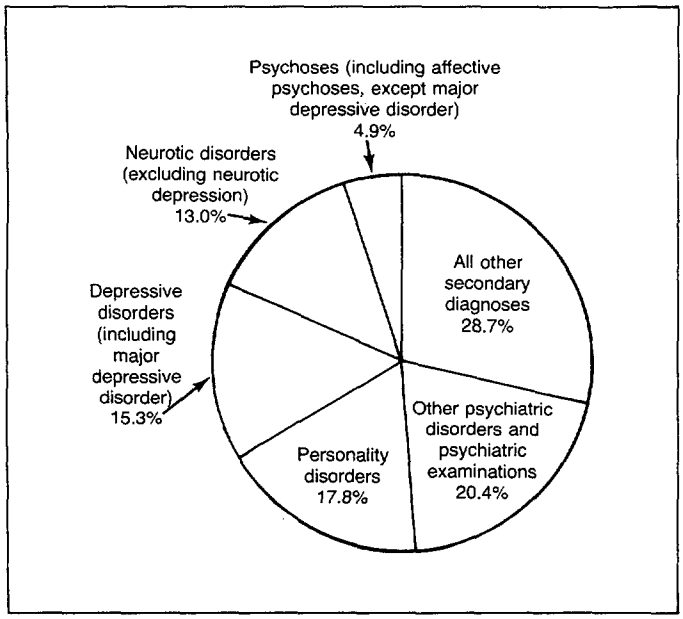

Figure 2. Percent distribution of secondary diagnoses in visits to office-based psychiatrists by diagnostic group: United States, 1985

information on the expected source of payment was not expected to attain the level of completeness and accuracy reached for other types of information collected, such as diagnoses or the use of therapeutic services. Nevertheless, this information should provide valuable insight into the relative importance of each payment source in reimbursing physicians for office-based patient care.

Table G shows that self-payment and private insurance predominate in paying for psychiatric services. By far the most common expected source of payment was self-payment, which was reported for 57.1 percent of the visits. This included both the visits in which all of the charges were to be paid by the patients and those in which only part of the charges were to be paid by the patients. The second and third most common expected sources of payment were other commercial insurance (29.0 percent of the visits) and Blue Cross or Blue Shield (16.1 percent). All other expected sources of payment were mentioned significantly less frequently, in a range of 0.2–6.1 percent of the visits.

Information on several other variables directly concerned with the characteristics of patient visits has been collected in NAMCS since its inception. Trend statistics for those items are presented in table H.

Visits to solo practitioners strongly predominated in 1985, with almost three-fourths of all visits to psychiatrists (72.5 percent) being made to these physicians. Although visits to solo practitioners also strongly outweighed those to other psychiatrists in 1975–76 and 1980–81, there was a significant change. The proportion of all visits that was made to psychiatrists in solo practice increased significantly between 1975–76 and 1980–81 (from 77.9 percent to 88.8 percent), then dropped significantly to the 1985 level. The underlying reasons for these changes cannot be determined from the available data.

Two diagnostic services relevant to psychiatric practice on which data were collected between 1975–76 and 1985 were blood pressure measurements and clinical laboratory

Table G. Number and percent of visits to office-based psychiatrists by expected source of payment: United States, 1985

Expected source of payment	*Number in thousands*	*Percent*
All visits	17,989[1]	100.0[1]
Self-pay	10,271	57.1
Medicare	1,001	5.6
Medicaid	1,106	6.1
Blue Cross or Blue Shield	2,897	16.1
Other commerical insurance	5,219	29.0
HMO or other prepaid plan	846	4.7
No charge	*225	*1.3
Other	668	3.7
Unknown	*31	*0.2

[1]Sums of categories do not equal the totals because more than one expected source of payment was recorded for some visits.

tests. Checking patients' blood pressures dropped significantly between 1975–76 and 1985 (from 5.4 percent of visits to 2.3 percent), although the intervening changes involving the 1980–81 period were not significant. In contrast, ordering or providing clinical laboratory tests remained essentially constant over the entire period, with 3.3 percent of the visits in 1985 involving one or more of these tests. It is important to note that no significant change occurred despite changes in the survey instrument which, if anything, encouraged more complete reporting of these tests.

The disposition of patients at the end of visits and the duration of visits also were remarkably stable over time, as no significant differences appeared between 1975–76 and 1985. In the vast majority of the 1985 visits (91.4 percent), the patients were instructed to return at a specified time. The remaining visits were essentially equally distributed among the other categories of patient disposition: return if needed (4.7 percent); no followup planned (2.8 percent); and all other patient dispositions (2.9 percent). Similarly, a large majority of the 1985 visits (68.0 percent) lasted 31–60 minutes. This was followed by the visits that lasted 16–30 minutes (19.4 percent). All other visit durations accounted for small, essentially equal, proportions of visits: 6.6 percent lasted 11–15 minutes, 3.2 percent lasted 61 minutes or more, and 2.9 percent lasted 10 minutes or less. The median duration of all visits was 45 minutes.

A very different picture revealing a great deal of change emerges when the information on the use of medications is inspected. In 1975 and 1976, only one-fourth of all visits to psychiatrists (27.1 percent) involved ordering or providing one or more medications to the patient. By 1980–81, this had increased to one-third (36.2 percent), and by 1985 it had increased again, to almost one-half (46.3 percent). At first glance, it appears that the initial increase could be the result of a major change in the method utilized in NAMCS to report the use of medication. In 1975 and 1976, physicians indicated the use of medication by simply checking one or more of three items in a list of therapeutic services ordered or provided; in 1980 and 1981, physicians listed specific drugs ordered or provided. The greater specificity of the questions used in the later period, as well as the obviously greater emphasis on the item, could have increased the responsiveness of participating physicians. However, no change of such a

Table H. Number and percent of visits to office-based psychiatrists by selected characteristics: United States, 1975–76, 1980–81, and 1985

Characteristic	1975–76[1]		1980–81[1]		1985	
	Number in thousands	Percent	Number in thousands	Percent	Number in thousands	Percent
All visits	15,308	100.0	15,905	100.0	17,989	100.0
Type of practice						
Solo	11,924	77.9	14,124	88.8	13,051	72.5
Other	3,385	22.1	1,781	11.2	4,939	27.5
Selected diagnostic services[2]						
Blood pressure check	819	5.4	529	3.3	418	2.3
Clinical lab test[3]	*376	*2.5	*259	*1.6	592	3.3
Use of medication						
Medication used[4]	4,148	27.1	5,759	36.2	8,324	46.3
No medication used	15,308	72.9	10,146	63.8	9,665	53.7
Patient disposition[2]						
No followup planned	632	4.1	433	2.7	501	2.8
Return at specified time	13,607	88.9	14,401	90.5	16,442	91.4
Return if needed	924	6.0	900	5.7	840	4.7
Other	923	6.0	489	3.1	522	2.9
Visit duration						
0–10 minutes[5]	826	5.4	482	3.0	527	2.9
11–15 minutes	*598	3.9	528	3.3	1,179	6.6
16–30 minutes	2,717	17.7	3,026	19.0	3,487	19.4
31–60 minutes	10,590	69.2	11,519	72.4	12,226	68.0
61 or more minutes	*577	3.8	*350	*2.2	571	3.2

[1]Statistics are average annual estimates.
[2]More than one was recorded for some visits.
[3]In the 1975, 1976, 1980, and 1981 surveys, measured by the physician checking "clinical lab test" in a list of diagnostic services ordered or provided. In the 1985 survey, measured by the physician checking "urinalysis," "hematology," "blood chemistry," and/or "other lab test" in a list of diagnostic services ordered or provided.
[4]In the 1975 and 1976 surveys, measured by the physician checking "drug prescribed," "injection," and/or "immunization desensitization" in a list of therapeutic services ordered or provided. In the 1980, 1981, and 1985 surveys, measured by the physician recording one or more specific medications, new or continued, as ordered or provided.
[5]Duration of zero minutes was recorded for visits in which there was no face-to-face contact between the patient and the physician.

magnitude was made in the questions between 1980–81 and 1985, yet the reports of using medication increased just as much. During the total 1975–85 period, the development of psychotropic drugs, clinical knowledge regarding advantageous applications of psychotropic drugs, and emphasis on health care cost-cutting measures all increased dramatically. Together, these observations lead to the conclusion that the statistical increases noted here are not artifacts created by methodological changes, but instead are reflections of actual changes in psychiatric treatment.

Since medication therapy and psychotherapy are the two principal methods of treating mental disorders, they are of extreme importance. For this reason, the remainder of this portion of this report is devoted to investigating different aspects of the use of medication and psychotherapy.

As table J shows, the use of psychotherapy is related to patient age, and the use of medication is related to both patient age and patient sex. Overall, psychotherapy was heavily utilized, as it was ordered or provided in 88.7 percent of all visits. It was used significantly more often with persons between the ages of 25 and 44 (91.8 percent) than with persons 45 years of age and older (83.0 percent). Its use with persons under 25 years of age (88.3 percent), however, did not differ significantly from its use with either of the two older age

Table J. Percent distribution of visits to office-based psychiatrists by use of psychotherapy and medication, according to age and sex of patient: United States, 1985

Use of psychotherapy and medication	Both sexes, all ages	Age of patient			Sex of patient	
		Under 25 years	25–44 years	45 years and over	Male	Female
All visits	100.0	100.0	100.0	100.0	100.0	100.0
Psychotherapy ordered or provided						
Yes	88.7	88.3	91.8	83.0	89.2	88.4
No	11.3	11.7	8.2	17.0	10.8	11.6
Medication ordered or provided						
Yes	46.3	33.1	40.9	62.9	40.6	50.2
No	53.7	66.9	59.1	37.1	59.4	49.8

groups. Furthermore, psychotherapy was used equally often with males (89.2 percent of visits) and females (88.4 percent). In contrast, medication was utilized more in the visits made by persons 45 years of age and older (62.9 percent) than in the visits made by persons 25–44 years of age (40.9 percent) or in the visits made by persons under 25 years of age (33.1 percent). In addition, it was ordered or provided in 50.2 percent of the visits made by females but in only 40.6 percent of the visits made by males. The latter finding may be at least partly due to the larger number of visits for depression made by females, since depression is one of the mental disorders relatively amenable to treatment with medication.

The extent to which the use of psychotherapy and medication overlapped is illustrated in figure 3. This shows that medication was used primarily as an adjunct to psychotherapy. In almost half of the visits (48.9 percent), only psychotherapy was ordered or provided. In another four-tenths (39.8 percent), both psychotherapy and medication were ordered or provided. Only in very small proportions of visits were only medication used (6.4 percent), or neither psychotherapy nor medication used (4.8 percent).

As table K shows, the use of medication was also related to both the visit status and the population density of the geographic area in which the visit took place, but not to the referral status of the visit. Medications were used substantially more often in return visits than in initial visits (47.7 percent, compared with 29.8 percent), and also substantially more often in visits in nonmetropolitan areas than in visits in metropolitan areas (71.5 percent, compared with 45.4 percent). They were used at essentially equal rates, however, in visits for which the patient had been referred (39.7 percent) and in those that were not referrals (46.5 percent).

The type of principal diagnosis influenced the use of medication, but not as clearly as expected (table L). Medication was utilized by far the most often in the visits in which the principal diagnoses were psychoses (85.6 percent). The corresponding proportions among the remaining diagnostic groups ranged from 20.1 percent of the visits in which the principal diagnoses were personality disorders to 54.8 percent of the visits in which the principal diagnoses were depressive disorders. Although there were some significant differences among these statistics, no clear pattern emerged. Given the broad range that appeared in the proportions, this relative lack of statistically significant findings undoubtedly was at least partly due to the small frequencies involved, with the consequent large relative standard errors.

