

A STUDY TO DETERMINE THE FEASIBILITY OF ESTABLISHING  
A PRIMARY CARE PHYSICIAN SYSTEM IN THE OUTPATIENT  
CLINICS OF BEN TAUB GENERAL HOSPITAL, HARRIS  
COUNTY HOSPITAL DISTRICT, HOUSTON, TEXAS

A Problem Solving Thesis

Submitted to the Faculty of

Baylor University

In Partial Fulfillment of the

Requirements for the Degree

of

Master of Hospital Administration

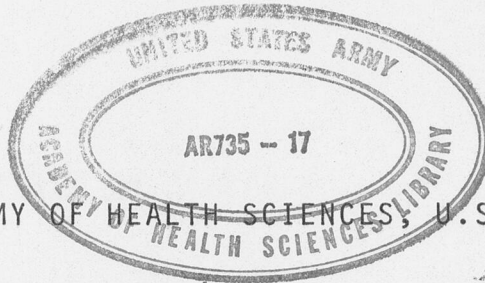
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August 1975

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## ABSTRACT

### A STUDY TO DETERMINE THE FEASIBILITY OF ESTABLISHING A PRIMARY CARE PHYSICIAN SYSTEM IN THE OUTPATIENT CLINICS OF BEN TAUB GENERAL HOSPITAL, HARRIS COUNTY HOSPITAL DISTRICT, HOUSTON, TEXAS

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The problem was to determine the feasibility of establishing a primary care physician system in the outpatient clinics of Ben Taub General Hospital, Harris County Hospital District, Houston, Texas.

Data for this paper was obtained from personal observations of the operation of the outpatient clinics at Ben Taub Hospital, unstructured interviews with staff members, a review of the literature, and a review of hospital publications and correspondence pertaining to the operation of the outpatient clinics.

The study concluded that the establishment of such a system was not currently feasible within existing organizational structure, philosophy, and resources, and recommended that the present system for delivery of ambulatory care be continued unchanged.

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CHAPTER 1

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of health care, a large proportion of the population is still lacking those clinical services that can be identified as "personal" or "family physician" services. This lack of services has led many to regard the current situation as a crisis, mainly because no clear alternative pattern of medical care has evolved.

Patients are becoming increasingly sophisticated about the care they receive. In many ways, they are demanding the expansion of services into the community, improved accessibility, increased comprehensiveness, and the provision of care in a manner which gives recognition to the dignity and privacy

## CHAPTER I

### INTRODUCTION

#### General Information

Historical, geographic, social, and economic factors influence the many patterns by which medical care can be provided to a population. In this country, the traditional pattern of patient-physician relations based upon a general practitioner system has become a social anachronism. In spite of increasing public and private expenditures on health and an emphasis on the development of new approaches to the delivery of health care, a large proportion of the population is still lacking those clinical services that can be identified as "personal" or "family physician" services. This lack of services has led many to regard the current situation as a crisis, mainly because no clear alternative pattern of medical care has evolved.<sup>1</sup>

Patients are becoming increasingly sophisticated about the care they receive. In many ways, they are demanding the expansion of services into the community, improved accessibility, increased comprehensiveness, and the provision of care in a manner which gives recognition to the dignity and privacy

due every human being.<sup>2</sup>

The dramatic growth of ambulatory services during the last two decades is reflected in the utilization statistics for ambulatory services. In an unprecedented fashion, utilization of emergency rooms has increased by 186 per cent between 1955 and 1965.<sup>3</sup> During the same period, the use of outpatient services rose by 73 per cent and admissions to hospitals by 38 per cent.<sup>4</sup> In similar studies, the American Hospital Association in a 1969 report entitled Outpatient Health Care stated that in 1953 there were two outpatient visits for every hospital admission; by 1967, the ratio had increased--four to one. During the period 1947-67, the rate of outpatient visits per 1,000 population rose from 232 to 562, six times as rapidly as the rate for inpatient admissions.<sup>5</sup>

The 1970 Guide Issue of Hospitals reports that between 1962 and 1969 the total number of outpatient visits to community hospitals increased by 71 per cent, from 70.7 million in 1962 to 120.8 million in 1969. Emergency room visits, comprising approximately one-third of the total, increased from an average of 5,254 visits per hospital for 1962 to an average of 8,600 visits per hospital for 1969. Currently, total emergency room visits are estimated at an average of

194 visits per 1,000 population annually and are projected to reach 300 per 1,000 population by 1980.<sup>6</sup> Although some discrepancy exists between the results of various studies, the trend is clear: patient visits to ambulatory care facilities are dramatically increasing and will continue to increase into the future.

As health planners focus on this complex situation, they must recognize that physical, mental, environmental, and social components of health cannot be separated; thus, many professional skills must be brought to bear upon a patient if the full benefits of modern medicine and society are to contribute to a solution of the problems. It is clear that many of the problems faced in American medicine today are the product of a series of changes in the concept of medical care. The increasing knowledge and complexity of medicine has led to a rapid increase in medical specialization, a growth in group practice, and the centralization of many activities at or near the hospital. The growing belief among many citizens of this country that health services constitute a right, and not a privilege, has encouraged a growth in the demand for personal health services.<sup>7</sup>

During the past few years, the winds of social change

have had an impact upon the American health care system. In response, hospital outpatient departments are beginning to emerge from an antiquated framework of organization which began with the development of dispensaries many decades ago. In their place are arising comprehensive ambulatory health care services which are available and accessible to all, utilize an integrated multidisciplinary approach, and are based upon the concept of primary family-centered health care.<sup>8</sup>

#### Hospital Setting and History

The Harris County Hospital District (HCHD) is a tax-supported, public authority which provides hospital care and health services to qualified, medically indigent legal residents of Harris County. HCHD which replaced the City-County Hospital System became operational on January 1, 1966. The hospital district, governed by a Board of Managers composed of seven members appointed by the Commissioners Court, includes Ben Taub General Hospital, Jefferson Davis Hospital, an administrative element, and five neighborhood health clinics located in outlying areas.

