Satisfaction of Patients in Two Air Force Family Practice Programs

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This study was carried out to determine if patients enrolled in family practice clinics were satisfied with their care and to ascertain if there was a difference in the level of satisfaction between two groups of family practice patients: one group at a teaching medical center and the other at a general acute care community hospital.

The overwhelming majority of family practice patients surveyed were extremely satisfied with the care they were receiving. The prime reasons for this satisfaction were physician continuity (having one physician for the whole family), personal attention, and having access to the health-care system. There were no differences in the levels of satisfaction between the groups at a teaching and a non-teaching facility. Overall, families that had received preventive health instructions from their physician had a stronger desire to remain with family practice and had fewer dislikes about the program than did the group of patients who had not received any preventive health instructions from their physician.

Organized family practice clinics are a relatively new concept within the United States Air Force. First established in 1971, they are still in a period of trial and development. Family practice was initiated in the Air Force with the expectation that it would reduce the fragmentation of care to the Air Force family, provide continuity of care, and improve the quality of care offered by the Air Force Medical Service.

As of November 1975, there were 12 formal family practice programs in the Air Force employing 65 family physicians, and there were three family practice residencies offering 65 rotating residencies to future family practitioners. Before any growth in these programs was planned, efforts were made to determine how Air Force families were receiving this new mode of care.

Attitudes to be tested were the extent of satisfaction/dissatisfaction of patients enrolled in family practice, the aspects the families liked about family practice, and the effect of preventive health education upon family practice patients. In addition, a comparison was made between family practice patients at a general acute care community hospital (the USAF Academy Hospital in Colorado) and a hospital with a family practice residency program (the Malcolm Grow USAF Medical Center at Andrews Air Force Base, Maryland).

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Methods

A questionnaire was sent to 300 families in each of the two programs. The procedure employed in selecting a sample involved the use of the family practice clinic's card files, listing the names of those participating in family practice, and the use of a random number table.

All the families on the rolls of the two clinics were the study universe, 2,200-2,300 at the teaching institution and 1,400-1,500 at the community hospital. From a table of random numbers, a list of digits was selected until the desired sample size was reached. The cards corresponding to those random numbers were pulled from the files and questionnaires were then mailed to each family.

Because the study population was selected at random from the whole, composition of the study group reflected the general population of clinic patients, as evidenced by later review of the demographic characteristics of the study group.

The survey[1] was divided into four parts. Part one contained seven questions concerned with demographic data such as clinic location, duty status, family size, length of participation in family practice clinics, and whether or not the family had received any preventive health instructions from their physician.

Part two of the questionnaire contained four questions and asked the respondents if they were satisfied with their care, if their care now surpassed their previous service, and requested that the respondents rank items they liked about family practice.

Part three of the survey dealt with the aspects of family practice the patients disliked, and part four was an open-ended question requesting the comments of those completing the survey.

The chi square test was used to find differences in the satisfaction levels of various groups, and Kendall's Coefficient of Concordance was used to see if there was an association in the way families ranked the aspects of family practice they liked and disliked.

Results

The response was astounding; of the 600 surveys mailed, 498 were

Table 1. Overall Satisfaction with Family Practice

"Overall, our family is satisfied with the care and services of the family practice clinic."

	Strongly Agree	Agree	Disagree	Strongly Disagree
Teaching facility	76%	22%	2%	0%
Community hospital	70%	28%	2%	0%
Overall Response	72%	25%	2%	0%

Table 2. Desire to Remain with Family Practice

"If your family had a choice of staying with the family practice clinic or returning to the old system, which would you choose?"