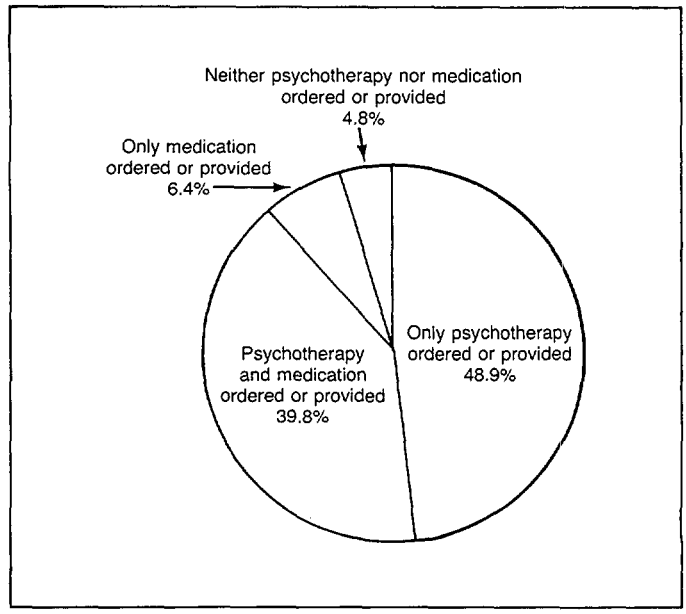

Figure 3. Percent distribution of psychotherapy and medication in visits to office-based psychiatrists: United States, 1985

The final aspect of medication usage to be considered here is its clear relationship with length of visit. As table M shows, visits in which medication was ordered or provided, compared with all other visits, were significantly more likely to last 0–20 minutes (18.9 percent, compared with 7.0 percent) or 21–40 minutes (30.6 percent, compared with 7.2 percent), and significantly less likely to last 41–50 minutes (40.4 percent, compared with 68.7 percent) or 51 minutes or longer (10.1 percent, compared with 17.1 percent). Several possible explanations could account for this. First, although we have seen that medication usually was used in conjunction with psychotherapy, it sometimes may have been used as a partial substitute. That is, some psychiatrists, in some cases, may have felt that when medication was used extended psychotherapy sessions were unnecessary. Second, some of the visits may have been brief follow-up visits made for the

Table K. Number and percent distribution of visits to office-based psychiatrists by use of medication, according to patient referral status, visit status, and metropolitan status: United States, 1985

Medication ordered or provided	All visits	Patient was referred for this visit		Visit status		Metropolitan status	
		Yes	No	New patient	Return visit	Metropolitan area	Nonmetropolitan area
	Number in thousands						
All visits	17,989	615	17,374	1,408	16,581	17,383	606
Yes	8,324	*244	8,079	419	7,905	7,891	433
No	9,665	371	9,294	989	8,677	9,493	*173
	Percent distribution						
All visits	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Yes	46.3	39.7	46.5	29.8	47.7	45.4	71.5
No	53.7	60.3	53.5	70.2	52.3	54.6	*28.5

Table L. Percent distribution of visits to office-based psychiatrists by use of medication, according to principal diagnosis: United States, 1985

Medication ordered or provided	All principal diagnoses	Principal diagnosis[1]					
		Psychoses[2]	Depressive disorders[3]	Neurotic disorders[4]	Personality disorders	Other psychiatric disorders and psychiatric examinations	All other principal diagnoses
All visits	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Yes	46.3	85.6	54.8	41.7	20.1	25.0	30.8
No	53.7	14.4	45.2	58.3	79.9	75.0	69.2

[1]Based on *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM).
[2]Includes affective psychoses, except major depressive disorder.
[3]Includes major depressive disorder.
[4]Excludes neurotic depression.

Table M. Percent distribution of visits to office-based psychiatrists by visit duration, according to use of medication: United States, 1985

Visit duration	All visits	Medication ordered or provided	
		Yes	No
All visits	100.0	100.0	100.0
0–20 minutes[1]	12.5	18.9	7.0
21–40 minutes	18.0	30.6	7.2
41–50 minutes	55.6	40.4	68.7
51 minutes or more	13.9	10.1	17.1

[1]Duration of zero minutes was recorded for visits in which there was no face-to-face contact between the patient and the physician.

purpose of continuing maintenance medication therapy. Third, psychiatric patients who need medication often, although not always, are the sickest patients. In some of the visits made by these patients, the psychiatrists may have decided that the patients were unable to benefit from extended psychotherapy sessions and so may have limited the duration of the visits. The final possibility also is related to the severity of patients' disorders. Since insurance coverage of treatment for mental disorders often is much more limited than coverage for other disorders, some of psychiatrists' sickest patients may have exhausted much or all of their insurance coverage and consequently may have been unable to afford longer psychotherapy visits.

Drug mentions

This portion of the report explores various aspects of the particular drug mentions that appeared in visits to psychiatrists, rather than the characteristics of the visits in which medication was ordered or provided.

There was a total of 14.8 million drug mentions in the 1985 visits to office-based psychiatrists. As shown in table N, most of the drugs were ordered using trade names (81.5 percent), were available to patients only with a prescription (95.9 percent), and were composed of a single active ingredient (94.2 percent). Two-thirds of the drug mentions (66.4 percent) were drugs not subject to the control regulations of the Drug Enforcement Administration, but almost one-third (30.8 percent) were controlled drugs. Most of the drug mentions (87.7 percent) were continuing medications; only 11.5 percent were newly ordered or provided. Undoubtedly the high proportion of return visits to psychiatrists was largely responsible for this predominance of continuing medications. Finally, most of the drug mentions (89.0 percent) were for treatment of the condition reflected in the principal diagnosis and only 10.3 percent were ordered for the treatment of other conditions.

Table N. Number and percent distribution of drug mentions in visits to office-based psychiatrists by selected characteristics: United States, 1985

Characteristic	Number in thousands	Percent distribution
All drug mentions	14,826	100.0
Entry status		
Generic name	2,325	15.7
Trade name	12,087	81.5
Undetermined	*414	*2.8
Prescription status		
Prescription drug	14,213	95.9
Nonprescription drug	*174	*1.2
Undetermined	*439	*3.0
Composition status		
Single ingredient drug	13,973	94.2
Combination drug	*439	*3.0
Undetermined	*414	*2.8
Control status		
Controlled drug	4,564	30.8
Uncontrolled drug	9,838	66.4
Undetermined	*424	*2.9
Use status		
New medication	1,703	11.5
Continuing medication	12,996	87.7
Undetermined	*126	*0.9
Diagnostic relevance		
Medication is for principal diagnosis	13,191	89.0
Medication is not for principal diagnosis	1,522	10.3
Undetermined	*112	*0.8

The NAMCS data files also contain American Hospital Formulary Service (American Druggist Blue Book Data Center, 1985) information as to the expected therapeutic effects of drugs mentioned. The therapeutic categories associated with the drugs ordered or provided by psychiatrists are shown in table O. As expected, most of the medications (85.4 percent) were central nervous system drugs; all other types of drugs

Table O. Number and percent distribution of drug mentions in visits to office-based psychiatrists by therapeutic category: United States, 1985

Therapeutic category[1]	Number in thousands	Percent distribution
All drug mentions	14,826	100.0
Central nervous system drugs	12,665	85.4
Psychotherapeutic agents	6,777	45.7
Antidepressants	4,267	28.8
Major tranquilizers	2,510	16.9
Anxiolytics, sedatives, and hypnotics	4,276	28.8
Benzodiazepines	3,968	26.8
Other anxiolytics, sedatives, and hypnotics	*308	*2.1
Antimanic agents	910	6.1
Other central nervous system drugs	*702	4.7
All other drug mentions	2,161	14.6

[1]Based on American Hospital Formulary Service Classification System, *Drug Product Information File*, The American Druggist Blue Book Data Center, San Bruno, Calif., 1985.

Table P. Number and percent of visits to office-based psychiatrists involving the most common generic drug ingredients: United States, 1985

Generic drug ingredient[1]	Number in thousands	Percent
All visits	17,989	100.0
Alprazolam	1,622	9.0
Lithium	910	5.1
Amitriptyline	881	4.9
Imipramine	837	4.7
Desipramine	685	3.8
Diazepam	581	3.2
Thioridazine	557	3.1
Doxepin	440	2.4
Chlordiazepoxide	360	2.0

[1]More than one generic drug ingredient may have been ordered or provided during a single visit.

accounted for only 14.6 percent of all drug mentions. The central nervous system drugs subclassified as psychotherapeutic agents were divided between antidepressants (28.8 percent of all drug mentions) and major tranquilizers (16.9 percent), statistics which did not differ significantly. Of the central nervous system drugs classified as anxiolytics, sedatives, and hypnotics, the vast majority were benzodiazepines (26.8 percent of all drug mentions). Only 2.1 percent were other anxiolytics, sedatives, and hypnotics. Finally, antimanic agents accounted for 6.1 percent of all drug mentions and other central nervous system drugs for 4.7 percent.

A tabulation of the number of visits in which each of the most common generic substances was used is presented in table P. The nine generic ingredients presented in this table are the only ones that appeared in statistically reliable numbers of visits. Of these, four were antidepressants—amitriptyline (utilized in 4.9 percent of the visits), imipramine (4.7 percent), desipramine (3.8 percent), and doxepin (2.4 percent). Three were anxiolytics—alprazolam (utilized in 9.0 percent of visits), diazepam (3.2 percent), and chlordiazepoxide (2.0 percent). Only one of the generic substances was an antipsychotic major tranquilizer (thioridazine, used in 3.1 percent of the visits), and one was the antimanic agent lithium (5.1 percent).

The average number of drugs utilized in individual visits rose with patient age, as shown in figure 4. There were

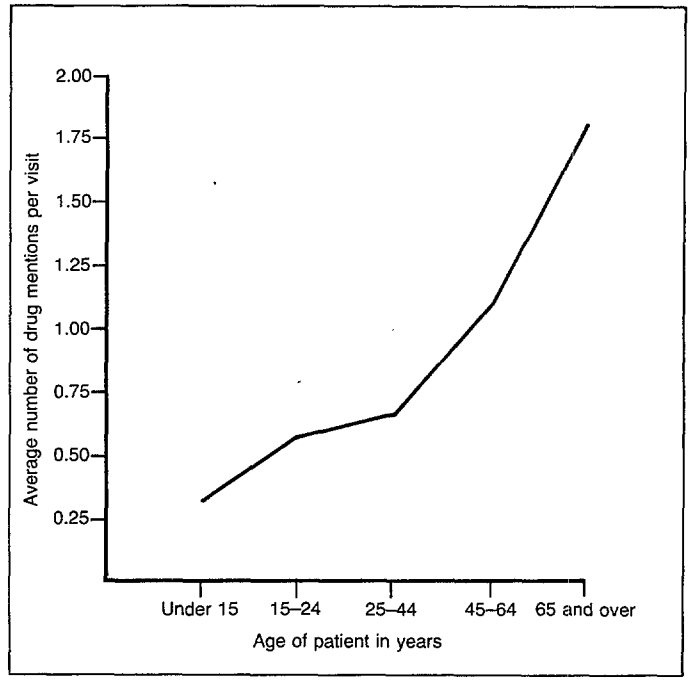

Figure 4. Average number of drug mentions per visit in visits to office-based psychiatrists by age of patient: United States, 1985

Table Q. Number, percent distribution, and average number per visit of drug mentions in visits to office-based psychiatrists by principal diagnosis: United States, 1985

Principal diagnosis[1]	Number in thousands	Percent distribution	Average number of drug mentions per visit
All drug mentions	14,826	100.0	0.82
Psychoses (including affective psychoses, except major depressive disorder)	5,165	34.8	1.76
Depressive disorders (including major depressive disorder)	5,391	36.4	1.02
Neurotic disorders (excluding neurotic depression)	1,924	13.0	0.61
Personality disorders	806	5.4	0.31
Other psychiatric disorders and psychiatric examinations	909	6.1	0.33
All other principal diagnoses	*631	*4.3	0.49

[1]Based on *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM).

no significant differences among the averages for the three youngest groups (0.31 drug mentions per visit for patients under 15 years of age, 0.59 per visit for those 15–24 years of age, and 0.65 for those 25–44 years of age). All, however, were smaller than the average of 1.16 drug mentions per visit for ages 45–64. This in turn was smaller than the average of 1.81 for visits made by patients 65 years of age and older.