The hospital district is affiliated with the Baylor College of Medicine. The faculty of the college is responsible for the medical services of each hospital which, in turn,

serve as the main teaching facilities for the college. The chief executive officer of the college is chief of staff and chairman of the medical board. Each departmental chairman of the medical school is chief of the corresponding service at each hospital. The house staff is appointed upon nomination by the college, and the teaching programs are coordinated within the affiliated residency programs of the college. HCHD also has an affiliation with the University of Texas Dental Branch which has the Oral Surgery Department under its direction.<sup>9</sup>

#### Ben Taub General Hospital

Ben Taub General Hospital (BTGH), located in the Texas Medical Center and physically joined to Baylor College of Medicine, is a 475-bed acute, general hospital with a substantial outpatient program and a comprehensive emergency center. The emergency center handles the bulk of Houston's emergency cases. Outpatient clinics are operated for cancer, dental, dermatology, gynecology, medical, neurology, neurological surgery, proctology, psychiatry, and urology, plus a number of specialty clinics within each classification. Ben Taub General Hospital's inpatient capability includes units for burns, general surgery, gynecology, male and female medicine, surgical specialties,

pediatrics, and psychiatry. It also provides complete ancillary services and houses a number of special research facilities to include the Baylor General Clinical Research Center and an extensive cardiac service.

#### Jefferson Davis Hospital

Jefferson Davis Hospital was built in 1938, but renovation of the interior which was begun in 1966 has transformed this facility into a modern hospital located near downtown Houston. After completion of Ben Taub Hospital in 1963, Jefferson Davis Hospital became a special hospital with facilities for obstetrics, physical medicine and rehabilitation, pediatrics, and chest diseases. The facility has 304 beds and 212 bassinets. Outpatient clinics are operated for obstetrics, high-risk maternal infant care, chest diseases, and pediatrics. Special facilities include a respiratory intensive care unit, physical and occupational therapy departments, and a pulmonary laboratory.

#### Neighborhood clinics

The Harris County Hospital District operates six neighborhood health clinics in conjunction with its community medicine service. These facilities, offering general practice services, are the Acres Homes, Baytown, Casa De Amigos,

Settegast, Ripley, and Sunnyside Health Clinics. The facilities at Ben Taub Hospital and Jefferson Davis Hospital are used as back-up for referrals of patients to specialty clinics or for inpatient hospitalization. Community participation in the organization of the neighborhood clinics is achieved through neighborhood health councils, one for each clinic and an areawide council that includes representatives from each neighborhood council.

	<u>1971</u>	<u>1973</u>	<u>1974</u>
Admissions	26,900	30,678	38,774
Births	9,768	9,665	9,469
Clinic Visits	345,301	429,570	436,344
Emergency Visits	63,375	78,191	87,100

Fig. 1.--Statistics: Harris County Hospital District<sup>10</sup>

The combined work load data for Harris County Hospital District is indicative that these facilities are providing a significant service to Harris County Residents.

#### Conditions Which Prompted the Study

With the "family unit" system a coming reality for billing purposes at the Harris County Hospital District

facilities, it is a logical extension to expect that a "family practice" system of medical care will also evolve. This, plus the crowded conditions in the outpatient clinics, makes a primary care physician system seem attractive. Currently, if a patient is seen in a particular clinic without therapeutic success, he is appointed to another clinic for care, with the hope that this new clinic can help the patient. This multiple service, or referral system of medical care, offers the patient no one physician, or even team of physicians, with whom he can relate. This leads to a lack of emotional support of the patient as is experienced by those who have a stable relationship with a personal physician. It also allows the "intra-institutional dump" to take place where one service refers troublesome or difficult diagnostic patients to another service. This could be a contributing factor with regards to the ever-climbing number of clinic visits. A primary care physician system might also establish more efficient use of doctor, clinic, and ancillary service time.

#### Statement of the Problem

The problem is to determine the feasibility of establishing a primary care physician system in the outpatient clinics of Ben Taub General Hospital, Harris County Hospital

District, Houston, Texas.

### Definitions

Primary Care Physician.--A primary care physician is a physician who: (1) serves as the initial point of contact with the patient and provides a means of entry into the health care system; (2) evaluates the patient's total health needs, provides personal medical care, and refers the patient to appropriate sources of care when consultation or specialized treatment is required; (3) develops a responsibility for the patient's comprehensive and continuous health care and, when needed, acts as a coordinator and integrator of the patient's health services; and (4) accepts responsibility for the patient's total health care, including the use of consultants, and interprets to the patient the nature of the care. The primary care physician is usually a family practitioner, generalist, internist, or pediatrician. In a multispecialty based system of care, an obstetrician, gynecologist, surgeon, or other specialist may serve as the primary care physician.<sup>11</sup>

The terms "primary care physician" and "primary physician" are used in the literature synonymously. For consistency, the term "primary care physician" will be utilized in this thesis except in quotations and references from the

literature.

### Objectives

The objectives of this study are to:

1. Conduct an extensive review of the literature for the purpose of developing a theoretical and conceptual approach to the solution of the problem.
2. Study the existing organization and operations of the outpatient clinics at Ben Taub Hospital.
3. Analyze and evaluate the present method of ambulatory care delivery and examine the advantages and disadvantages of alternative approaches to providing personalized, comprehensive health care in a primary care physician system.
4. Determine the feasibility of establishing a primary care physician system; and, based upon the feasibility, recommend the best approach to the solution of the problem.

### Criteria

The conclusions and recommendations of this study must:

1. Insure that the advantages of the proposed solution are equal to or superior to those currently being provided by the existing system.
2. Insure that the proposed solution affords quality

patient care which encompasses the principles of:

- a. Comprehensive personal care.
- b. Family oriented continuity of care.
- c. Accessible, convenient care, acceptable to the patient.
- d. Coordination of inpatient and outpatient follow-up care.

3. Insure that the proposed solution is acceptable to the providers of the care and is feasible within the resources of the hospital.

4. Insure that the proposed solution is feasible within any broader constraints imposed by parent administrative bodies or regional planning agencies.

5. Insure that the implementation of the proposed solution does not unduly interrupt or detract from the hospital's current operation.

#### Limitations

The limitations established for this study by the administrator, Harris County Hospital District, are as follows:

1. Recommendations must be consistent with the current political organization and policies of Harris County, Texas, as they apply to the hospital district.

2. The proposed solution must be implemented within the existing facilities of the outpatient clinics at Ben Taub General Hospital.

