

CONDUCT OF A STUDY  
OF  
MEDICAL CARE

AMERICAN MEDICAL  
ASSOCIATION



SUGGESTIONS  
FOR  
COMMITTEES...

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BUREAU OF MEDICAL ECONOMICS  
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## Suggestions on Conduct of a Study of Medical Care

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*Prepared by the Bureau of Medical Economics*

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The American Medical Association, in accordance with resolutions adopted by the Board of Trustees, is urging state and county medical societies to make a study of the prevailing need for medical and preventive medical services where such may be insufficient or unavailable. Many factors affect the demand and supply of medical services. In some communities, owing to conditions which may be peculiar to these areas, the demand for medical services may be much greater than in other communities having entirely different characteristics. Likewise, there are in different communities variations in the number and nature of the services and facilities to meet the dissimilar and fluctuating medical needs.

This study is intended to encourage state and county medical societies to inventory the medical needs or demands and the medical services or supply in their respective jurisdictions. Such a stock taking, so to speak, should enable medical societies to determine whether there is a satisfactory balance in their communities. It is essential to know the nature and number of deficiencies which exist in those communities where medical services and facilities may be insufficient or unavailable. It is of no less importance to have a knowledge of those counties or areas in which the demand for medical care is being satisfactorily met with existing services, agencies and facilities.

Regardless of whether the study in a county reveals an insufficiency or unavailability of

medical and preventive medical services or shows sufficient and easily available services, a complete report should be made. One copy of this report should be retained by the county medical society, one copy should be sent to the state medical society of which the county is a component part, and one copy should be forwarded to the Bureau of Medical Economics, American Medical Association. State and county medical societies are to assume responsibility for the actual conduct of the study, which is to be undertaken with the cooperation of all local agencies concerned with medical services. The Bureau of Medical Economics is prepared to assist medical societies with those details of the study on which the suggestions or instructions may be incomplete.

This study must not be considered just another effort to compile statistical tables. The information to be collected on the forms provided is to enable county medical societies more easily and accurately to judge the completeness or insufficiency of the local services and facilities for the care of the indigent sick. If the study should stop when the various individuals, agencies and organizations fill out the forms with the desired information, but little will have been accomplished. It will be necessary, as will be emphasized repeatedly, that the first essential is to know the demands for medical care and the means at hand to meet these demands. Such a knowledge can come only from a very careful study of each local community. If the results of the study indicate that there is need for a revision of present methods or the initiation of supplementary facilities, the accumulated information can be used as the basis for the formulation of preferable procedures.

The wide geographic, population, industrial, social and educational differences within the more than two thousand counties in which

medical societies are now organized make it inconceivable that the same program will fit all or even a majority of these counties. The number and character of the agencies concerned with medical services for the indigent will vary greatly. In some counties these agencies will be limited almost entirely to the elected or appointed officials of the villages, cities, townships and counties, but in most cases there will be some additional voluntary organizations whose assistance will be valuable. In other counties the number of voluntary philanthropic, welfare, relief, fraternal, civic and other organizations concerned directly or indirectly with medical relief will be large. Where county medical societies have arrangements for coordination and combined effort with any of these organizations, it will be necessary, for the purpose of this study, simply to develop and expand these arrangements for the interchange of factual data and opinions concerning the needs for the methods to improve the distribution of medical services for the indigent.

The study will be incomplete if confined solely to an examination of the insufficiency of medical facilities and services for the indigent. *There is a further necessity to determine the number of persons or families who for any reason do not, or are unable to, obtain needed medical care for remediable conditions.* This requires inquiries as to the efforts that have been made to obtain medical services and the extent to which failure to receive such services is due to a lack of desire.

#### RESPONSIBILITY FOR CONDUCT OF STUDY

The responsibility for the actual conduct of the study falls chiefly on county medical societies, but state medical societies have definite functions in this project. The supply side of medical services has been separated according

to the geographic spread of certain medical services and facilities. Those services and facilities which are provided by state agencies for the needs of the entire state are to be studied by the state medical society. Those services and facilities which are ordinarily limited to county areas are to be studied by county medical societies.