Similar statistics on drug mentions according to principal diagnosis are displayed in table Q. Most drug mentions were associated with principal diagnoses of depressive disorders or psychoses (36.4 percent and 34.8 percent, respectively). This distribution reflects the intensity of drug utilization during visits. Visits with psychoses as the principal diagnoses had the highest intensity—an average of 1.76 drug mentions per

visit—and visits with depressive disorders as the principal diagnoses had the second highest—1.02 per visit. The averages for the remaining diagnostic categories ranged from only 0.33 per visit (for the residual category of other psychiatric disorders and psychiatric examinations) to 0.61 per visit (for neurotic disorders).

Finally, there is a clear relationship between the principal diagnosis and the types of medication used, but there is no simple correspondence between the two (table R). In visits in which psychoses were the principal diagnoses, major tranquilizers were the most commonly utilized medications, accounting for 34.1 percent of all drug mentions. All other drug types accounted for statistically equal proportions of the drug mentions. In visits with depressive disorders as the principal diagnoses, antidepressants and anxiolytics, sedatives, and hypnotics constituted almost three-fourths of all medications used (41.0 percent and 30.9 percent, respectively). The remaining three drug groups accounted for small and essentially equal proportions of the total. In the visits with principal diagnoses of neurotic disorders, which include anxiety disorders, more than half of all drug mentions (56.8 percent) were anxiolytics, sedatives, and hypnotics. An additional one-fourth of all drug mentions (29.8 percent) were antidepressants. All other drug mentions accounted for only very small proportions of the total. Lastly, in the group of visits with all other principal diagnoses, no one type of drug was utilized significantly more often than the other types. The limited nature of the relationship between the principal diagnosis and medications utilized undoubtedly reflects the multifaceted nature of many psychiatric disorders and variations in psychiatrists' style of medical practice, as well as the limitations on data analysis imposed by the influence of secondary diagnoses.

Table R. Number and percent distribution of drug mentions in visits to office-based psychiatrists by therapeutic category, according to principal diagnosis: United States, 1985

Therapeutic category[2]	All principal diagnoses	Principal diagnosis[1]			
		Psychoses[3]	Depressive disorders[4]	Neurotic disorders[5]	All other principal diagnoses
	Number in thousands				
All drug mentions	14,826	5,165	5,391	1,924	2,346
Antidepressants	4,267	864	2,209	*573	*621
Major tranquilizers	2,510	1,759	*463	*41	*248
Anxiolytics, sedatives, and hypnotics	4,276	834	1,665	1,092	*685
All other central nervous system drugs	1,612	*753	*385	*63	*412
All other drug mentions	2,161	955	*670	*156	*381
	Percent distribution				
All drug mentions	100.0	100.0	100.0	100.0	100.0
Antidepressants	28.8	16.7	41.0	29.8	26.5
Major tranquilizers	16.9	34.1	*8.6	*2.1	*10.6
Anxiolytics, sedatives, and hypnotics	28.8	16.2	30.9	56.8	29.2
All other central nervous system drugs	10.9	14.6	*7.1	*3.3	*17.6
All other drug mentions	14.6	18.5	12.4	*8.1	*16.2

[1]Based on *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM).
[2]Based on American Hospital Formulary Service Classification System, *Drug Product Information File*, The American Druggist Blue Book Data Center, San Bruno, Calif., 1985.
[3]Includes affective psychoses, except major depressive disorder.
[4]Includes major depressive disorder.
[5]Excludes neurotic depression.

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Table 1. Number, percent distribution, and rate of visits to office-based psychiatrists by sex and age of patient: United States, 1985

Sex and age of patient	Number in thousands	Percent distribution	Rate per 1,000 civilian noninstitutionalized population
All visits	17,989	100.0	77
Male			
All ages	7,308	40.6	65
Under 15 years	541	3.0	21
15–24 years	737	4.1	39
25–34 years	1,914	10.6	97
35–44 years	2,332	13.0	154
45–54 years	800	4.4	74
55–64 years	651	3.6	63
65 years and over	*334	1.9	*30
Female			
All ages	10,681	59.4	89
Under 15 years	*280	*1.6	*11
15–24 years	993	5.5	51
25–34 years	2,727	15.2	132
35–44 years	3,141	17.5	196
45–54 years	1,491	8.3	130
55–64 years	1,208	6.7	103
65 years and over	841	4.7	53

Table 2. Number and percent distribution of visits to office-based psychiatrists by selected characteristics, according to age of patient: United States, 1985

Characteristic	All ages	Under 15 years	15–24 years	25–34 years	35–44 years	45–64 years	65 years and over
				Number in thousands			
All visits	17,989	821	1,730	4,640	5,473	4,149	1,175
Visit status							
New patient	1,408	*93	*178	381	*342	*325	*89
Return visit	16,581	728	1,552	4,259	5,131	3,824	1,087
Metropolitan status							
Metropolitan area	17,383	812	1,703	4,537	5,310	3,937	1,083
Nonmetropolitan area	606	*10	*27	*103	*163	*212	*92
Type of practice							
Solo	13,051	640	1,326	3,394	4,136	2,810	745
Other	4,939	*182	404	1,246	1,337	1,339	430
Psychotherapy ordered or provided							
Yes	15,960	698	1,555	4,262	5,027	3,534	884
No	2,029	*123	*175	378	446	615	*292
Medication ordered or provided							
Yes	8,324	*208	636	1,828	2,306	2,409	938
No	9,665	614	1,094	2,812	3,167	1,740	*238
Patient instructed to return at specified time							
Yes	16,442	776	1,549	4,278	5,138	3,670	1,031
No	1,548	*46	*181	363	*335	479	*145
				Percent distribution			
All visits	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Visit status							
New patient	7.8	*11.3	*10.3	8.2	6.3	7.8	*7.6
Return visit	92.2	88.7	89.7	91.8	93.7	92.2	92.4
Metropolitan status							
Metropolitan area	96.6	98.8	98.5	97.8	97.0	94.9	92.2
Nonmetropolitan area	3.4	*1.2	*1.5	*2.2	*3.0	*5.1	*7.8
Type of practice							
Solo	72.5	77.9	76.6	73.1	75.6	67.7	63.4
Other	27.5	*22.1	23.4	26.9	24.4	32.3	36.6
Psychotherapy ordered or provided							
Yes	88.7	85.0	89.9	91.8	91.9	85.2	75.2
No	11.3	*15.0	*10.1	8.2	8.1	14.8	24.8
Medication ordered or provided							
Yes	46.3	*25.3	36.7	39.4	42.1	58.1	79.8
No	53.7	74.7	63.3	60.6	57.9	41.9	*20.2
Patient instructed to return at specified time							
Yes	91.4	94.4	89.5	92.2	93.9	88.5	87.7
No	8.6	*5.6	*10.5	7.8	6.1	11.5	*12.3

Table 3. Number and percent distribution of visits to office-based psychiatrists by selected characteristics, according to sex of patient: United States, 1985

Characteristic	Both sexes	Male	Female	Both sexes	Male	Female
	Number in thousands			Percent distribution		
All visits	17,989	7,308	10,681	100.0	100.0	100.0
Ethnicity and race						
Hispanic	615	*288	*327	3.4	*3.9	3.1
White, not Hispanic	16,524	6,715	9,809	91.9	91.8	91.9
Other races, not Hispanic	851	*305	546	4.7	*4.2	5.1
Visit status						
New patient	1,408	559	850	7.8	7.6	8.0
Return visit	16,581	6,750	9,832	92.2	92.4	92.0
Geographic region						
Northeast	6,337	2,421	3,916	35.2	33.1	36.7
Midwest	3,945	1,788	2,157	21.9	24.5	20.2
South	3,763	1,472	2,291	20.9	20.1	21.4
West	3,945	1,628	2,317	21.9	22.3	21.7
Metropolitan status						
Metropolitan area	17,383	7,074	10,310	96.6	96.8	96.5
Nonmetropolitan area	606	*234	372	3.4	*3.2	3.5
Type of practice						
Solo	13,051	5,401	7,650	72.5	73.9	71.6
Other	4,939	1,907	3,031	27.5	26.1	28.4
Visit duration						
0–20 minutes[1]	2,251	922	1,329	12.5	12.6	12.4
21–40 minutes	3,242	1,211	2,032	18.0	16.6	19.0
41–50 minutes	10,003	4,203	5,800	55.6	57.5	54.3
51 or more minutes	2,494	973	1,521	13.9	13.3	14.2
Patient instructed to return at specified time						
Yes	16,442	6,635	9,807	91.4	90.8	91.8
No	1,548	674	874	8.6	9.2	8.2

[1]Duration of zero minutes was recorded for visits in which there was no face-to-face contact between the patient and the physician.

Table 4. Number and percent distribution of visits to office-based psychiatrists by metropolitan status: United States, 1975–76, 1980–81, and 1985

Metropolitan status	1975–76[1]		1980–81[1]		1985	
	Number in thousands	Percent distribution	Number in thousands	Percent distribution	Number in thousands	Percent distribution
All visits	15,308	100.0	15,905	100.0	17,989	100.0
Metropolitan area	14,358	93.8	14,936	93.9	17,383	96.6
Nonmetropolitan area	951	6.2	970	6.1	606	3.4

[1]Statistics are average annual estimates.

Table 7. Number and percent distribution of visits to office-based psychiatrists by selected characteristics, preceding [illegible]

Table 5. Number of visits to office-based psychiatrists by geographic region and selected characteristics: United States, 1985

Characteristic	*All regions*	*Northeast*	*Midwest*	*South*	*West*
All visits	17,989	6,337	3,945	3,763	3,945
Age of patient					
Under 15 years	821	*175	390	*124	*133
15–24 years	1,730	567	318	535	311
25–34 years	4,640	1,942	962	714	1,023
35–44 years	5,473	1,812	1,227	1,088	1,347
45–54 years	2,290	805	421	506	558
55–64 years	1,859	691	437	366	365
65 years and over	1,175	*346	*191	429	*209
Visit status					
New patient	1,408	*348	513	*263	*284
Return visit	16,581	5,989	3,432	3,500	3,661
Metropolitan status					
Metropolitan area	17,383	6,104	3,666	3,691	3,922
Nonmetropolitan area	606	*233	*279	*71	*23
Type of practice					
Solo	13,051	5,115	2,401	2,366	3,169
Other	4,939	1,222	1,544	1,397	776
Patient instructed to return at specified time					
Yes	16,442	6,030	3,362	3,309	3,741
No	1,548	*307	583	454	*204
Visit duration					
0–20 minutes[1]	2,251	661	683	583	*324
21–40 minutes	3,242	755	778	951	759
41–50 minutes	10,003	4,359	1,755	1,642	2,246
51 minutes or more	2,494	563	729	586	615
Psychotherapy ordered or provided					
Yes	15,960	5,685	3,599	3,135	3,540
No	2,029	652	*346	627	405
Medication ordered or provided					
Yes	8,324	2,695	1,749	2,027	1,854
No	9,665	3,642	2,196	1,736	2,091

[1]Duration of zero minutes was recorded for visits in which there was no face-to-face contact between the patient and the physician.