	Definitely Stay	Most Likely Stay	Happy Either Way	Most Likely Return	Definitely Return
Teaching facility	89%	10%	.8%	.4%	0%
Community hospital	86%	13%	.4%	.4%	0%
Overall Response	87%	11%	.6%	.4%	0%

Table 3. Comparison of Present to Past Outpatient Care

"How does the care your family is now receiving through family practice clinic compare to outpatient care you have received in the past? The care now received is:"

	Much Better	Slightly Better	Same	Slightly Worse	Much Worse
Teaching facility	86%	9%	5%	.4%	0%
Community hospital	77%	18%	5%	.4%	0%
Overall Response	81%	13%	5%	.4%	0%

returned. Patients from the community hospital returned 239 and 242 were returned from the teaching institution. There were 52 surveys returned marked address unknown and 17 respondents could not be included in the study for various reasons. Slightly over 50 percent of the surveys returned were returned by the end of the first week, an indication of the interest in this subject. The response of the second week slowed, but increased in the third week as a result of a reminder letter mailed during the second week.

The high response rate was attributed to the following factors: the questionnaire and reminder letter were hand addressed; a reminder letter was mailed 10 days after the questionnaire; it took a short time to complete the survey (five to ten minutes); the families were, in a sense, privileged since waiting lists to enroll in family practice do exist; and the positive response expressed by the respondents regarding their family practice clinic. The main factor responsible for the high return rate was probably the genuine and overwhelmingly favorable response to family practice. In addition to completing the survey, some 70 percent of those who responded took time to write additional comments. Table 1 demonstrates the patients' attitudes toward their care and gives a major clue as to why over 90 percent of the surveys were accounted for.

As a cross-check to the query on families' satisfaction, questions were asked requesting families to compare family practice to their past care, and asking if they desired to return to the previous general therapy clinic system in which appointments were made according to specialty, rather than physician or family. (Tables 2 and 3 show the results of those questions.)

The reasons for patients' satisfaction with Air Force family practice programs were (in order of preference):

1. Having one doctor for our family.
2. Our doctor cares about us.
3. Having one doctor for all our problems.
4. Appointments are readily available.
5. The permanent relationship with our doctor.
6. Availability of a family doctor 24 hours a day.
7. Knowing our doctor is trained in family medicine.

8. Our doctor explains our problems.

There were no statistically significant differences in the satisfaction levels of patients related to length of participation, family size, sponsor's duty status, or facility. Those families at the general acute care community hospital were as satisfied as those at a medical center with a family practice residency program.

The major reasons for patient dissatisfaction were having to wait in the clinic waiting area for appointments, having to see other family practice doctors besides their regular family physician, being unsure of family practice doctors' skills, having difficulty in obtaining an appointment, and preferring to see a different specialist.

Over one half (58 percent) of the families enrolled in family practice had received preventive health instructions from their physician, and within this group 89 percent had followed or attempted to follow that advice.

There was a difference in the extent of satisfaction between those families that received preventive health instructions and those that did not. Those who had were on the whole more satisfied, had fewer dislikes, and had a stronger desire to remain with a family practitioner than did families who did not receive health education.