3. The present level of professional and ancillary personnel employed in the clinics cannot be exceeded.

4. The current operating budget of the hospital cannot be exceeded.

#### Assumptions

The assumptions are that:

1. The social, economic, and geopolitical conditions which affect the delivery of ambulatory care will remain relatively constant within the Ben Taub Hospital service area.

2. The demand for ambulatory medical care among patient and potential patients of Ben Taub Hospital will continue to increase.

3. The purpose and operating policies of Ben Taub Hospital will remain relatively constant.

4. The formal affiliation between Baylor College of Medicine and the Harris County Hospital District will remain in effect.

5. The establishment of a primary care physician system is feasible and will improve the delivery of ambulatory

patient care.

6. Although specific resource limitations have been placed on the study, the theoretical and model approaches to the problem could be utilized for justification of additional resources in the future.

#### Factors Bearing on the Problem

Factors bearing on the problem are as follows:

1. The outpatient clinics of Ben Taub Hospital provide care for 300,000 residents of Harris County who made 270,000 visits in 1974. When combined with data from the emergency center, the total ambulatory case load reached 360,000 patient-visits. This work load equates to about 1,200 patients a day being seen in sixty-two general and specialty clinics and represents a 26 per cent increase in patient load since 1970.<sup>12</sup>

2. The clinics of Ben Taub Hospital are primarily for those who cannot afford the cost of private care. As an exception to this, the hospital functions as an emergency facility for Harris County and accepts all patients who have emergency needs. All patients are available for teaching purposes, and all clinics are "teaching clinics" for house officers and medical students.<sup>13</sup>

3. The Ben Taub Hospital is affiliated with Baylor College of Medicine. The faculty of the college is responsible for the medical services of the hospital. Each departmental chairman of the medical school is chief of the corresponding service at the hospital. Staffing of the inpatient services and clinics is almost exclusively by house officers (interns, residents, and fellows).<sup>14</sup>

4. The hospital and medical college, because of their individual missions, have different perspectives and priorities concerning the various aspects of the organization and delivery of ambulatory care within the hospital. Additionally, lines of authority, organizational relationships, and functional activities between various elements concerned with ambulatory care are not clearly delineated.

5. The current system of medical practice in the clinics is basically one of an episodic, specialty-oriented approach which has been well characterized by Dr. Leslie J. Sandlow as "the single disease entity-organ related clinic."<sup>15</sup> For example, separate clinics were operated for diabetes, endocrine and metabolic disorders, arthritis and hypertension. This specialty referral system of medical care offers the patient no one physician, or even team of physicians, with whom

he can relate on a continuous basis.

6. The hospital administrator is concerned with the crowded conditions in the clinics, the ever-climbing number of clinic visits, the apparent duplication of services, and the excessive cross referrals referred to as the "intrainstitutional dumping syndrome" whereby one service refers troublesome, difficult, or nontherapeutic-responding patients to another service.

7. The administration expects that a primary care physician system would achieve more efficient use of doctor, clinic, and ancillary service time. Additionally, the expected establishment of a "family unit" system for billing would be simplified if a family-centered system of medical care also existed.

8. Patient dissatisfaction with the present system is reflected in the number and types of complaints. The present system reportedly leads to a lack of emotional support of the patient as experienced by patients who have a stable relationship with a primary care physician.

9. Dissatisfaction on the part of some house staff members with the existing system for delivery of ambulatory care and the desire to participate in a system of comprehensive,

continuity of primary care would simulate the environment of private practice.<sup>16</sup>

### Research Methodology

The research methodology applied prior to the on-site phase of the study consisted of consultations with the faculty member who visited the hospital, and discussions with the thesis committee to fully define the scope and nature of the problem. An extensive review of the available literature pertinent to the subject was conducted prior to and during all phases of the study. Model programs and innovative solutions to similar problems were conceptually gleaned from the literature to be applied later during the on-site phase of the study in the realistic environment of the hospital.

During the period March 1-15, 1975, the on-site phase of the study was conducted within the outpatient clinics of the Ben Taub General Hospital, Houston, Texas. After initial interviews with N. J. Vaughn, Administrator, Harris County Hospital District; Dan Alderman, Associate Administrator, Ben Taub Hospital; and Don Archer, Assistant Administrator for Clinics, a detailed tour of the facility was made. During the on-site study, interviews and discussions were held with concerned hospital members from management, administration,

medical and house staff, nursing services, and general support services. The opinions of students and individual patients were also obtained. Observations of clinic operations and procedures was an important aspect of the study to reinforce verbal and written communications.

The approach, conclusions, and recommendations for the solution of the problem were finally developed and formulated, within the parameters delineated above, based upon literature experience applied and tailored to the specific requirements and circumstances of Ben Taub General Hospital.

#### Review of the Literature

Comprehensive patient care is a philosophical concept which was defined by Dr. Lester J. Evans as:

. . . the kind of compassionate, personalized, birth-to-death attention--preventive, advisory, and rehabilitative, as well as diagnostic and therapeutic--that the ideal family physician used to give within the limits of his knowledge and facilities.<sup>17</sup>

While this is an oversimplified and historically oriented definition it does underscore the basic principles of comprehensive care. The challenge to medicine today is adapting the concept to contemporary society so that medical care does not become increasingly an episodic, impersonal, and even haphazard matter of a patient's shopping in bewilderment

from specialist to specialist, none of whom may know the emotional, social, or environmental problems interacting with his organic complaint. The aim should be to combine the concentrated knowledge and skills of the specialist with the broad understanding, wisdom, and continuing care of the generalist, who serves as the primary physician for the patient to see that he receives precisely as little or as much care as he requires. The concept is a broad one and in the pluralistic system of medical care, many institutions, agencies, and categories of personnel are involved. Different vehicles of delivery of comprehensive ambulatory care are being utilized which include hospital-based ambulatory and outpatient clinics, private solo and group practices, medical school service plans, health maintenance organizations, hospital satellite clinics, neighborhood health centers, and mobile health units.<sup>18</sup> The system most appropriate for a given community will depend on many local factors, including the preference of physicians and patients, the existing medical practice systems, socioeconomic factors, and the role of public and private health institutions. Irrespective of the delivery system utilized,

several essential conditions must be met, without which meaningful comprehensive care cannot be achieved. First, every patient must be able to enjoy a personalized doctor-patient relationship with at least one physician, preferably a primary care physician who will usually be a family practitioner, internist, or pediatrician. This doctor should have primary responsibility for the patient's treatment, medical and related records, and for referring him as needed to other physicians or health services. Second, every patient and his physician must have access to the whole spectrum of services--preventive, diagnostic, therapeutic, rehabilitative, and consultative--as needed, through organized referral channels which do not involve breaking the primary doctor-patient relationship, do not require unnecessary duplication of diagnostic tests or other services, and provide complete and continuous records of all medical and other health and health-related information.<sup>19</sup>

Traditionally, the hospital outpatient department has been associated with episodic care of the medically indigent. At best, care was fractionated among separate specialty and subspecialty clinics with little concern for integration of the services. Patients with multiple, unrelated diseases

could be simultaneously followed in several clinics which would bear no relationship to each other either functionally or temporally. In this system, a patient may see multiple physicians, none of whom know the patient's overall problems, nor is the patient able to identify with any one physician as his primary physician.