Table 6. Percent distribution of visits to office-based psychiatrists by selected characteristics, according to geographic region: United States, 1985

Characteristic	All regions	Northeast	Midwest	South	West
All visits	100.0	100.0	100.0	100.0	100.0
Age of patient					
Under 15 years	4.6	*2.8	9.9	*3.3	*3.4
15–24 years	9.6	8.9	8.0	14.2	7.9
25–34 years	25.8	30.6	24.4	19.0	25.9
35–44 years	30.4	28.6	31.1	28.9	34.1
45–54 years	12.7	12.7	10.7	13.4	14.1
55–64 years	10.3	10.9	11.1	9.7	9.2
65 years and over	6.5	*5.5	*4.8	11.4	*5.3
Visit status					
New patient	7.8	5.5	13.0	*7.0	*7.2
Return visit	92.2	94.5	87.0	93.0	92.8
Metropolitan status					
Metropolitan area	96.6	96.3	92.9	98.1	99.4
Nonmetropolitan area	3.4	*3.7	*7.1	*1.9	*0.6
Type of practice					
Solo	72.5	80.7	60.9	62.9	80.3
Other	27.5	19.3	39.1	37.1	19.7
Patient instructed to return at specified time					
Yes	91.4	95.2	85.2	87.9	94.8
No	8.6	*4.8	14.8	12.1	*5.2
Visit duration					
0–20 minutes[1]	12.5	10.4	17.3	15.5	8.2
21–40 minutes	18.0	11.9	19.7	25.3	19.2
41–50 minutes	55.6	68.8	44.5	43.6	56.9
51 minutes or more	13.9	8.9	18.5	15.6	15.6
Psychotherapy ordered or provided					
Yes	88.7	89.7	91.2	83.3	89.7
No	11.3	10.3	8.8	16.7	10.3
Medication ordered or provided					
Yes	46.3	42.5	44.3	53.9	47.0
No	53.7	57 5	55.7	46.1	53.0

[1]Duration of zero minutes was recorded for visits in which there was no face-to-face contact between the patient and the physician.

Table 7. Number and percent distribution of visits to office-based psychiatrists by selected characteristics, according to type of practice: United States, 1985

Characteristic	Both practice types	Solo practice	Other type of practice	Both practice types	Solo practice	Other type of practice
	Number in thousands			Percent distribution		
All visits	17,989	13,051	4,939	100.0	100.0	100.0
Referred for this visit						
Yes	615	429	*187	3.4	3.3	*3.8
No	17,374	12,622	4,752	96.6	96.7	96.2
Visit status						
New patient	1,408	856	552	7.8	6.6	11.2
Return visit	16,581	12,195	4,386	92.2	93.4	88.8
Metropolitan status						
Metropolitan area	17,383	12,471	4,912	96.6	95.6	99.5
Nonmetropolitan area	606	580	*26	3.4	4.4	*0.5
Patient instructed to return at specified time						
Yes	16,442	12,183	4,259	91.4	93.3	86.2
No	1,548	868	680	8.6	6.7	13.8
Visit duration						
0–20 minutes[1]	2,251	1,268	982	12.5	9.7	19.9
21–40 minutes	3,242	1,949	1,293	18.0	14.9	26.2
41–50 minutes	10,003	8,011	1,992	55.6	61.4	40.3
51 minutes or more	2,494	1,822	672	13.9	14.0	13.6
Psychotherapy ordered or provided						
Yes	15,960	11,637	4,324	88.7	89.2	87.5
No	2,029	1,414	615	11.3	10.8	12.5
Medication ordered or provided						
Yes	8,324	5,599	2,725	46.3	42.9	55.2
No	9,665	7,452	2,214	53.7	57.1	44.8
Principal diagnosis[2]						
Psychoses (including affective psychoses, except major depressive disorder)	2,928	1,721	1,207	16.3	13.2	24.4
Depressive disorders (including major depressive disorder)	5,287	3,529	1,758	29.4	27.0	35.6
Neurotic disorders (excluding neurotic depression)	3,165	2,807	359	17.6	21.5	7.3
Personality disorders	2,587	2,194	393	14.4	16.8	8.0
Other psychiatric disorders and psychiatric examinations	2,743	2,093	650	15.2	16.0	13.2
All other principal diagnoses	1,279	707	571	7.1	5.4	11.6

[1]Duration of zero minutes was recorded for visits in which there was no face-to-face contact between the patient and the physician.
[2]Based on *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM).

Table 8. Number and percent distribution of visits to office-based psychiatrists by principal diagnosis, according to age of patient: United States, 1985

Principal diagnosis[1]	All ages	Under 15 years	15–24 years	25–34 years	35–44 years	45–64 years	65 years and over
				Number in thousands			
All visits	17,989	821	1,730	4,640	5,473	4,149	1,175
Psychoses (including affective psychoses, except major depressive disorder)	2,928	*30	*293	700	690	935	*279
Depressive disorders (including major depressive disorder)	5,287	*67	410	1,101	1,618	1,541	550
Neurotic disorders (excluding neurotic depression)	3,165	*163	*229	866	1,214	524	*169
Personality disorders	2,587	*42	*195	1,023	940	387	-
Other psychiatric disorders and psychiatric examinations	2,743	394	423	673	707	468	*79
All other principal diagnoses	1,279	*126	*180	*276	*305	*293	*99
				Percent distribution			
All visits	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Psychoses (including affective psychoses, except major depressive disorder)	16.3	*3.6	17.0	15.1	12.6	22.5	23.7
Depressive disorders (including major depressive disorder)	29.4	*8.1	23.7	23.7	29.6	37.1	46.8
Neurotic disorders (excluding neurotic depression)	17.6	*19.8	*13.2	18.7	22.2	12.6	*14.3
Personality disorders	14.4	*5.1	*11.3	22.0	17.2	9.3	-
Other psychiatric disorders and psychiatric examinations	15.2	48.0	24.4	14.5	12.9	11.3	*6.7
All other principal diagnoses	7.1	*15.3	*10.4	*5.9	*5.6	*7.1	*8.4

[1]Based on *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM)

Table 9. Number and percent distribution of visits to office-based psychiatrists by principal diagnosis, according to geographic region: United States, 1985

Principal diagnosis[1]	All regions	Northeast	Midwest	South	West
		Number in thousands			
All visits	17,989	6,337	3,945	3,763	3,945
Psychoses (including affective psychoses, except major depressive disorder)	2,928	939	543	556	890
Depressive disorders (including major depressive disorder)	5,287	1,345	1,374	1,273	1,294
Neurotic disorders (excluding neurotic depression)	3,165	1,167	870	608	520
Personality disorders	2,587	1,462	*214	400	511
Other psychiatric disorders and psychiatric examinations	2,743	855	735	579	574
All other principal diagnoses	1,279	569	*209	*346	*155
		Percent distribution			
All visits	100.0	100.0	100.0	100.0	100.0
Psychoses (including affective psychoses, except major depressive disorder)	16.3	14.8	13.8	14.8	22.6
Depressive disorders (including major depressive disorder)	29.4	21.2	34.8	33.8	32.8
Neurotic disorders (excluding neurotic depression)	17.6	18.4	22.0	16.2	13.2
Personality disorders	14.4	23.1	*5.4	10.6	13.0
Other psychiatric disorders and psychiatric examinations	15.2	13.5	18.6	15.4	14.6
All other principal diagnoses	7.1	9.0	*5.3	9.2	*3.9

[1]Based on *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM).

Table 10. Number and percent distribution of secondary diagnoses in visits to office-based psychiatrists by type of diagnosis, according to age of patient: United States, 1985

Type of secondary diagnosis	All ages	Under 15 years	15–24 years	25–34 years	35–44 years	45–54 years	55–64 years	65 years and over
				Number in thousands				
All secondary diagnoses	6,428	*268	521	1,331	2,151	734	898	525
Mental disorder diagnoses	4,586	*194	416	1,013	1,683	518	517	*243
All other secondary diagnoses	1,843	*74	*105	*318	467	*216	381	*282
				Percent distribution				
All secondary diagnoses	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Mental disorder diagnoses	71.3	72.5	79.9	76.1	78.3	70.6	57.5	46.3
All other secondary diagnoses	28.7	*27.5	*20.1	23.9	21.7	*29.4	42.5	53.7

Table 11. Number and percent distribution of secondary diagnoses in visits to office-based psychiatrists by diagnosis, according to sex of patient: United States, 1985

Diagnosis[1]	Both sexes	Male	Female
	Number in thousands		
All secondary diagnoses	6,428	2,419	4,009
Psychoses (including affective psychoses, except major depressive disorder)	*312	*104	*208
Depressive disorders (including major depressive disorder)	983	357	626
Neurotic disorders (excluding neurotic depression)	836	*306	530
Personality disorders	1,145	470	675
Other psychiatric disorders and psychiatric examinations	1,309	663	646
All other secondary diagnoses	1,843	520	1,323
	Percent distribution		
All secondary diagnoses	100.0	100.0	100.0
Psychoses (including affective psychoses, except major depressive disorder)	4.9	*4.3	*5.2
Depressive disorders (including major depressive disorder)	15.3	14.7	15.6
Neurotic disorders (excluding neurotic depression)	13.0	12.6	13.2
Personality disorders	17.8	19.4	16.8
Other psychiatric disorders and psychiatric examinations	20.4	27.4	16.1
All other secondary diagnoses	28.7	21.5	33.0

[1]Based on *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM).

Table 12. Number and percent distribution of visits to office-based psychiatrists by use of medication, according to expected source of payment: United States, 1985

Medication ordered or provided	All expected sources of payment[1]	Expected source of payment: Self payment	Medicare	Medicaid	Blue Cross or Blue Shield	Other commercial insurance	HMO or other prepaid plan	No charge	Other	Unknown
	Number in thousands									
All visits	17,989	10,271	1,001	1,106	2,897	5,219	846	*225	668	*31
Yes	8,324	4,074	845	966	1,500	2,267	*334	*113	*301	*10
No	9,665	6,197	*157	*140	1,397	2,952	512	*112	367	*20
	Percent distribution									
All visits	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Yes	46.3	39.7	84.4	87.3	51.8	43.4	39.4	*50.1	45.0	*33.3
No	53.7	60.3	*15.6	*12.7	48.2	56.6	60.6	*49.9	55.0	*66.7

[1]Totals do not equal sums of sources because more than one expected source of payment was indicated for some visits.

Table 13. Number and percent distribution of visits to office-based psychiatrists by treatment method and principal diagnosis, according to sex of patient: United States, 1985

Treatment method and principal diagnosis	Both sexes	Male	Female	Both sexes	Male	Female
	Number in thousands			Percent distribution		
All visits	17,989	7,308	10,681	100.0	100.0	100.0
Psychotherapy ordered or provided						
Yes	15,960	6,515	9,445	88.7	89.2	88.4
No	2,029	793	1,236	11.3	10.8	11.6
Medication ordered or provided						
Yes	8,324	2,964	5,360	46.3	40.6	50.2
No	9,665	4,345	5,321	53.7	59.4	49.8
Principal diagnosis[1]						
Psychoses (including affective psychoses, except major depressive disorder)	2,928	1,246	1,682	16.3	17.0	15.8
Depressive disorders (including major depressive disorder)	5,287	1,781	3,506	29.4	24.4	32.8
Neurotic disorders (excluding neurotic depression)	3,165	1,309	1,857	17.6	17.9	17.4
Personality disorders	2,587	1,238	1,350	14.4	16.9	12.6
Other psychiatric disorders and psychiatric examinations	2,743	1,203	1,541	15.2	16.5	14.4
All other principal diagnoses	1,279	533	746	7.1	7.3	7.0

[1]Based on *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM).

Table 14. Number of visits to office-based psychiatrists by principal diagnosis and selected characteristics: United States, 1985

Characteristic	All principal diagnoses	Principal diagnosis[1]					
		Psychoses[2]	Depressive disorders[3]	Neurotic disorders[4]	Personality disorders	Other psychiatric disorders and psychiatric examinations	All other principal diagnoses
All visits	17,989	2,928	5,287	3,165	2,587	2,743	1,279
Psychotherapy ordered or provided							
Yes	15,960	2,484	4,710	2,982	2,400	2,493	892
No	2,029	444	577	*183	*188	*250	387
Medication ordered or provided							
Yes	8,324	2,507	2,896	1,320	521	686	394
No	9,665	421	2,391	1,845	2,066	2,057	885
Patient instructed to return at specified time							
Yes	16,442	2,732	4,996	3,006	2,466	2,314	928
No	1,548	*197	*291	*159	*121	430	*351
Visit duration							
0–20 minutes[5]	2,251	727	593	*223	*108	*290	*310
21–40 minutes	3,242	1,063	1,151	371	*114	380	*164
41–50 minutes	10,003	937	2,810	2,073	2,027	1,460	696
51 minutes or more	2,494	*200	733	498	*339	614	*109

[1]Based on *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM)
[2]Includes affective psychoses, except major depressive disorder.
[3]Includes major depressive disorder.
[4]Excludes neurotic depression.
[5]Duration of zero minutes was recorded for visits in which there was no face-to-face contact between the patient and the physician.