In many counties there are state institutions for the care of patients with mental and nervous diseases, tuberculosis and epilepsy and for the care of the feeble-minded, criminals and others. Such institutions are maintained for the entire state, and the counties in which these institutions are located use them only in proportion with the remainder of the state. The study of such institutional facilities and services should be made by or under the direction of the state medical society. There are also other state agencies concerned with state-wide health and medical services such as the state departments of health, education and welfare, state schools for the deaf and blind, the state registrars of vital statistics in states in which vital statistics are not a part of the state health department, university and charity hospitals which accept for care sick persons from all sections of the state, state agencies which have an interest in or are charged with the provision of or arrangement for medical services and facilities to the aged, unemployed crippled and handicapped.

State medical societies are requested to assume this part of the study, since it is believed that they are in a position to secure a more accurate record of state-wide medical and health facilities than would be possible for county medical societies.

#### ORGANIZATION FOR THE STUDY

The study of medical care contemplated by the resolutions of the Board of Trustees falls logically into two phases. The first phase is

the collection of information concerning the prevailing medical and preventive medical needs; the second phase is the study of these needs and recommendations of preferable procedures for meeting these needs. This is consistent with the processes of diagnosis and treatment characteristic of all good medical practice.

The collection of information and the preparation of recommendations should be delegated to a special committee or referred to an appropriate existing committee in both state and county medical societies. It will be the function of these committees to determine the most satisfactory method by which the desired information can be obtained, to make a list of the individuals, agencies or organizations from which information is to be requested, and to determine the appropriate manner of approach to secure the assistance of these persons and agencies.

It should not be necessary for committee members themselves to fill in the answers to all the questions asked on the information forms. It might save time and energy to distribute among the committee members forms pertaining to different types of individuals or organizations to be visited; e. g., one member might be asked to secure the cooperation of the physicians and dentists, another the hospitals and nurses, another the health department and schools, another the county commissioners, welfare and relief agencies, while still another might be asked to get all the information and material needed from industrial, fraternal, mutual benefit, group hospitalization, community health associations and similar groups. Thus it will be seen that it should not be necessary, unless deemed desirable, for the entire committee to visit all individuals and agencies.

Whenever possible, the selection of committee members (if a new, special committee is appointed) and the distribution of the work should be made with consideration of those who may have some helpful knowledge of the work of an agency or organization, or a personal acquaintance with the person in charge of the work concerning which information is desired. Such personal familiarity with individuals or agencies should facilitate the approach for statistical and other information for which reference to records will be needed.

#### ACCURACY

The greatest possible statistical accuracy must be emphasized continuously throughout the study. The records of many agencies and organizations should provide the answers to a considerable number of the questions for which statistics are required. Some individuals or agencies may have no records from which to provide the answers to questions which require statistical information. In these instances an estimate will need to take the place of statistical accuracy. Whenever estimates are recorded, it is of the greatest importance that *such figures be stated as estimates*. Committee members should suggest to all who cannot furnish actual figures that their estimates should not be overgenerous. A too liberal estimate in a single instance or on a single item might not distort the other information pertaining to one small community, but the consolidation of a large number of overgenerous estimates would certainly give a marked distortion for a state and an unexplainable exaggeration if carried in equal proportion throughout the United States. Estimates must always be recorded as estimates.

Many of the questions call for answers that do not involve figures or statistics. It is very important that these replies be candid and complete. Honesty and thoroughness should char-



acterize every detail of the study. It would be unfortunate if some phase of either the need or the supply of medical care should be misrepresented. This study is intended to be a self examination of those individuals and agencies on which the public must depend for its medical care. Statements have been circulated by certain individuals and interests hostile toward the medical profession to create the general belief that medical services and facilities are grossly insufficient or intentionally difficult to obtain. Within all possibilities of attainment, this study should strive to reveal the true situation in every county examined.

#### COMPLETENESS

All possible information should be obtained from members of medical societies as to the amount of free care given. They should be asked to express an opinion as to a better distribution of the burden of gratuitous service among all the members of the medical society.