The traditional system for delivery of ambulatory care was equally unpalatable and professionally unrewarding for the physician. To be assigned to the outpatient clinics generally meant that the physician was: (1) less competent than his colleagues who enjoyed the inpatient services; (2) in disrepute and had to serve his time in the clinics for some social or professional transgression; or (3) the new man in the hierarchy and had to serve his apprenticeship in the clinics until an opening occurred in the hallowed halls of the inpatient regions of the hospital.<sup>20</sup>

Recognizing this situation, Dr. John E. Deitrick of Cornell University Medical College characterized outpatient departments as follows:

. . . outpatient departments of hospitals are generally second rate. The clinics have been called the step-children of the hospital; they serve in a subordinate position as screening services to provide the most interesting patients for the ward services.<sup>21</sup>

Until recently, outpatient clinics have been extremely poor models of ambulatory care. However, within the past few years, changes have been taking place to correct this situation. Recognizing the historical problems of the outpatient clinics and applying the concepts of comprehensive care, hospitals throughout the country are seeking new organizational methods for delivery of ambulatory care which meet the growing demand for readily accessible and available family-centered, comprehensive health care.

The literature in the ambulatory health care area has increased dramatically since 1970. Many authors have offered goals and guidelines for improving ambulatory care. Dr. Lowell Bellin, Deputy Health Commissioner for the city of New York in the key note address to a 1971 conference on ambulatory care, stated that the most important factors to be included in restructuring an outpatient clinic which delivers mainly episodic, specialty-oriented care to a more comprehensive, family-oriented system, should include:

1. Organizing the services into a department of ambulatory care and granting status to the chief of the newly created service equivalent to that of the chief of any of the other specialty services.

2. Establishing a primary physician system.
3. Emphasizing general clinics over specialty clinics.
4. Instituting a unit record system with the problem-oriented medical record at the heart of the system.<sup>22</sup>

The guidelines set out by Dr. Herbert Freilich, Assistant Commissioner for Ambulatory Care, Department of Hospitals, New York City, reflect a consensus of opinion from the literature and include the following suggestions:

1. There should be an ambulatory care committee within the medical staff organization.
2. There should be a well-qualified and interested chief of ambulatory care on a full-time basis.
3. There should be an ambulatory care coordinator within each clinic or specialty department.
4. The medical staff for ambulatory care should be integrated with the inpatient staff.
5. The number of specialty clinics should be limited in favor of general clinics.
6. Each patient should be assigned to one personal primary physician or team of physicians to insure continuity of care.

7. The relationship of the outpatient service to the emergency service should be clearly defined and coordinated.

8. The system should permit easy accessibility and entry.

9. The institutional philosophy should reflect a commitment to the concept.

10. The outpatient policy should be for delivering comprehensive, family-centered care that is coordinated with the specialty clinics.<sup>23</sup>

Within the past five years, not only have conceptual goals and guidelines to improve ambulatory care appeared in the literature, but there have also been numerous interesting and innovative trial programs attempted, to add substance to the theoretical models. One of the earliest programs aimed at providing family-centered comprehensive ambulatory care, which generated much enthusiasm, was the 1957 Family Health Maintenance Demonstration Project of the Montefiore Medical Group. Utilizing a group practice-team concept of an internist, pediatrician, public health nurse, and social worker, comprehensive, personalized care was provided to 150 volunteer families from the Health Insurance Plan of New York. The

authors concluded that the demonstration was successful in improving the physical health of the family and in improving patient acceptance of the personalized approach.<sup>24</sup>

In 1967, Dr. Count Gibson applied the concepts of family-centered care and organized the Columbia Point Neighborhood Health Center into four family health care team units, each caring for 350 families. Each team was composed of an internist, pediatrician, nurse, and social worker. The team met daily to develop and coordinate plans for families under active care. The author felt that the program was so successful in providing comprehensive care that the entire structure of the center was reorganized to accommodate the family health care group concept. Indigenous family health workers were added to the teams and a part-time obstetrician-gynecologist was used for consultations.<sup>25</sup>

In developing the Ambulatory Care Unit of the Gouverneur Hospital in New York City, Drs. Howard Brown and Raymond Alexander physically and, to a significant degree, administratively detached the unit from the parent hospital. They noted frequently the inpatient service so dominates the interests of a hospital that little attention is given to adapting the outpatient services to the needs of the patient. They saw this

change in structure as a unique opportunity to begin new programs in providing comprehensive ambulatory care. In order to achieve continuity, most subspecialty clinics in medicine, pediatrics, and general surgery were eliminated and the patients transferred to the general clinics in these medical specialties. Although many of the staff had subspecialty skills and the use of these skills was encouraged through consultations, the goal was for each adult patient to have one internist, and each child one pediatrician, as his personal physician. To further the concepts of continuity of care, a core of full-time physicians was recruited.<sup>26</sup>

The concept of the health team was introduced at the Yale-New Haven Medical Center in 1965 by Drs. Jerome Beloff and Richard Weinerman, who emphasized that effective family health maintenance implies a unified, personalized, and continuous service system. Their basic health team consisted of a student-physician, a public health nurse, and a community aide supported by appropriate consultants. The teams were charged with providing and coordinating the health care of a given number of families for a period of thirty months. Despite some acceptance problems for the program among certain medical faculty members, Drs. Beloff and Weinerman concluded

that families received improved care from the health team as compared with the previous system of fragmented outpatient clinic care because of: (1) better coordination of the management of health problems through the use of the family health plan; (2) placing responsibility for implementing procedures jointly on the family and the health team; (3) emphasizing preventive medicine and continuing health education; and (4) improving the techniques of communication among the health care specialists so that problems were viewed from different perspectives.<sup>27</sup>