Table 15. Number and percent distribution of visits to office-based psychiatrists by selected characteristics, according to use of medication: United States, 1985

Characteristic	All visits	Medication ordered or provided		All visits	Medication ordered or provided	
		Yes	No		Yes	No
	Number in thousands			Percent distribution		
All visits	17,989	8,324	9,665	100.0	100.0	100.0
Psychotherapy ordered or provided						
Yes	15,960	7,167	8,793	88.7	86.1	91.0
No	2,029	1,157	872	11.3	13.9	9.0
Patient instructed to return at specified time						
Yes	16,442	7,799	8,643	91.4	93.7	89.4
No	1,548	525	1,022	8.6	6.3	10.6
Visit duration						
0–20 minutes[1]	2,251	1,572	679	12.5	18.9	7.0
21–40 minutes	3,242	2,548	694	18.0	30.6	7.2
41–50 minutes	10,003	3,365	6,638	55.6	40.4	68.7
51 minutes or more	2,494	839	1,655	13.9	10.1	17.1

[1]Duration of zero minutes was recorded for visits in which there was no face-to-face contact between the patient and the physician.

Table 16. Number and percent distribution of visits to office-based psychiatrists by visit duration, according to age of patient: United States, 1985

Visit duration	All ages	Under 25 years	25–34 years	35–44 years	45–64 years	65 years and over
	Number in thousands					
All visits	17,989	2,552	4,640	5,473	4,149	1,175
0–20 minutes[1]	2,251	*273	501	475	598	404
21–40 minutes	3,242	*296	695	774	1,074	403
41–50 minutes	10,003	1,616	2,830	3,307	1,933	*316
51 or more minutes	2,494	366	614	917	544	*52
	Percent distribution					
All visits	100.0	100.0	100.0	100.0	100.0	100.0
0–20 minutes[1]	12.5	*10.7	10.8	8.7	14.4	34.4
21–40 minutes	18.0	11.6	15.0	14.1	25.9	34.3
41–50 minutes	55.6	63.3	61.0	60.4	46.6	26.9
51 or more minutes	13.9	14.3	13.2	16.8	13.1	*4.4

[1]Duration of zero minutes was recorded for visits in which there was no face-to-face contact between the patient and the physician.

Table 17. Average number of drug mentions per visit for visits to office-based psychiatrists, by age of patient: United States, 1985

Age of patient	Average number of drug mentions per visit
All visits	0.82
Under 15 years	*0.31
15–24 years	0.59
25–44 years	0.65
45–64 years	1.16
65 years and over	1.81

Table 18. Number and percent distribution of drug mentions in visits to office-based psychiatrists by therapeutic category, according to age of patient: United States, 1985

Therapeutic category[1]	All ages	Under 25 years	25–44 years	45–64 years	65 years and over
	Number in thousands				
All drug mentions	14,826	1,277	6,608	4,812	2,129
Antidepressants	4,267	*342	1,919	1,435	*571
Major tranquilizers	2,510	*280	1,110	850	*270
Anxiolytics, sedatives, and hypnotics	4,276	*226	1,981	1,405	*664
All other central nervous system drugs	1,612	*283	777	*410	*142
All other drug mentions	2,161	*147	820	*712	*481
	Percent distribution				
All drug mentions	100.0	100.0	100.0	100.0	100.0
Antidepressants	28.8	*26.7	29.0	29.8	26.8
Major tranquilizers	16.9	*21.9	16.8	17.7	*12.7
Anxiolytics, sedatives, and hypnotics	28.8	*17.7	30.0	29.2	31.2
All other central nervous system drugs	10.9	*22.1	11.8	*8.5	*6.7
All other drug mentions	14.6	*11.5	12.4	14.8	*22.6

[1]Based on American Hospital Formulary Service Classification System, *Drug Product Information File*, The American Druggist Blue Book Data Center, San Bruno, Calif., 1985.

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Appendix I
Technical notes

This report is based on data collected during the period March 1985 through February 1986 in the National Ambulatory Medical Care Survey (NAMCS), a sample survey of office-based physicians conducted by the Division of Health Care Statistics of the National Center for Health Statistics (NCHS). The NAMCS survey design and procedures are presented in the following sections.

Statistical design

Scope of the survey

The target population of the 1985 NAMCS includes office visits made within the conterminous United States by ambulatory patients to nonfederally employed physicians who are principally engaged in office-based patient care practice, but not in the specialties of anesthesiology, pathology, or radiology. Telephone contacts and nonoffice visits are excluded from the NAMCS.

Sample design

The NAMCS utilizes a three-stage survey design that involves probability samples of primary sampling units (PSU's), physician practices within PSU's, and patient visits within physician practices. The first-stage sample of 84 PSU's was selected jointly by the National Opinion Research Center of the University of Chicago and the Survey Research Center of the University of Michigan. The National Opinion Research Center was the organization responsible for NAMCS field and data processing operations under contract to NCHS. A PSU is a county, a group of adjacent counties, or a metropolitan statistical area (MSA). The U.S. Bureau of the Census designations of MSA's, including the U.S. Office of Management and Budget additions of July 1981, were used. A modified probability-proportional-to-size procedure using separate sampling frames for MSA's and for nonmetropolitan counties was used to select the sample PSU's independently within each of the four census regions. The 1980 census figures of the number of occupied housing units were the basis for calculating the probability of selecting the PSU's.

The second stage consisted of a probability sample of practicing physicians, selected from the masterfiles 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 and subspecialties of anesthesiology, pathology, and radiology.

The 1985 NAMCS physician universe included 276,430 doctors of medicine and 11,776 doctors of osteopathy (see table I).

Eligible physicians were stratified into 15 groups within metropolitan/nonmetropolitan status. Doctors of medicine were stratified into 14 specialty groups as follows:

Cardiovascular disease
Dermatology
General and family practice
General surgery
Internal medicine
Neurology
Obstetrics and gynecology
Ophthalmology
Orthopedic surgery
Otorhinolaryngology
Pediatrics
Psychiatry
Urological surgery
All other specialties.

Doctors of osteopathy were included as a separate stratum. The number of physicians selected from each stratum was based on optimum sample design research for the 1985 NAMCS conducted by the NCHS Office of Research and Methodology (Tomkins and Shimizu, 1985).

The 1985 NAMCS physician sample included 5,032 physicians. Sample physicians were screened at the time of the survey to ensure that they met the aforementioned criteria; 928 physicians did not meet the criteria and were, therefore, ruled out of scope (ineligible) for the study. The most common reasons for being out of scope were that the physician was retired or employed in teaching, research, or administration. Of the 4,104 in scope (eligible) physicians, 2,879 (70.2 percent) participated in the study. Of the participating physicians, 397 saw no patients during their assigned reporting period because of vacations, illnesses, or other reasons for being temporarily out of office-based practice. The physician universe, sample size, and response data by physician strata are shown in table I.

The third stage was the selection of patient visits within the annual practices of the sample physicians. The stage involved two steps. First, the total physician sample was divided into 52 random subsamples of approximately equal size; then each subsample was randomly assigned to 1 of the 52 weeks

NOTE: A list of references follows the text.

Table I. Number of physicians in the universe, total sample and sample response categories, and response rates, by physician strata: National Ambulatory Medical Care Survey, 1985

Physician strata	Universe[1]	Sample					
		Total	Out of scope	In scope	Non-respondents	Respondents	Response rate
	Number						Percent
All strata	288,206	5,032	928	4,104	1,225	2,879	70
Cardiovascular disease	8,684	220	27	193	96	97	50
Dermatology	5,116	131	15	116	39	77	66
General and family practice	51,611	749	144	605	204	401	66
General surgery	20,577	290	54	236	78	158	67
Internal medicine	39,077	381	82	299	101	198	66
Neurology	4,478	113	16	97	34	63	65
Obstetrics and gynecology	22,509	322	38	284	74	210	74
Ophthalmology	11,835	510	49	461	121	340	74
Orthopedic surgery	12,574	318	40	278	70	208	75
Otorhinolaryngology	5,593	142	20	122	44	78	64
Pediatrics	21,499	205	56	149	26	123	83
Psychiatry	20,081	235	57	178	47	131	74
Urological surgery	6,893	288	26	262	63	199	76
All other specialties	45,903	617	220	397	95	302	76
Doctors of Osteopathy	11,776	511	84	427	133	294	69

[1]These data were derived from the American Medical Association and the American Osteopathic Association masterfiles and represent the total number of physicians eligible for the National Ambulatory Medical Care Survey.

in the survey year. Second, a systematic random sample of visits was selected by the physician during the assigned reporting week. The visit 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 for determining the visit sampling rate is described later in this appendix. The 1985 NAMCS responding sample physicians completed 71,594 Patient Records.

Data collection and processing

Field procedures

Both mail and telephone contacts were used to enlist sample physicians for NAMCS. Initially, physicians were sent introductory letters from the Director of NCHS. When appropriate, a letter from the physician's specialty organization endorsing the survey and urging his participation was enclosed with the NCHS letter. Approximately 2 weeks prior to the physician's assigned reporting period, a field representative telephoned the physician to briefly explain the study and arrange an appointment for a personal interview. Physicians who did not initially respond were usually recontacted via telephone or special explanatory letter and requested to reconsider participation in the study.

During the personal interview, the field representative determined the physician's eligibility for the study, obtained his cooperation, delivered survey materials with verbal and printed instructions, and assigned a predetermined Monday–Sunday reporting period. A short induction 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 instructional session or were offered separate instructional sessions.

The field representative telephoned the sample physician prior to and during the assigned reporting week to answer questions that might have arisen and to ensure that survey procedures were going smoothly. At the end of the reporting week, the participating physician mailed the completed survey materials to the field representative, who edited the forms for completeness before transmitting them for central data processing. Problems of missing or incomplete data were resolved through telephone followup by the field representative to the sample physicians.

Data collection

The actual data collection for NAMCS was carried out by the sample physicians, often assisted by their office staff. Two data collection forms were employed by the physicians: the Patient Log and the Patient Record (see appendix III). The Patient Log was used to sequentially list all patients seen in the physician's office during the assigned reporting week and served as the sampling frame to indicate the office visits for which data were to be recorded on the Patient Records. A perforation between the patient's name on the Patient Log and patient visit information on the Patient Record permitted the physician to detach and retain the listing of patients, thus assuring the anonymity of the patients.

Based on the physician's estimate of the expected number of office visits and expected number of days in practice during the assigned reporting week, each physician was assigned a visit sampling rate. The visit sampling rates were designed so that about 30 Patient Records would be completed by each physician during the assigned reporting week. Physicians expecting 10 or fewer visits each day recorded data for all visits, while those expecting more than 10 visits per day recorded data for every second, third, or fifth visit based on the predetermined sampling interval. These visit sampling procedures minimized the physician's data collection workload and maintained approximately equal reporting levels among sample physicians regardless of practice size. For physicians

recording data for every second, third, or fifth patient visit, a random start was provided on the first page of the Patient Log so that predesignated sample visits recorded on each succeeding page of the Patient Log provided a systematic random sample of patient visits during the reporting period.

Data processing

In addition to followups for missing and inconsistent data made by the field staff, numerous clerical edits were performed on data received for central data processing. These manual edit procedures proved quite efficient, reducing item nonresponse rates to 2 percent or less for most data items.

Information contained in item 8 (Patient's complaint, symptom, or other reason for visit) of the Patient Record was coded according to "A Reason for Visit Classification for Ambulatory Care" (RVC) (NCHS, 1979). Diagnostic information (item 11 of the Patient Record) was coded according to the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM). A maximum of three entries were coded from each of these items. Quality control for the medical coding operation involved a two-way 100-percent independent verification procedure. A dependent verification procedure was used to review and adjudicate all records with coding discrepancies.