Hospitals should be asked not only as to the amount of free and part-pay facilities and services available and actually supplied but also as to details concerning the patients whom the hospital could not accommodate and the reasons why care could not be given.

Representatives of public and private organizations, visiting nurses and every one else concerned with medical care should be asked to explain the difficulties encountered in securing needed care for any person. They should be urged to be specific and to explain just why they think these persons needed medical care, whether the illness was diagnosed and whether medical care was desired. It is important to know just what efforts were made by the patient or any other persons or agencies to obtain needed medical services. The reasons for failure to secure medical care should be given

in detail, so that complete and dependable evidence may be assembled concerning each such situation.

The forms which are provided for the use of state and county medical societies have been prepared with a full realization that many other questions could have been added on which valuable information might be secured in the larger and more completely organized urban districts. The forms have been kept as simple and short as seemed consistent with a fair and uniform study of the problem. County medical societies that desire additional information, not asked for on the forms, are at liberty to attach to the forms such other questions as they believe may be helpful to them in securing a complete understanding of the problem of medical demand and supply in their counties.

#### AVOID ERRORS

Mail or personal inquiries to individuals or families about illness and quantity and expense of medical care offer many opportunities for error. Judgments of the character and extent of illness based on lay diagnoses of illness and on lay estimates of need for medical care are unreliable. Even medically diagnosed illness and medically determined need for treatment do not indicate insufficiency if there is no desire on the part of the patient for such care. The ratio of the number receiving medical care to the number reported ill means little unless the person who is ill is known to need and desire medical care.

Comparative expenditures for medical care by income classes are often wholly misleading as a measure of treatment received. The sliding scale of fees charged by physicians, the care given free or at nominal cost in private practice or in hospitals, clinics or outpatient departments and the large percentage of the nominal

charges never collected indicate that neither the amount charged nor even the amount actually paid is a dependable measure of the quantity or quality of the medical services received in the low-income class.

Possible duplications and deficiencies in public and private facilities for medical care should be located and the methods of distributing medical services should be carefully examined to determine whether better organization would produce greater economy and more effective distribution.

Consideration should also be given to the service received through general supervision of social conditions by health departments, as well as certain special services given by such departments in schools and through other agencies or institutions. The major portion of these services is received by persons in low-income groups—if for no other reason than that they constitute more than half the population.

#### PROCEDURE

The forms on which information is to be recorded have been prepared according to a functional grouping of the individuals and agencies or organizations which provide or arrange for medical care. It is contemplated that the individuals or agencies whose activities are covered (for the purpose of this study) by one particular form shall be requested to fill in the answers to the questions. Sufficient time should be given each individual, agency or organization to prepare the information desired with the greatest possible accuracy and completeness.

It is desirable that the committee member either return for the completed form at a designated time or that a date be fixed, convenient to the person who must furnish the information, when the form may be expected by mail at the

office of the secretary of the county medical society.

Each form used by either state or county medical societies on which to secure information concerning medical care should be filled in at the top of the form with the name of the medical society and name and address of the secretary before being left with the persons or agencies which are to be asked to provide and record the information.

Many state and county medical societies are already engaged in programs similar to the one suggested by the resolutions and they may be able to adjust their programs to the one proposed with little change in organization and personnel.

After the completed forms have been collected by committee members or have been returned to the office of the secretary of the county medical society, the committee should then consolidate the information obtained on a summary sheet which will be provided. This summary sheet will be furnished in triplicate. One copy of the completed summary sheet (blue) is to be retained by the county medical society, one copy (pink) is to be forwarded to the state medical society, and one copy (buff) is to be forwarded to the Bureau of Medical Economics, American Medical Association, 535 North Dearborn Street, Chicago. The information forms (white) are each numbered to indicate the arbitrarily selected functional groupings of individuals and agencies. The summary sheets carry the same numbers to indicate the functional subdivisions.

(NOTE.—It must be remembered that many county medical societies may find some questions on the white forms or perhaps some entire forms that will not apply in their counties. For example, there are many counties in which there are no hospitals; therefore, no hospital forms [white] will be used. Briefly, committees are expected to use their best judgment

in the manner of collecting information, but the summary sheet should show the nearest possible true picture of medical needs and the means to meet these needs.)