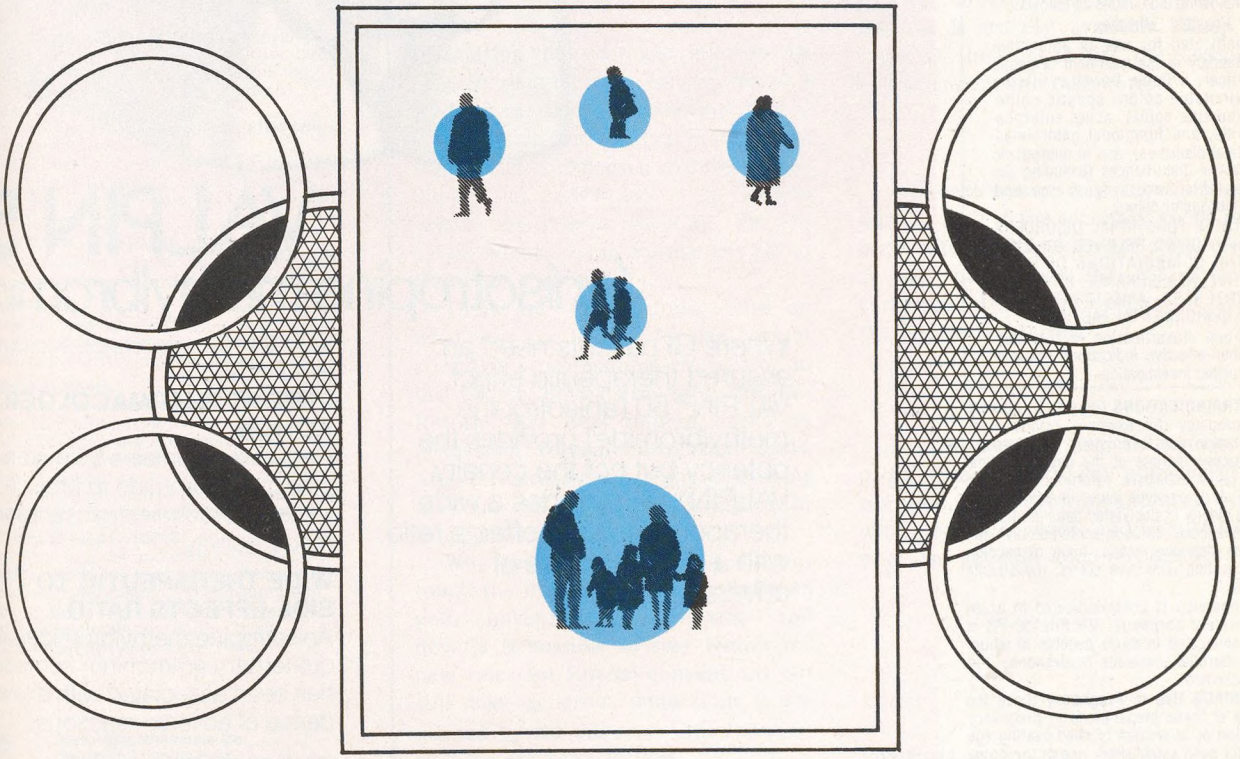
Conclusions and Recommendations

Family practice patients in the Air Force facilities involved in this study are exceedingly pleased with the care they receive. With 94 percent of the respondents stating family practice was much better or slightly better than previous care, and 97 percent agreeing with the statement that their family was satisfied with family practice, there is little doubt that the surveyed population is satisfied.

Major recommendations to the Department of Defense as a result of this study were that family practice be expanded to all Department of Defense facilities, that additional resources be dedicated to training family practitioners, and that preventive health education be stressed not only by family practitioners but by all medical specialties.

Reference

1. Babbie ER: Survey Research Methods. Belmont, Calif, Wadsworth Publishing Co, 1973



P-H Doctor's Tax Report

Tax Reform Act Changes T&E Deductions for Many Convention-bound Doctors

Starting this year you may not be able to deduct what you spend at a medical or dental convention if it is held outside the United States. You may forfeit substantial deduction dollars if the convention is in Jamaica instead of Puerto Rico or the US Virgin Islands, or in Europe instead of Hawaii or a US city.

There are still no dollar limits on what you can deduct for the cost of attending a professional convention in the United States. However, the Tax Reform Act does impose limits on deductible foreign convention costs. And the already strict record-keeping rules are made even more stringent for foreign conventions.

Why the Tax Reform Act did not touch the liberal deduction rules when your convention is in the states and how it is possible to stay within the new rules for foreign conventions but still take generous deductions is explained by the editors of the *Prentice-Hall Doctor's Tax Report.*

If Your Convention is in the United States

The rules for deducting the cost of attending a convention held in the United States have not changed. And that goes for conventions anywhere in the states – Hawaii, Puerto Rico – or a possession such as the US Virgin Islands. You can still make the convention trip, sit in on the sessions, improve your professional skills, do some sightseeing, and deduct most of the cost.