The NAMCS medication data (item 14 of the Patient Record) was classified and coded according to a scheme developed at NCHS based on the Drug Product Information File maintained by the American Druggist Blue Book Data Center. A description of the drug coding scheme and of the NAMCS drug data processing procedures is contained in *Vital and Health Statistics*, Series 2, No. 90 (NCHS, 1982). A two-way 100-percent independent verification procedure was used to control the medication coding operation. As an additional quality control, all Patient Records with differences between drug coders or with illegible drug entries were reviewed and adjudicated.

Information from the Induction Interview and Patient Records was keypunched with 100 percent verification and converted to computer tape. Extensive computer consistency and edit checks were performed to ensure complete and accurate data. Incomplete data items were imputed by assigning a value from a randomly selected Patient Record with similar characteristics; patient sex and age, physician specialty, and broad diagnostic categories were used as the basis for these imputations.

Estimation procedures

Statistics from the NAMCS were derived by a multistage estimation procedure that 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) ratio adjustment to fixed totals. Each component is briefly described below.

Inflation by reciprocals of probabilities of selection

Because the survey utilized a three-stage sample design, three probabilities of selection existed: (1) the probability of selecting the PSU, (2) the probability of selecting the physician within the PSU, and (3) the probability of selecting the office visit within the physician's practice. The overall probability of including a physician in the sample was the product of the probability of the PSU being selected times the probability of the physician being selected. The probability of selecting the physician within a PSU was 1.0 for physicians in nonmetropolitan areas and was the PSU weight divided by the sampling interval for physicians in metropolitan areas. The probability of selecting the office visit was defined as the number of office visits during the physician's assigned 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 NAMCS data were adjusted to account for sample physicians who were in scope but did not participate in the study. This adjustment was calculated to minimize the impact of response 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 the 15 physician strata. The ratio adjustment was a multiplication factor that had as its numerator the number of physicians in the universe in each physician specialty strata and as its denominator the estimated number of physicians in that particular specialty strata. The numerator was based on figures obtained from the AMA and AOA master files, and the denominator was based on data from the sample.

Reliability of estimates

As in any survey, results are subject to both sampling and nonsampling errors. Nonsampling errors include reporting and processing errors, as well as biases due to nonresponse or incomplete response. The magnitude of the nonsampling errors cannot be computed. However, these errors were kept to a minimum by procedures built into the operation of the survey. To eliminate ambiguities and encourage uniform reporting, careful attention was given to the phrasing of questions, terms, and definitions. Also, extensive pretesting of most data items and survey procedures was performed. The steps taken to reduce bias in the data 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. Because survey results are subject to sampling and nonsampling errors, the total error will be larger than the error due to sampling variability alone.

Because 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, definitions, instructions, and procedures. However, the probability design of NAMCS permits the calculation

NOTE: A list of references follows the text.

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, but does not include estimates of any systematic biases that may be in the data. The chances are about 68 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 of 100 that the difference would be less than twice the standard error, and about 99 of 100 that it would be less than 2 1/2 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. In 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 (NCHS, 1966, 1969). Approximate relative standard errors for aggregate estimates are presented in figures I and II. 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 follow.

Estimates of aggregates

Figure I presents approximate relative standard errors for aggregate estimates of office visits, and figure II presents approximate relative standard errors for aggregate estimates of drug mentions. In each figure, curve *A* represents the relative standard errors appropriate for estimates based on all physicians, and curves *B–D* represent relative standard errors appropriate for estimates based on the individual physician group indicated.

Alternatively, relative standard errors (RSE's) for aggregate estimates may be calculated using the following general formula, where x is the aggregate of interest in thousands, and A and B are the appropriate coefficients from table II.

$$\mathrm{RSE}(x) = \sqrt{A + \frac{B}{x}} \times 100.0$$

Estimates of percents

Approximate relative standard errors (in percent) for estimates of percents may be calculated from figures I and II as follows. From the appropriate curve, obtain the relative standard error of the numerator and denominator of the percent.

NOTE: A list of references follows the text.

Table II. Coefficients appropriate for determining relative standard errors by type of estimate and physician groups: National Ambulatory Medical Care Survey, 1985

Type of estimate and physician group	Coefficient A	Coefficient B
Visits		
All physician groups	0.001493373	28.258848
Ophthalmology, orthopedic surgery, urological surgery	0.003343029	10.785509
Cardiovascular disease, dermatology, general and family practice, internal medicine, neurology, obstetrics and gynecology, Doctors of Osteopathy, otorhinolaryngology, psychiatry, and all other specialties	0.005780329	29.680397
General surgery and pediatrics	0.010470160	40.657939
Drug mentions		
All physician groups	0.001884167	46.903471
Ophthalmology and urological surgery	0.006309853	9.381846
Dermatology, general and family practice, neurology, obstetrics and gynecology, Doctors of Osteopathy, orthopedic surgery, and otorhinolaryngology	0.006777396	37.687413
Cardiovascular disease, general surgery, internal medicine, pediatrics, psychiatry, and all other specialties	0.011745980	60.088822

Square each of the RSE values, subtract the resulting value for the denominator from the resulting value for the numerator, and extract the square root. This approximation is valid if the RSE of the denominator is less than 0.05 or if the RSE's of the numerator and denominator are both less than 0.10.

Alternatively, RSE's for percents may be calculated using the following general formula, where p is the percent of interest and x is the denominator of the percent in thousands, using the appropriate coefficient from table II.

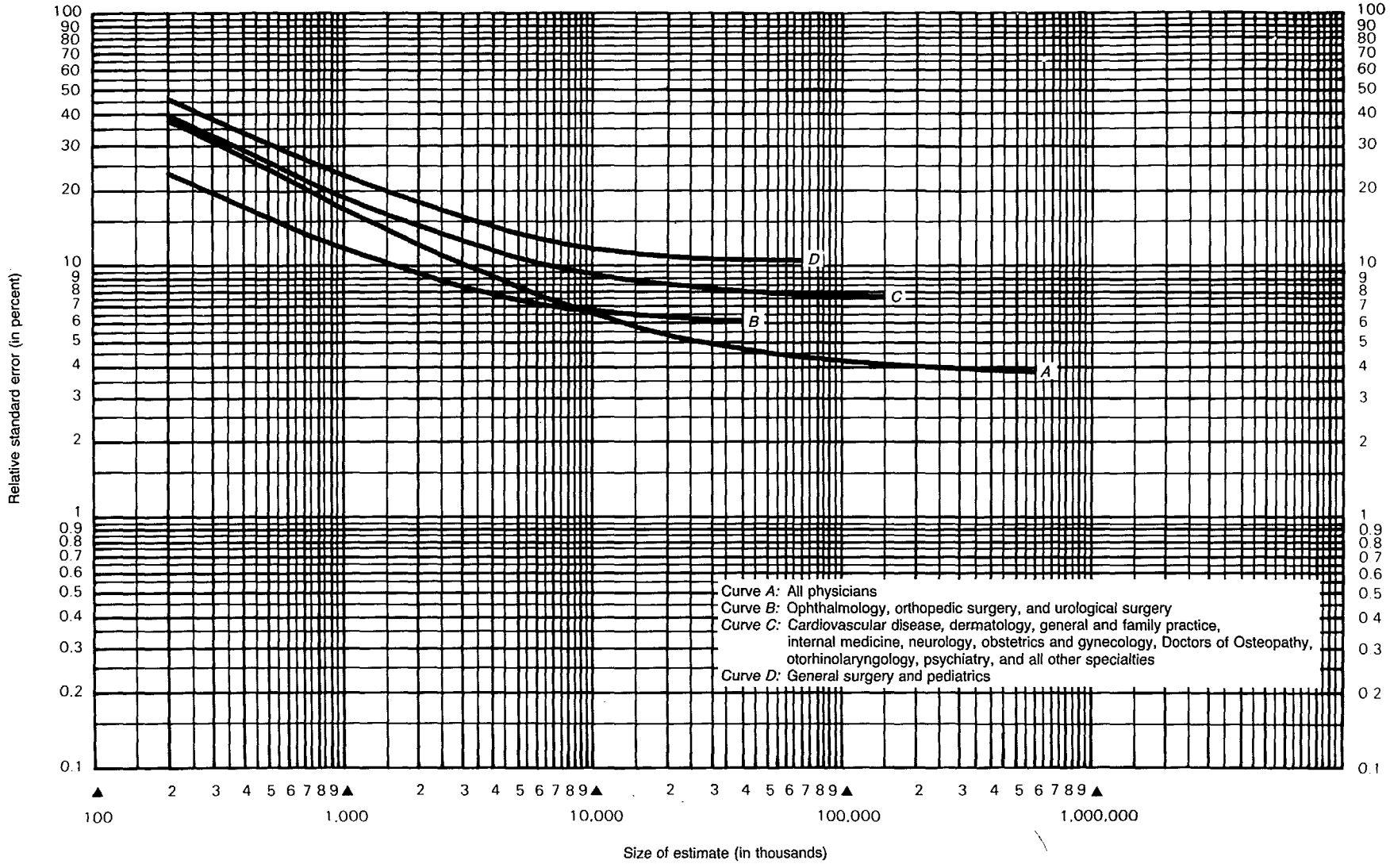
$$\mathrm{RSE}(p) = \sqrt{\frac{B \bullet (1 - p)}{p \bullet x}} \times 100.0$$

Estimates of rates where numerator is not a subclass of denominator

Approximate relative standard errors for rates in which the denominator is the total United States 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 figures I or II.

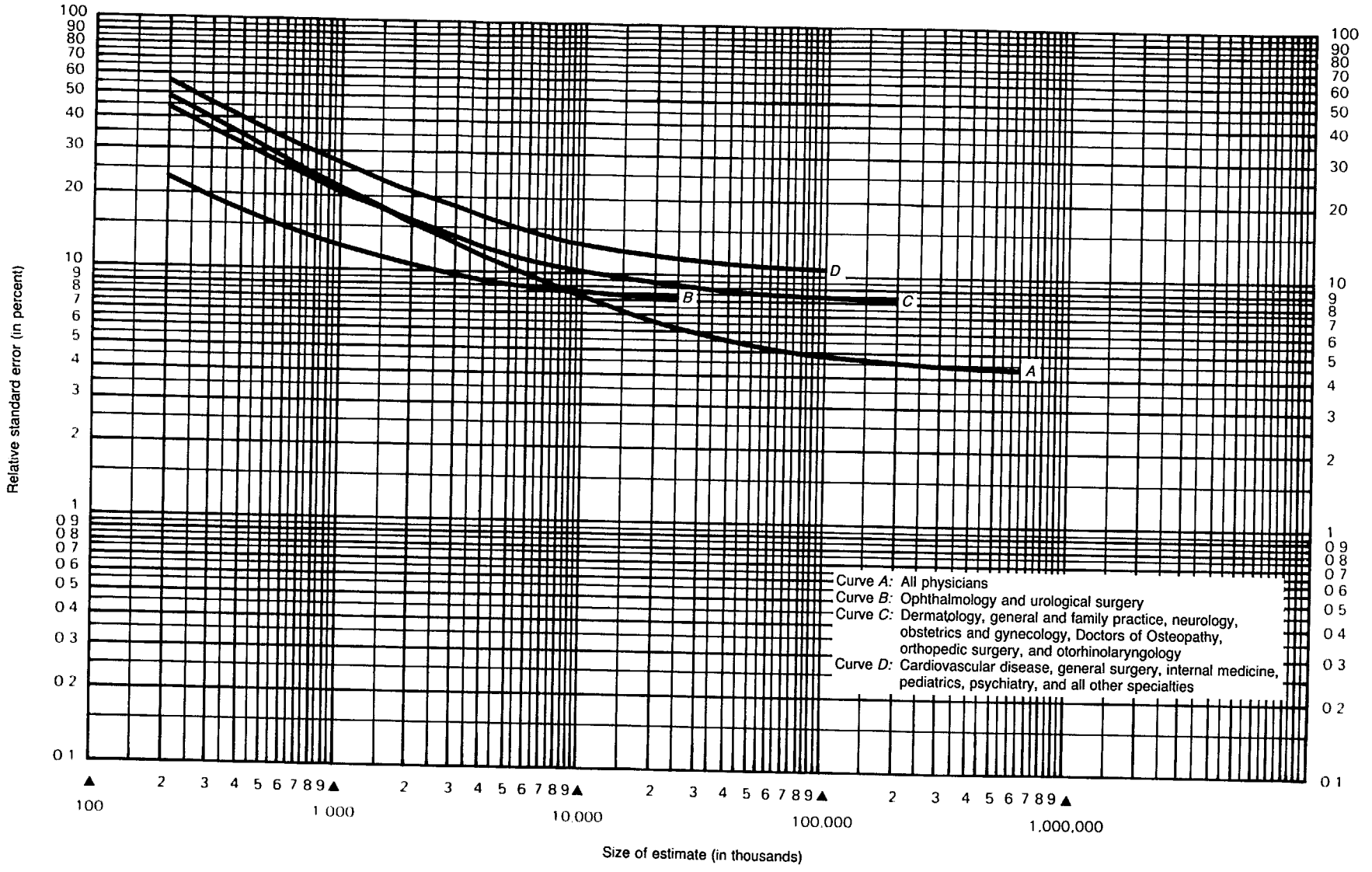
Estimates of differences between two statistics

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 squares of each standard error considered separately. This formula represents the standard error quite accurately for the difference between separate and uncorrelated characteristics, although it is only a rough approximation in most other cases.