#### PREPARATION OF REPORT

After the information concerning the supply and need of medical care contained on the white forms (Nos. 1-8) has been consolidated and entered on the summary sheet, the committee will be ready for the second phase of the study—an examination of the collected data and the preparation of a report and recommendation of preferable procedures to supply those services which are found to be insufficient or unavailable. The committee, familiar with the local medical demands, facilities and conditions, is to use its own judgment in the interpretations of any existing local medical needs and the recommendations of means to supply those needs; however, reports and recommendations which record medical needs satisfactorily met are just as important as reports and recommendations which set forth deficiencies and preferable procedures to meet the needs. One copy of the completed report and recommendations is to be retained by the county medical society, one copy is to be sent to the state medical society and one copy is to be forwarded to the Bureau of Medical Economics, American Medical Association, 535 North Dearborn Street, Chicago.

#### DETERMINATION OF INDIGENCE

Since the main objective of the study is to determine actual medical needs and recommend appropriate means to supply the medical needs of the indigent and low-income groups, it is necessary to establish some method of economic selection of those who belong in these groups. Here experience has shown that a division of functions contributes to success.

Determination of income groups may well be left to public and private agencies and professional social workers, who should, however, under no conditions invade the field of medical service or attempt either to diagnose or treat disease or to decide who shall furnish medical care. Their function is to facilitate the contact between patients and physicians. In every endeavor to organize the provision of medical care the distinction between individuals or institutions that furnish medical *facilities* and physicians or dentists who are alone authorized by law to give *medical service* should be kept constantly in view. This distinction is of importance in determining the functions and in judging the activities of hospitals, clinics, laboratories and health departments.

Some of the most difficult, but nevertheless essential, problems in the distribution of medical care are concerned with the methods of payment for medical services. Fundamentally, the payment for medical care of the indigent is a public responsibility. The physician also shares with other citizens in this public responsibility, but his contributions are not limited to tax payments or to money donations. He makes further contributions whenever he gives his services without charge or at reduced fees in accordance with long established custom. In most localities some provisions are made to pay for medical care given to the indigent. Arrangements for more equitable payments through the county medical society in such a manner as to insure free choice of physician and good medical care have, in many places, been found satisfactory to patients, physicians and the paying agency.

In the preparation of recommendations, county medical society committees will need to determine whether the primary needs in their communities (where needs are found to exist)

require methods to meet medical emergencies or so-called catastrophes or whether the community needs also require some additional means to provide routine medical care. Recommendations to meet specific needs should be tested before adoption by the following principles, adopted by the House of Delegates of the American Medical Association in 1934:

First: All features of medical service in any method of medical practice should be under the control of the medical profession. No other body or individual is legally or educationally equipped to exercise such control.

Second: No third party must be permitted to come between the patient and his physician in any medical relation. All responsibility for the character of medical service must be borne by the profession.

Third: Patients must have absolute freedom to choose a legally qualified doctor of medicine who will serve them from among all those qualified to practice and who are willing to give service.

Fourth: The method of giving the service must retain a permanent, confidential relation between the patient and a "family physician." This relation must be the fundamental and dominating feature of any system.

Fifth: All medical phases of all institutions involved in the medical service should be under professional control, it being understood that hospital service and medical service should be considered separately. These institutions are but expansions of the equipment of the physician. He is the only one whom the laws of all nations recognize as competent to use them in the delivery of service. The medical profession alone can determine the adequacy and character of such institutions. Their value depends on their operation according to medical standards.

Sixth: In whatever way the cost of medical service may be distributed, it should be paid for by the patient in accordance with his income status and in a manner that is mutually satisfactory.

Seventh: Medical service must have no connection with any cash benefits.

Eighth: Any form of medical service should include within its scope all legally qualified doctors of med-

icine of the locality covered by its operations who wish to give service under the conditions established.

Ninth: Systems for the relief of low-income classes should be limited strictly to those below the "comfort level" standard of incomes.

Tenth: There should be no restrictions on treatment or prescribing not formulated and enforced by the organized medical profession.