If you attend the convention primarily for practice-related reasons, you can deduct the full cost of such things as transportation, meals, lodging, convention fees, and practice-related entertainment. If you want to do some sightseeing while you are in the convention city, go ahead and enjoy yourself; but there is no deduction allowed for such "purely pleasure" expenses.

The tax-wise physician makes certain he or she can prove that the trip was primarily for professional purposes. Otherwise, no travel expenses are deductible. Forms of proof acceptable to the IRS include:

1. *A program* of the convention sessions is usually available. Keep a copy of this, check off the sessions you attended, and take notes.

2. If each session has *a sign-in book,* sign in. And if the secretary keeps this book after the sessions are concluded, as any need arises he can furnish certified extracts, photostats, or even the books themselves.

3. The key to any deduction is proof. *Keep a diary,* pay your registration fees, transportation and hotel bills with a *business check,* and be sure that you also get and keep *receipted bills.*

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For Doctors Who Attend Foreign Conventions

Brand new rules apply to all foreign conventions beginning in 1977. What the Reform Act did was put an end to sham conventions – foreign trips that are essentially vacations in disguise. Obviously, the new rules apply to doctors who attend a foreign convention. And if a doctor is going on behalf of an employer such as a hospital or a professional corporation, the employing organization is also subject to the new rules. If the organization imburses the doctor it can only deduct what the doctor is allowed to deduct.

Two a Year

You can attend two foreign conventions a year and get deductions subject to the limits explained below. The cost of attending more than two is not deductible. If you do attend more than two conventions in a year you select the two that are deductible.

A foreign convention is any convention, seminar, or similar meeting that is held outside the United States and its possessions or the Trust Territory of the Pacific. So a convention in Hawaii or the US Virgin Islands is not affected by the new rules, while a convention in Canada, Mexico, or the Bahamas is.

The Cost of Getting Transportation

As long as you spend at least half of your time on professional matters you get a deduction for the full cost of your round trip fare. But even if you spend less than half of your time at the convention, you can deduct some of your transportation expense. There are two limitations:

1. *Coach or economy fare:* The deductions can not exceed the lowest coach or economy rate charged by a commercial airline with regularly scheduled flights to the convention city. Exception: If there is no coach or economy rate, the deduction is limited to the lowest first-class rate charged by the airline.

2. *Half is enough:* You can deduct the full coach or economy fare if you devote at least half the days of the trip to practice-related activities. The days spent getting to and from the convention are ignored entirely. If you spend less than half the days at the convention, you can only deduct a proportionate amount.

The Reform Act is very specific about what constitutes a *convention day*. A full convention day needs at least six hours of scheduled activities. But to get your deductions, you need only attend two thirds of the hours of those activities – a minimum of four hours. A half day has at least three hours of scheduled activities, and you need only attend for two hours.

Only practice-related activities go towards meeting these rules. Time spent at social functions does not count. But if you attend a banquet, the time during which a speaker makes a practice-related presentation is taken into account. Of course, the costs of entertaining professional associates are deductible under the usual rules.

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Orinase complements a diabetes meal plan

Orinase should be administered only when meal planning does not by itself provide adequate blood sugar control. Effort should be made, after beginning Orinase administration, to continue proper meal planning, since oral hypoglycemic therapy is an adjunct to, rather than a substitute for, this measure.

Nearly 20 years of experience with Orinase

- Orinase usually lowers blood sugar satisfactorily in patients with mild, maturity-onset diabetes.
- Orinase provides relief of common hyperglycemia-related diabetic symptoms, e.g., polyuria, polydipsia, and pruritus.
- Orinase is rapidly metabolized and excreted; and prolonged hypoglycemic episodes, which can be particularly dangerous in the older patient, have rarely been reported. Certain factors, such as hepatic and renal disease, may, however, predispose patients to hypoglycemia.
- Simple b.i.d. or once-daily dosage may be prescribed.
- Dosage range of 1 to 6 tablets daily allows wide flexibility in adjusting to patient needs.
- Orinase is contraindicated in juvenile or unstable, brittle diabetic patients.