EXAMPLE OF USE OF CHART: An estimate of 10 million office visits to general and family practice physicians (read on scale at bottom of chart) has a relative standard error of 9.4 percent (read from curve *C* on scale at left of chart) or a standard error of 940,000 office visits (9.4 percent of 10 million office visits).

Figure I. Approximate relative standard errors for estimated numbers of office visits based on all physicians (*A*) and on individual physician groups (*B–D*): National Ambulatory Medical Care Survey, 1985



EXAMPLE OF USE OF CHART: An estimate of 20 million drug mentions to general surgeons (read on scale at bottom of chart) has a relative standard error of 12.1 percent (read from curve *D* on scale at left of chart) or a standard error of 2,420,000 drug mentions (12.1 percent of 20 million drug mentions)

Figure II. Approximate relative standard errors for estimated numbers of drug mentions based on all physicians (*A*) and on individual physician groups (*B–D*): National Ambulatory Medical Care Survey, 1985

Tests of significance

In this report, the determination of statistical inference is based on the *t*-test. The Bonferroni inequality was used to establish the critical value for statistically significant differences (0.05 level of significance) (Miller, 1966). Terms relating to differences, such as "higher," "less," and so forth, 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 and rate computation

The population figures used in computing annual visit rates are presented in table III. The figures are based on the July 1, 1985, estimates of the civilian noninstitutionalized population of the United States. Because NAMCS includes data for only the conterminous United States, the original population estimates were modified to exclude Alaska and Hawaii. For this reason, the population estimates should not be considered official and are presented here solely to provide denominators for rate computations

Rounding of numbers

Estimates presented in this report are rounded to the nearest thousand. For this reason detailed figures within tables do not always add to totals. Rates and percents are calculated on the basis of the original, unrounded figures and may not agree precisely with percents calculated from rounded data.

NOTE: A list of references follows the text.

Systematic bias

No formal attempt was undertaken to determine or measure systematic bias in the 1985 NAMCS data. It should be noted, however, that there are several factors affecting the data which indicate that these data underrepresent the total number of office visits. Some of these factors are briefly discussed below:

- Physicians who participated in NAMCS did a thorough and conscientious job in keeping the Patient Log; however, a postsurvey evaluation study conducted among a random sample of participating physicians indicates that a small number of patient visits may have been accidentally omitted from the Patient Log; although this number is quite small, such omissions would result in an undercoverage of office visits. The same postsurvey study indicates that the inclusion of patient visits which did not actually occur was infrequent and would have a negligible effect on survey estimates.
- As previously stated, the physician universe for the 1985 NAMCS included all non-Federal, office-based, patient-care physicians on the AMA and AOA masterfiles. The NAMCS was designed to provide statistically unbiased estimates of office visits to this designated population. Not included in the universe were physicians who were classified as federally employed or hospital-based, or who were principally engaged in research, teaching, adminis-

Table III. Population used in computing annual visit rates shown in this report by selected demographic characteristics: July 1, 1985

Characteristic	All ages	Less than 15 years	15–24 years	25–34 years	35–44 years	45–54 years	55–64 years	65 years and over
Race				Number in thousands				
All races	232,175	51,373	38,141	40,337	31,141	22,243	22,006	26,934
Male	112,112	26,283	18,836	19,702	15,142	10,764	10,326	11,060
Female	120,062	25,090	19,305	20,635	15,999	11,479	11,680	15,874
White	198,020	41,906	31,772	34,244	26,889	19,258	19,602	24,349
Male	96,191	21,570	15,781	16,954	13,237	9,394	9,247	10,009
Female	101,829	20,336	15,991	17,290	13,652	9,864	10,355	14,341
Black	27,959	7,876	5,322	4,838	3,266	2,357	2,049	2,250
Male	12,992	3,984	2,521	2,165	1,451	1,053	919	898
Female	14,966	3,892	2,801	2,673	1,815	1,304	1,130	1,352
Other races	6,196	1,591	1,047	1,255	986	627	356	334
Male	2,929	729	534	584	454	316	161	153
Female	3,267	862	513	672	532	311	195	181
Region								
Northeast	49,756	---	---	---	---	---	---	---
Midwest	58,601	---	---	---	---	---	---	---
South	80,129	---	---	---	---	---	---	---
West	43,688	---	---	---	---	---	---	---
Metropolitan status of area								
Metropolitan	178,349	---	---	---	---	---	---	---
Nonmetropolitan	53,825	---	---	---	---	---	---	---

tration, or other nonpatient care activity. Consequently, ambulatory patient visits to these physicians in an office setting would not be included in NAMCS estimates. In an attempt to measure the number of office visits to physicians not in the NAMCS universe, a NAMCS Complement Survey was conducted in 1980. This study involved a sample of approximately 2,000 physicians selected from among the 230,000 physicians in the AMA and AOA masterfiles who were not eligible (in scope) for the 1980 NAMCS. Details of the Complement Survey methodology and results are presented in Series 13, No. 77 (NCHS, 1984). Results indicate that about 17 percent of the Complement Survey physicians saw some ambulatory patients in an office setting and that an estimated 69 million office visits were made to these physicians in 1980.

NOTE: A list of references follows the text.

Appendix II
Definitions of terms

Terms relating to the survey

Office—Premises identified by physicians as locations for their ambulatory practices, customarily including consultation, examination, or treatment spaces the patients associate with a particular physician.

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

Physician—A duly licensed doctor of medicine or doctor of osteopathy. For purposes of this NAMCS, physicians are classified as in scope or out of scope as follows:

- *In scope*—Physicians currently in practice who spend some time caring for ambulatory patients in office locations except as excluded below.
- *Out of scope*
  —Physicians in the specialties and subspecialties of anesthesiology, pathology, and radiology.
  —Physicians who are federally employed, including those physicians who work for the Veterans' Administration or who are in military service.
  —Physicians who treat patients only in institutional settings, such as nursing homes and hospitals.
  —Physicians employed full time in industry or by institutions and having no private practice, for example, physicians who work for the Ford Motor Company.
  —Physicians who spend no time seeing ambulatory patients, for example, physicians who only teach, are engaged in research, or are retired.

Patient—A person under a physician's care for health reasons. For purposes of this NAMCS, patients are defined as in scope or out of scope as follows:

- *In scope*—A patient seen by an in-scope physician or a staff member in the physician's office, except as excluded below.
- *Out of scope*
  —Patients seen by the physician in a hospital, nursing home, or other extended care institution, or in the patient's home. If the physician has a private office located in a hospital that meets the definition of "office," the ambulatory patients seen there are considered in scope.
  —Patients seen by the physician in an institution, including outpatient clinics of hospitals, for whom the institution has primary responsibility over time.
  —Patients who contact and receive advice from the physician via telephone.
  —Patients who come to the office only to leave a specimen, to pick up insurance forms, or to pay a bill.
  —Patients who come to the office to pick up medications previously prescribed by the physician.

Visit—A direct, personal exchange between an ambulatory patient and a physician or a staff member working under the physician's supervision for the purpose of seeking care and rendering personal health services.

Drug mention—The physician's entry of a pharmaceutical agent prescribed or provided—by any route of administration—for prevention, diagnosis, or treatment. Generic names as well as brand name drugs are included, as are nonprescription as well as prescription drugs. Along with all new drugs, the physician also records continued medications, if the patient was specifically instructed during the visit to continue the medication.

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 physician masterfiles maintained by the American Medical Association or the American Osteopathic Association.

Region of practice location—One of the four geographic regions, excluding Alaska and Hawaii, that correspond to those used by the U.S. Bureau of the Census:

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

Metropolitan status of practice location—A physician's practice is classified by its location in a metropolitan or nonmetropolitan area. Metropolitan areas are metropolitan statistical areas (MSA's) as defined by the U.S. Office of Management and Budget. The definition of an individual MSA involves two considerations: first, a city or cities of specified population that constitute the central city and identify the county in which it is located as the central county; second, economic and social relationships with "contiguous" counties that are metro-

politan in character, so that the periphery of the specific metropolitan area may be determined. MSA's may cross State lines. In New England, MSA's consist of cities and townships rather than counties.

Terms relating to the Patient Record

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

Race—White, Black, Asian or Pacific Islander, or American Indian or Alaskan Native. Physicians were instructed to mark the category they judged to be the most appropriate for each patient based on observation or prior knowledge. The following definitions were provided to the physician:

- *White*—A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.
- *Black*—A person having origins in any of the black racial groups of Africa.
- *Asian or Pacific Islander*—A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands, including, for example, China, India, Japan, Korea, the Philippine Islands, and Samoa.
- *American Indian or Alaskan Native*—A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition.

Ethnicity—Category judged by the physician to be the most appropriate. The following definitions were provided:

- *Hispanic origin*—A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.
- *Not Hispanic*—A person not of Hispanic origin.

Expected source(s) of payment—The source(s) that to the best of the physician's knowledge describes how charges incurred this visit will be paid:

- *Self pay*—Charges billed directly to the patient which will not be reimbursed by a third party.
- *Medicare*—Charges paid in part or in full by a Medicare plan, including payments made directly to the physician, as well as payments reimbursed to the patient.
- *Medicaid*—Charges paid in part or in full by a Medicaid plan, including payments made directly to the physician, as well as payments reimbursed to the patient.
- *Blue Cross/Blue Shield*—Charges paid by Blue Cross or Blue Shield either directly to the physician or reimbursed to the patient.
- *Other commercial insurance*—Charges paid by a private insurance company, including payments made directly to the physician, as well as payments reimbursed to the patient.
- *HMO/prepaid plan*—Charges included under a health maintenance organization (HMO) plan or other prepayment plan, including independent practice associations (IPA's) and preferred provider organizations (PPO's).
- *No charge*—Visits for which no fee is charged (not including visits paid for as part of a total care package; for example, pregnancy visits for which a flat fee was charged).
- *Other*—All other sources of payment not in the preceding categories; for example, workman's compensation programs and Civilian Health and Medical Programs of Uniformed Services (CHAMPUS).
- *Unknown*—This category indicates that none of the previous source of payment categories was checked.

Was patient referred for this visit by another physician?—Referrals are any visits that are made at 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 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. "Most important" refers to that problem which in the physician's judgment was most responsible for the patient's visit.

Glucose tests this visit—Any test(s) ordered, provided, or specimen taken to measure the patient's glucose level, including test for diagnosis, screening, or patient evaluation.