In 1966, the outpatient department of Beth Israel Hospital designed to provide health care for a population of 163,000 people in the north section of Manhattan's lower east side, operated fifty-three specialty clinics with a yearly visit total of about 100,000 patients. Members of the staff were growing increasingly dissatisfied with the organization and provision of ambulatory services and recognized that patient needs were not being met by dependence on specialty clinics for on-going care. In no single clinic could the total needs of a patient be met. A feasibility plan was developed by the Committee on Ambulatory Services of the medical board to establish a comprehensive care unit on a

demonstration basis, to be evaluated after six months of operation. The demonstration unit was developed in order to achieve high-quality total patient care, as family-centered as possible, under the supervision of a personal physician.<sup>28</sup>

Initially, 1,200 patients were assigned to the comprehensive care unit which was staffed by two internists, two public health nurses, one social worker, one aide, and one medical secretary. The team had a separate suite of offices and facilities within the outpatient department building. Patients were seen by their personal physician on an individual appointment basis. Appointment times varied, depending on whether the patient was new or returning for continuing care. Walk-in patients without appointments were seen by the public health nurse and, when necessary, by the physician. Appointments for consultations with other specialists were coordinated by the comprehensive care unit. A unit medical record and a family folder was maintained within the comprehensive care unit.<sup>29</sup>

While it was never intended to have a personal physician directly provide 24-hours-a-day, 7-days-a-week coverage, patients had access to continuous service through a relationship which was established with the emergency room at Beth

Israel Hospital. Briefly, this was accomplished through a card file from the comprehensive care unit left in the emergency room each evening and during weekends containing all patients' names, diagnoses, drugs, data of next clinic appointment, and the name of their personal physician. In this manner, the patients were given the security of having a receptive place to call at all times and they could be seen in the emergency room as needed.<sup>30</sup>

As a result of professional and patient satisfaction with the demonstration project, the entire ambulatory care program was scheduled for reorganization into a group of comprehensive care units with concurrent elimination of the traditional general medical clinics. By 1968, four comprehensive care units had been implemented and were taking full responsibility for all adult patients who sought general medical services in the outpatient department. The pediatric service was incorporated into the concept but remained as a separate pediatric care unit within the outpatient department. New patients were referred to either the adult care unit or pediatric clinic for assignment to a primary care physician responsible for their total medical supervision. Self-referral specialty services were offered in obstetrics, psychiatry,

geriatrics, and dentistry; however, a patient entering one of these clinics on his own was encouraged to enroll in a primary care unit. The remaining specialty and subspecialty clinics comprised the consultation service. Referral to these services were made only by a primary care physician or subsequent to a hospital discharge. To avoid fragmentation of care, all patients were referred back to the primary care physician after completion of specialty care. Within the near future, it is planned that all outpatients will receive ambulatory care in comprehensive care units.<sup>31</sup>

Organizationally, a Department of Ambulatory Health Services was created by the trustees of the Beth Israel Medical Center, and a full-time medical director was appointed with rank and authority equal to that of other major clinical department directors. An administrator of the service was appointed to serve under the direct supervision of the medical director with the responsibility for administrative operation of the department. The internal organizational structure of the Department of Ambulatory Health Services of Beth Israel Hospital is shown in Appendix A.<sup>32</sup>

Dr. Leslie J. Sandlow, Director of Ambulatory Care,

Michael Reese Hospital and Medical Center, writing in Hospital Topics, describes the ambulatory services at that institution prior to reorganization as follows:

. . . clinics were generally single-disease-entity clinics. If a person were unfortunate enough to have more than one physical problem, he could spend an entire week running from one clinic to another. Not only did a patient spend much time at the clinic, but the care was fragmented and impersonal. No one physician was responsible for coordinating the overall care for the patient.<sup>33</sup>

In 1968, Dr. Sandlow reorganized the outpatient clinics under the administrator for ambulatory care who was responsible for the physical facilities and the general operation of the service. A physician was appointed as director of ambulatory care for each major clinical department with the responsibility to coordinate the comprehensive care program. The directors were formed into an ambulatory care committee to formulate new programs and policies of care. The goals of the committee were: (1) to develop programs which would be people-oriented rather than disease-oriented, and (2) to provide comprehensive care to as many patients as possible.<sup>34</sup>

Continuity of care was achieved by assigning medical residents to the clinics throughout their full residency period. Each resident would devote two or three afternoons a week to the clinic caring for patients who were assigned

specifically to him. In addition to specific clinic hours set aside for appointments with his personal patients, the physician was responsible for the comprehensive care of the patient at all times. When unavailable, the physician had to designate another physician to take care of the patient. If the patient needed to be admitted to the hospital, the resident remained his medical counsel during the period of hospitalization and again assumed the care in the clinic upon discharge. This was equally the case when consultations or specialized treatment in other clinics were required. Success in the program was measured subjectively by increased patient and provider satisfaction and objectively by a 10 per cent decrease in the appointment no-show rate.<sup>35</sup>

A current popular innovation is to incorporate ambulatory patient care services within family practice units. Dr. Gordon M. Kerr, writing in Canadian Hospital on organizational and structural concepts being incorporated into the ambulatory care facility of the new Mount Sinai Hospital in Toronto, describes how the traditional outpatient department was eliminated in favor of a comprehensive ambulatory patient care system. The nucleus of the system is separate and self-contained family practice units which provide

complete care to all members of the families who enroll with the unit. The units are staffed with generalists, internists, and pediatricians; ancillary medical paraprofessionals; and administrative support personnel. The family practice units have available, on the same floors, consultative and specialized treatment capability. An important aspect of the new organization is its utilization by the Toronto College of Medicine as a major teaching facility for ambulatory care.<sup>36</sup>

At the Milton S. Hershey Medical Center Hospital in Hershey, Pennsylvania, a family practice ambulatory care unit is employed to provide comprehensive, primary family health care to enrollees from the local community. Organized within the Department of Family and Community Medicine and consisting of six physicians with supporting personnel, the unit provides care to approximately ten thousand patients. The physicians in the group are divided into two groups of three members each, with each group collectively sharing responsibility for enrolled families. Patients are seen by appointment Monday through Saturday, and three evenings a week. An on-call system has been established for off-hour emergencies. Unit medical records are maintained within the group on a

family basis. In addition to the medical care aspects, the unit is heavily committed to family medicine education for medical students and residents. As additional family practitioners become available, the concept will incrementally expand to take in new segments of the population still without a primary physician.<sup>37</sup>

### Summary

In summarizing the literature review, several trends have emerged within the past decade which call for changes in the traditional methods of delivering ambulatory care.