When meal planning is insufficient in the elderly, maturity-onset diabetic patient

0.5 Gm tablets

Orinase®

tolbutamide, Upjohn

lowers blood sugar to help relieve diabetic symptoms

patient on Orinase must be fully instructed: about the nature of his disease; how to prevent and detect complications; how to control his condition; not to neglect dietary restrictions, develop a careless attitude or disregard instructions relative to body weight, exercise, personal hygiene, and avoidance of infection; how to recognize and counteract impending hypoglycemia; how and when to test for glycosuria and ketonuria; how to use insulin; and to report to the physician immediately if he does not feel as well as usual.

Caution, very close observation, and careful adjustment of dose are necessary when: insulin is withdrawn during the trial period in order to avoid ketosis, acidosis, and coma; thiazide diuretics are administered which may result in aggravation of diabetic state and increased tolbutamide requirement, temporary loss of control, or even secondary failure; treating patients with impaired hepatic and/or renal function and debilitated, malnourished, or semistarved patients in order to avoid severe hypoglycemia which may require corrective therapy over several days; and treating patients with severe trauma, infection, or surgical procedures where temporary return to insulin or addition of insulin may be necessary. Response to tolbutamide is diminished in patients receiving therapy with beta-blocking agents.

As some diabetics are not suitable candidates, it is essential that the physician familiarize himself with the indications, limits of application, and selection of patients for therapy.

Patients must be under continuous medical supervision, and during the initial test period should communicate with the physician daily, and during the first month report at least once weekly for physical examination and definitive evaluation. After a month, examinations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory lowering of persistent elevation of blood sugar, or failure to obtain and hold clinical improvement indicate non-responsiveness to

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Costs While at the Convention

The rules governing deductions for subsistence expenses (meals and lodging, tips, taxis, and other expenses for your "personal sustenance and comfort") are tighter than those for travel. You get no deduction unless the convention schedules full days of practice-related activities of at least six hours or half days of at least three hours. If the convention does so, you then have a choice –

1. *Day by day:* You can deduct your subsistence expenses for any one day you attend two thirds of the hours of the activities scheduled that day. And of course, you can deduct half your subsistence for any half day you attend two thirds of the scheduled activities.

2. *Aggregate method:* Or you can deduct your subsistence expenses for the full and half days of the convention if you attend at least two thirds of the total hours of professional activities scheduled at the convention.

The aggregate method allows you to deduct subsistence for *all* convention days even if you spend one third of the convention days vacationing. However, even if you attend less than two thirds of the total hours you can use the day-by-day method and deduct subsistence for those days you attend two thirds of the hours of scheduled activities.

Note that your deduction can not exceed the per diem limit applicable to United States civil servants at the convention location during the calendar month in which the convention begins.

Below is a list of some of the most appealing foreign convention sites. The accompanying figures represent the latest maximum dollar per diem allowances established for United States civil servants. Your deductions for subsistence expenses while attending a foreign convention cannot exceed these dollar amounts.

• Acapulco	$50*
• Athens	36*
• Bermuda	62*
• London	52
• Montreal	46
• Munich	46
• Nassau	61*
• Paris	62
• Rio de Janeiro	58
• Rome	43
• Tel Aviv	48
• Tokyo	57

*During season

Report Requirements

The Tax Reform Act requires you to do a lot more paper work. To get any deduction for your trip(s) you must attach two statements to your tax return. One is a statement signed by you, the convention goer, that includes the total days of the trip (excluding travel to and from the convention), the number of hours of each day devoted to convention activities, and a program of scheduled activities. The other is a statement signed by an officer of the group sponsoring the convention that lists the schedule of practice-related activities on each day and the number of hours which you attended such activities.

The above tax information is adapted from P-H DOCTOR'S TAX REPORT, published bi-weekly by Prentice-Hall, Inc., Englewood Cliffs, NJ 07632. Address inquiries attn: R. M. Shaw.