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

- *Breast exam*—Examination of breast.
- *Pelvic exam*—Self-explanatory.
- *Rectal exam*—Any manual or proctoscopic examination of the rectum.
- *Visual acuity test*—Self-explanatory.
- *Urinalysis*—Any physical, chemical, or microscopic examination of urine.
- *Hematology*—Any laboratory examination of blood, including counts, clotting studies, and tests.
- *Blood chemistry*—Chemical analysis or test of blood.
- *Pap test*—Papanicolaou test.
- *Other lab test*—Any other laboratory test, except glucose test.
- *Blood pressure check*—Self-explanatory.
- *EKG*—Electrocardiogram.
- *Chest x ray*—Single or multiple x ray examination for diagnostic or screening purposes.
- *Other radiology*—Any single or multiple x ray examination for diagnostic or screening purposes, excluding chest x rays, including computed tomography and any diagnostic nuclear medicine imaging procedure.
- *Ultrasound*—Any single or multiple ultrasound imaging examination.
- *Other service*—Any other diagnostic services not included or listed in the preceding categories.

Physician's diagnosis—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. The term "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 diagnoses—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 patient's reason for visit.

Diagnostic groups—Principal diagnoses and secondary diagnoses in visits to psychiatrists were each classified in the following groups:

All psychiatric diagnoses—For 1975–76 data, includes ICDA codes 290–309, Y00.1, and Y03.4 (that is, all ICDA psychiatric diagnoses listed below). For 1980–81 and 1985 data, includes ICD–9–CM codes 290–316, V67.3, V70.1, V70.2, V79.0, and V79.1 (that is, all ICD–9–CM psychiatric diagnoses listed below).

Psychoses, including affective psychoses—For 1975–76 data, includes ICDA codes 290–295, 296.1–296.3, 296.8, 296.9, and 297–299 (that is, senile and presenile dementia; alcoholic psychosis; psychosis associated with intracranial infection; psychosis associated with other cerebral condition; psychosis associated with other physical conditions; schizophrenia; manic-depression psychosis, manic type; manic-depressive psychosis, depressed type; manic-depressive psychosis, circular type; other affective psychosis; unspecified affective psychosis; paranoid states; other psychoses; and unspecified psychosis). For 1980–81 and 1985 data, includes ICD–9–CM codes 290–295, 296.0, 296.1, 296.4–296.9, and 297–299 (that is, senile and presenile organic psychotic conditions; alcoholic psychoses; drug psychoses; transient organic psychotic conditions; other chronic organic psychotic conditions; schizophrenic conditions; manic disorder, single episode; manic disorder, recurrent episode; bipolar affective disorder, manic; bipolar affective disorder, depressed; bipolar affective disorder, mixed; bipolar affective disorder, unspecified; manic-depressive psychosis, other and unspecified; other and unspecified affective psychoses; paranoid states; other nonorganic psychoses; and psychoses with origin specific to childhood).

Depressive disorders, including major depressive disorder—For 1975–76 data, includes ICDA codes 296.0 and 300.4 (that is, involutional melancholia and depressive neurosis). For 1980–81 and 1985 data, includes ICD–9–CM codes 296.2, 296.3, 300.4, and 311 (that is, major depressive disorder, single episode; major depressive disorder, recurrent episode; neurotic depression; and depressive disorder, not elsewhere classified).

Neurotic disorders, excluding depression—For 1975 data, includes ICDA codes 300.0–300.3 and 300.5–300.9 (that is, anxiety neurosis; hysterical neurosis; phobic neurosis; obsessive-compulsive neurosis; neurasthenia; depersonalization syndrome; hypochondriacal neurosis; other neurosis; and unspecified neurosis). For 1980–81 and 1985 data, includes ICD–9–CM codes 300.0–300.3, and 300.5–300.9 (that is, anxiety states; hysteria; phobic disorders; obsessive-compulsive disorders; neurasthenia; depersonalization syndrome; hypochondriasis; other neurotic disorders; and unspecified neurotic disorder).

Personality disorders—For 1975–76 data, includes ICDA code 301 (that is, personality disorders). For 1980–81 data, includes ICD–9–CM code 301 (that is, personality disorders).

Other psychiatric disorders and psychiatric examinations—For 1975–76 data, includes codes 302–309, Y00.1, and Y03.4 (that is sexual deviation; alcoholism; drug dependence; physical disorders of presumably psychogenic origin; special symptoms, not elsewhere classified; transient situational disturbances; behavior disorders of childhood; mental disorders not specified as psychotic associated with physical conditions; general psychiatric examination; and follow-up psychiatric examination not needing further psychiatric care). For 1980–81 and 1985 data, includes ICD–9–CM codes 302–310, 312–316, V67.3, V70.1, V70.2, V79.0, and V79.1 (that is, sexual deviations and disorders; alcohol dependence syndrome; drug dependence; nondependent abuse of drugs; physiological malfunction arising from mental factors; special symptoms or syndromes, not elsewhere classified; acute reaction to stress; adjustment reaction; specific nonpsychotic mental disorders due to organic brain damage; disturbance of conduct, not elsewhere classified; disturbance of emotions specific to childhood and adolescence; hyperkinetic syndrome of childhood; specific delays in development; psychic factors associated with diseases classified elsewhere; follow-up examination following psychotherapy and other treatment for mental disorder; general psychiatric examination, requested by the authority; general psychiatric examination, other and unspecified; special screening for depression; and special screening for alcoholism).

All other diagnoses—For 1975–76 data, includes all residual ICDA codes and diagnoses. For 1980–81 and 1985 data, includes all residual ICD–9–CM codes and diagnoses.

Have you seen patient before?—"Seen before" means provided care for at any time in the past. Item 12b refers to the patient's current episode of illness.

Nonmedication therapy—Physicians were instructed to check any of the following services that were ordered or provided during the current visit:

- *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, and manipulative therapy.
- *Ambulatory surgery*—Any surgical procedure performed in the office or ordered to be performed elsewhere on an outpatient basis, including suture of wounds, reduction of fractures, application or removal of casts, incision and draining of abscesses, application of supportive materials for fractures and sprains, irrigations, aspirations, dilations, and excisions.

- *Radiation therapy*—Therapeutic use of x rays and other high energy modalities, radium, cobalt, and brachytherapy for surface, intracavity, or interstitial applications, including nuclear medicine therapeutic procedures.
- *Psychotherapy*—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.
- *Family planning*—Services, counseling, or advice that might enable patients to determine the number and spacing of their children, including both contraception and infertility services.
- *Diet counseling*—Instruction, recommendations, or advice regarding diet or dietary habits.
- *Other counseling*—Instructions and recommendations regarding any health problem, including advice or counsel about a change of habit or behavior. This also includes instruction on the proper use of drugs and devices and their possible adverse effects.
- *Corrective lenses*—Provision, ordering, or prescription for glasses or contact lenses.
- *Other*—Treatments or nonmedication therapies ordered or provided that are not listed or included in the preceding categories.

Medication therapy this visit—The physician was instructed to list, using brand or generic names, all medications including drugs, vitamins, hormones, ointments, and suppositories ordered, injected, administered, or provided this visit including prescription and nonprescription drugs, vaccinations, immunizations, and desensitization agents. Also included are drugs and medications ordered or provided prior to the visit that the physician instructed or expected the patient to continue taking.

- *New medication?*—Indicates whether the medication was newly prescribed for the patient at the time of the visit.
- *For Dx in item 11a?*—Indicates whether the medication was ordered or provided for the principal diagnosis in item 11a of the Patient Record.

Disposition this visit—Eight categories are provided to describe the physician's disposition of the case. The physician was instructed to check as many of the categories as apply:

- *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 either on a particular day to report on progress, or at any time if the need should arise.
- *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 instructed to consult again with the referring physician.
- *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 hospital admission.
- *Other*—Any other disposition of the case not included in the preceding categories.

Duration of this visit—Time the physician spent with the patient, not including time the patient spent waiting to see the physician, time the patient spent receiving care from someone other than the physician without the presence of the physician, and time the physician spent in reviewing such things as records and test results. If the patient was provided care by a member of the physician's staff but did not see the physician during the visit, the duration of visit was recorded as 0 minutes.

Appendix III. Patient Log and Patient Record form

D 779329

PATIENT LOG

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

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

Record items 1-16 for this patient

CONTINUE LISTING PATIENTS ON NEXT PAGE

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.

Department of Health and Human Services
Public Health Service
National Center for Health Statistics

D 779329

OMB No. 0937-0141
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456-232

PATIENT RECORD
NATIONAL AMBULATORY MEDICAL CARE SURVEY

1. DATE OF VISIT — Month / Day / Year

2. DATE OF BIRTH — Month / Day / Year

3. SEX
1 ☐ FEMALE
2 ☐ MALE

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

5. ETHNICITY
1 ☐ HISPANIC ORIGIN
2 ☐ NOT HISPANIC

6. EXPECTED SOURCE(S) OF PAYMENT *[Check all that apply]*
1 ☐ SELF-PAY
2 ☐ MEDICARE
3 ☐ MEDICAID
4 ☐ BLUE CROSS/ BLUE SHIELD
5 ☐ OTHER COMMERCIAL INSURANCE
6 ☐ HMO/PRE-PAID PLAN
7 ☐ NO CHARGE
8 ☐ OTHER *[Specify]*

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

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

9. GLUCOSE TESTS THIS VISIT *[Check all ordered or provided]*
1 ☐ NONE
2 ☐ BLOOD
3 ☐ URINE
4 ☐ ORAL

10. OTHER DIAGNOSTIC SERVICES THIS VISIT *[Check all ordered or provided]*
1 ☐ NONE
2 ☐ BREAST EXAM
3 ☐ PELVIC EXAM
4 ☐ RECTAL EXAM
5 ☐ VISUAL ACUITY
6 ☐ URINALYSIS
7 ☐ HEMATOLOGY
8 ☐ BLOOD CHEMISTRY
9 ☐ PAP TEST
10 ☐ OTHER LAB TEST
11 ☐ BLOOD PRESSURE CHECK
12 ☐ EKG
13 ☐ CHEST X-RAY
14 ☐ OTHER RADIOLOGY
15 ☐ ULTRASOUND
16 ☐ OTHER SERVICE *[Specify]*

11. PHYSICIAN'S DIAGNOSES
a. PRINCIPAL DIAGNOSIS/PROBLEM ASSOCIATED WITH ITEM 8a.
b. OTHER SIGNIFICANT CURRENT DIAGNOSES

12. HAVE YOU SEEN PATIENT BEFORE?
1 ☐ YES 2 ☐ NO
IF YES, FOR THE CONDITION IN ITEM 11a?
1 ☐ YES 2 ☐ NO

13. NON-MEDICATION THERAPY *[Check all services ordered or provided this visit]*
1 ☐ NONE
2 ☐ PHYSIOTHERAPY
3 ☐ AMBULATORY SURGERY
4 ☐ RADIATION THERAPY
5 ☐ PSYCHOTHERAPY
6 ☐ FAMILY PLANNING
7 ☐ DIET COUNSELING
8 ☐ OTHER COUNSELING
9 ☐ CORRECTIVE LENSES
10 ☐ OTHER *[Specify]*

14. MEDICATION THERAPY *[Record all new or continued medications ordered or provided at this visit. Use the same brand name or generic name entered on any Rx or office medical record.]*
IF NONE, CHECK HERE ☐

	a. NEW MEDICATION? YES	a. NEW MEDICATION? NO	b. FOR DX IN ITEM 11a? YES	b. FOR DX IN ITEM 11a? NO
1	1 ☐	2 ☐	1 ☐	2 ☐
2	1 ☐	2 ☐	1 ☐	2 ☐
3	1 ☐	2 ☐	1 ☐	2 ☐
4	1 ☐	2 ☐	1 ☐	2 ☐
5	1 ☐	2 ☐	1 ☐	2 ☐

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

16. DURATION OF THIS VISIT *[Time actually spent with physician]*
_____ Minutes

*U. S. Government Printing Office 1988: 201-855/80002

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