These trends include:

1. A rapidly advancing biomedical technology.
2. An increase in the number of specialists and a decrease in generalists.
3. A maldistribution of physicians, particularly in the intercity and rural areas.
4. Paradoxically, the increasing use of hospital emergency facilities as sources of primary care, while at the same time an increasing dissatisfaction by both providers and recipients of the care being dispensed in those facilities.
5. The disappearance of the tradition of free care and free time provided by clinic physicians as government and

other third-party sources increasingly provide funds for the payment of medical services.

6. Increasing criticism of the episodic, fragmented, disease-oriented care rendered by many traditional outpatient departments which is the antithesis of personalized, continuous, and comprehensive care.

7. Increasing recognition by third-party payers that inclusion of ambulatory care benefits in a health insurance program reduces overall hospitalization insurance costs because it discourages overhospitalization secondary to financial considerations.<sup>38</sup>

The numerous approaches and model programs for the delivery of comprehensive family-center health care suggested by the literature to correct the deficiencies and capitalize on the previously mentioned trends, contain certain common concepts and techniques which, if adopted, have generally improved the delivery of ambulatory care. No attempt is made to consider all the possible methods of organizing ambulatory care; rather, only those methods pertinent to a large, hospital-based outpatient department are emphasized within the limitations of this study. A summarization of the more successful concepts which have been employed by model programs for the

improvement of ambulatory care delivery are included in the following paragraphs.

The purpose, philosophy, and goals of the health care institution and the scope of its services should be clearly defined. The purpose of an ambulatory care program should: (1) include specific goals which relate and are accessible to the needs of the service community; (2) be consistent with the overall philosophy of the institution; (3) be recognized and accepted by the community as compatible with its expectations for health care; (4) be explicit as to the type of care to be provided and in what manner; (5) be integrative with other services of the institution; and (6) be based on sound, long-range, comprehensive planning which recognizes and clearly defines the target population.<sup>39</sup>

The scope of the services and the staffing for the services should strive to eliminate episodic care and stress a personalized, comprehensive type of care. Family members should be assigned to the same primary care practitioner on an on-going basis for the purpose of continuity of health services. Patients return to the primary care practitioner after receiving specialized care. An adjunct to this method is to establish small primary care units, with each unit

designed to provide comprehensive care to a segment of the service population. This implies the use of a team concept in the provision of ambulatory care. The team may vary in composition and application and may include any combination of physicians, nurses, nurse practitioners, physicians' assistants, social workers, and other allied and community health workers.

Ambulatory care service in a hospital-based program should be organized under a department of ambulatory care or comparable organization headed by a full-time chief of service who has equal status and authority with other chiefs of hospital services. The department of ambulatory care should include emergency services, general and specialty outpatient clinics, employee health services, home care services, and related services as are applicable. The department should be staffed by enough paid, full-time physicians to insure stability to the continuous and comprehensive nature of the program. The full-time staff can be supplemented by a part time staff and other physicians in a training capacity. Those eligible and qualified should be allowed inpatient duties and sufficient time off for inservice educational activities.

Physical facilities should complement the organizational

goals and structure and should strive to eliminate the traditional congested, crowded, and dehumanizing waiting areas that currently exist in many institutions. The patient's comfort and mental well-being should be considered in the design of ambulatory care facilities.

A patient appointment system which minimizes patient waiting time and increases productivity of provider personnel is mandatory. Scheduled appointments are generally preferred to a block appointment system. Walk-in patients can be handled by nonappointment committed physicians after screening by paramedical personnel who either treat, triage for immediate physician care, or refer for a later appointment into the primary care system. A unit medical record system utilizing the problem-oriented medical record appears to be the preferred method of medical record keeping.

Other factors to be considered in a comprehensive ambulatory care program include but are not limited to: (1) an internal quality control and evaluation mechanism; (2) a data feedback and medical information system; (3) continuing education programs; (4) community relations; and (5) methods for financing ambulatory care.<sup>40</sup> These are broad areas of study in themselves and are beyond the scope of this thesis.

### Footnotes

<sup>1</sup>Marie B. Rhyne and Israel L. Prais, "Patterns of Medical Care: Comprehensive Care vs. Categorical Disease Programs," Medical Care, X (January-February, 1972), 1.

<sup>2</sup>Jefferson J. Vorzimer and Gerald Katz, "Toward Comprehensive Ambulatory Care: A Case History of Decisive Change," Medical Care, VIII (January-February, 1970), 76-81.

<sup>3</sup>Medical Care Chart Book (Ann Arbor: Bureau of Public Health Economics, School of Public Health, University of Michigan, 1962), p. 162.

<sup>4</sup>Ibid., p. 1630

<sup>5</sup>American Hospital Association, Outpatient Health Care, Report and Recommendations of a Conference on Hospital Outpatient Care (Chicago: American Hospital Association, 1969), p. 34.

<sup>6</sup>Gordon A. Friesen and Richard R. Downs, "Don't Let Your Emergency Room Become an Accident Case," Hospital Management, CXI (April, 1971), 1.

<sup>7</sup>Rhyne and Prais, pp. 1-7.

<sup>8</sup>Vorzimer and Katz, pp. 76-77.

<sup>9</sup>Harris County Hospital District, Houston, Texas, "Harris County Hospital District," 1974, pp. 1-3. (Mimeographed.)

<sup>10</sup>Harris County Hospital District, Houston, Texas, "Outpatient Visit Comparison, 1966-1974," December 31, 1974, pp. 108. (Mimeographed Report.)

<sup>11</sup>American Academy of General Practice, Organization and Management of Family Practice (Kansas City, Mo.: American Academy of General Practice, 1970), pp. 1-8.

<sup>12</sup>Harris County Hospital District, "Outpatient Visit Comparison, 1966-1974," pp. 1-8.

<sup>13</sup>Harris County Hospital District, Outpatient Clinic Procedure Manual (Houston: Harris County Hospital District, 1974), p. 1.

<sup>14</sup>Harris County Hospital District, Patient Information Manual (Cleveland: Hospital Publications, Inc., 1972), p. 2.

<sup>15</sup>Leslie J. Sandlow, "Changing from Specialty Clinics to Comprehensive Care Units," Hospital Topics, XLIX (November, 1971), 55-56.

<sup>16</sup>Interview with Phil Davis, MD, Director of Outpatient Medical Clinics, Ben Taub General Hospital, Houston, Texas, March 3, 1975.

<sup>17</sup>Report to the Governor and Board of Regents for New York State, Education for the Health Professions: A Comprehensive Plan for Comprehensive Care to Meet New York's Need in an Age of Change (Albany, N.Y.: Committee on Medical Education, 1963), p. 9.

<sup>18</sup>Benjamin Wainfield, "Outpatient Services," Hospitals, XLVI (April, 1972), 148.

<sup>19</sup>Anne R. Somers, "What Price Comprehensive Care?" Archives of Environmental Health, XVII (July, 1968), 6-20.

<sup>20</sup>American Hospital Association, Reshaping Ambulatory Care Programs (Chicago: American Hospital Association, 1973), p. 3.

<sup>21</sup>John E. Deitrick, "Organization of Outpatient Departments," Journal of Medical Education, XLI (July, 1966), 710-11.

<sup>22</sup>American Hospital Association, Reshaping, p. 7.

<sup>23</sup>Herbert Freilich, "A Guide to Improve Ambulatory Care Service," Hospital Management, CVII (March, 1969), 52-55.

<sup>24</sup>George A. Silver, Martin Cherkasky, and Joseph Axelrod, "An Experience with Group Practice," New England Journal of Medicine, CCLVI (April 25, 1957), 785-91.

<sup>25</sup>Count D. Gibson, "The Neighborhood Health Center: The Primary Unit of Health Care," American Journal of Public Health, LVIII (July, 1968), 1188-91.

<sup>26</sup>H. J. Brown and R. S. Alexander, "Gouverneur Ambulatory Care Unit, A New Approach to Ambulatory Care," American Journal of Public Health, LIV (October, 1964), 1661-65.

<sup>27</sup>Jerome S. Beloff and Richard E. Weinerman, "Yale Studies in Family Health Care I," Journal of the American Medical Association, CXCIX (February 6, 1967), 383-89.

<sup>28</sup>Vorzimer and Katz, p. 77.

<sup>29</sup>Ibid., p. 78.

<sup>30</sup>Ibid., p. 79.

<sup>31</sup>Ibid., p. 80.

<sup>32</sup>American Hospital Association, Reshaping, p. 35.

<sup>33</sup>Sandlow, p. 55.

<sup>34</sup>Ibid.

<sup>35</sup>Ibid., p. 56.

<sup>36</sup>Gordon M. Kerr, "A New Concept in Ambulatory Care," Canadian Hospital, XLIX (April, 1972), 54-61.

<sup>37</sup>American Hospital Association, Reshaping, pp. 54-55.

<sup>38</sup>Ibid., pp. 9-10.

<sup>39</sup>Ibid., pp. 15-18.

<sup>40</sup>Ibid., pp. 15-26.

## CHAPTER II

### DISCUSSION

#### Introduction

A recommendation that the community hospital become the focal point for a new system of community health care because it possesses more of the capabilities required for the development of a new health care system appeared in the 1968, Report of the Secretary's Advisory Committee on Hospital Effectiveness.<sup>1</sup> In attempting to define this new role of the community hospital as the focal point for community health programs, Somers concluded that the majority of community health services could be best provided within the hospital walls.<sup>2</sup> Within the context of these concepts, 300,000 residents of Harris County consider Ben Taub Hospital their community hospital and turn to it for health services.

The type of care optimally to be provided to the patients of Ben Taub Hospital should: (1) be available to all eligible residents of Harris County; (2) be accessible without financial barriers; (3) be acceptable to recipients and providers of care; and (4) insure continuity and comprehensiveness in scope.

Against this background, the current organizational structure and operations of the outpatient clinics of Ben Taub Hospital will be examined. Next, the feasibility of establishing a primary care physician system within the clinics will be evaluated. Finally, an alternative approach to the solution of the problem will be presented.

### Current Organizational Structure and Staffing of the Clinics

#### Organizational Objectives

The objectives for the outpatient clinics, Ben Taub Hospital, are as follows:

1. Insure that competent medical attention is available within the hospital district of Harris County.
2. Provide a clinic service which is of value in caring for the sick.
3. Provide the physical facilities, equipment, services, and qualified personnel to assist the physician in his practice of medicine in the clinics.
4. Develop the clinic services to insure maximum utilization of facilities in accordance with the ever-changing concepts of medical care.
5. Interpret to patients and members of the community

the purpose, goals, and responsibilities of the Ben Taub Hospital outpatient services.

6. Provide the highest attainable standards of ambulatory care at a reasonable cost to the patient.

7. Provide the employees of the clinics job satisfaction, opportunities, and benefits which they can reasonably expect from their association with the hospital.<sup>3</sup>

#### Organizational structure

The formal organizational charts for the Harris County Hospital District, Ben Taub General Hospital, and the Medical Staff of Ben Taub Hospital are shown in Appendixes B, C, and D. The current administrative organization of the outpatient clinics is shown in Appendix E. The outpatient clinics consist of sixty-two general and specialty clinics providing ambulatory patient care for virtually all phases of medicine, pediatrics, psychiatry, and surgery to a target population of approximately 300,000 resident of Harris County.<sup>4</sup> The clinics occupy four floors in one wing of the hospital adjacent to the corresponding inpatient services. The clinics are "teaching clinics" in that all patients are available for teaching purposes for medical students and residents.

Appendix F provides selected, representative work

load data for January, 1975. The clinics receive an average of 22,000 patients a month, or about twelve hundred patients a day. Of this total, approximately 25 per cent are new patients. The emergency center receives on the average 7,500 patients a month, or about 250 patients a day. The work load statistics of the clinics are exclusive of the statistics of the emergency center.<sup>5</sup>

Administratively, the clinics are under the supervision of an assistant administrator who is also responsible for other services as shown in Appendix C. Directly under the assistant administrator is the director and assistant director for the clinics who are responsible for the control and daily professional support operations. The three positions are staffed by health care administrative and nursing personnel. The Outpatient and Emergency Room Committee of the Medical Staff, chaired currently by the Deputy Chief of General Surgery Service and consisting of physician and administrative representatives from the major clinical services, directs the professional and policy-making activities.<sup>6</sup>

The emergency center, an additional line responsibility of the assistant administrator for outpatient clinics, is an organizationally separate activity under the administrative

supervision of the Director of the Emergency Center and the medical supervision of the Director of Emergency Services, a branch of the General Surgery Service. The emergency center is located adjacent to the outpatient clinics and functionally shares professional physician staff and some facilities.<sup>7</sup>

### Staffing

The professional staffing of the clinics, as well as the inpatient hospital services, is through an affiliation agreement with the Baylor College of Medicine which has contracted to be the exclusive medical staffing body for the medical facilities of the entire hospital district. The general and specialty clinics are staffed by paid and volunteer visiting staff, house officers, clinical fellows, and medical students. Their lines of authority are vertical ones to their respective specialty chiefs.

The Director of Outpatient Clinics has the overall staffing supervision for the nursing services within the clinics. Each clinic is managed by a registered nurse or licensed vocational nurse and a unit clerk. They are responsible for the proper handling of clinic procedures, patient care, supplies, and operational problems. Nursing staffing may vary widely within the separate clinics, depending upon

multiple factors. Social services are available in every clinic.<sup>8</sup>

### Current Operating Procedures of the Clinics

#### Clinic eligibility and Admission Procedures

Eligibility for care within the hospital is determined according to means and place of residence. The clinics of Ben Taub Hospital are primarily for those who cannot afford the cost of private care. As an exception to this, the hospital functions as a category I emergency facility for Harris County and accepts all patients who have emergency needs. All patients, as their condition permits, must be interviewed upon initial application to assure their eligibility for tax-supported services and to determine the reasonable charges, if any, they will be expected to pay. Once eligibility has been determined, patients are issued a hospital identification card which will be utilized to identify all documents relating to their care and administration.

The clinics operate basically on a pay-as-you-go system. Patients, other than those on full third-party support, are expected to pay in advance for each visit; the percentage they pay is determined by their financial rating

category. All patients go to the cashier to pay, or to be charged for their visit in advance of their medical services. The cashier issues a receipt as evidence of payment or charge. The patient produces this receipt, his appointment slip, and his identification plate when he arrives at the appointed clinic area for treatment. Ancillary service charges, adjusted according to patient financial rating, are postcharged. Charges can be paid immediately or the patient can be billed by the Data Processing Service. No necessary service is withheld for financial reasons, and patients troubled by costs and accumulated medical care bills are referred to the Social Services Department who make financial adjustment as circumstances warrant with the business office. Public assistance patient charges are billed to the responsible agency.<sup>9</sup>

#### Medical records

The hospital utilizes a unit medical-record system keyed to the patient's registration number. The medical record contains the entire history of the patient, which includes inpatient and outpatient clinical records, administrative data, and financial documents. A problem-oriented approach to the internal organization of the medical record has been in effect for several years, and the majority of

records are in a transition state from a source to a problem-oriented presentation of medical data. The extent of the use and application of the problem-oriented approach varies between the respective clinical services.

Medical records are the responsibility of the Medical Records Department and internal control of the medical record is in accordance with the standards of the Joint Commission on Accreditation of Hospitals. Medical records are furnished to the respective clinics by personal pickup or through an elevator or pneumatic conveyer system based upon prior coordinated appointment schedules. Records for walk-in patients can be retrieved and delivered to the clinics, usually within thirty to sixty minutes after request. In emergency situations, the record is available within a few minutes. At the end of the normal working day, medical records from the clinics are returned to the Medical Records Department.<sup>10</sup>

#### Appointment procedures and patient disposition

Appointment schemes vary from clinic to clinic, from highly specific time assignments for each patient, to block appointments irrespective of the size of the case load. Appointments are generally controlled by the respective

clinics and coordinated for record and accounting purposes by the clinic appointment office. Appointments can be acquired in several ways:

1. A patient may walk in and request an appointment from the screening nurse. Whether or not the patient is seen on that day depends on the case load and the appointment system of the particular clinic. Clinics in general surgery, psychiatry, pediatrics, and general medicine are essentially walk-in clinics with appointments on the same day scheduled for the purpose of administrative and financial accounting.

2. A patient may telephone the clinic to which he has been referred, has been seen in the past, or would like to be seen.

3. A patient may telephone the clinic appointment office which may refer the call to the appropriate clinic or may give the patient an appointment directly based on prior authorization of block times for specific clinics. This is the closest relationship to a centralized system. The clinic appointment office functions as a central coordinating office for purposes of medical record control, distribution, and administrative flow. The system could best be described as a retrospective, partially centralized system based upon a

functionally decentralized concept.

4. Upon discharge from an inpatient service, a follow-up appointment can be made by ward personnel to the respective clinic.

5. Patients may be appointed from clinic to clinic for the purpose of referral and consultation.

6. Patients may be referred from the emergency center to clinics for follow-up care. An appointment is issued with or without prior clinic clearance depending on the time of day.<sup>11</sup>

In view of the facts that: (1) 1,200 patients a day are seen in the clinics; (2) a 30 to 35 per cent no-show appointment rate exists; (3) about 50 per cent of all patients are walk-in; and (4) about 25 per cent of mailed appointment slips are undeliverable, one would have to conclude that the present system is a good compromise as a reasonably effective appointment system.<sup>12</sup>

Having obtained an appointment, the patient presents his appointment slip and cashier's receipt at the clinic desk to the clerk. The clerk checks the slip for validation by the cashier and invites the patient to be seated. The appointment slip is checked, matched to the patient's unit record,

and the record is placed for pick-up by the nurse. In most clinics, patients are called by the nurse, placed directly outside the examining room, or escorted into the clinic area where nursing service personnel carry out preliminary procedures prior to the physician's examination.

Upon conclusion of the visit with the physician, the patient may emerge with ancillary service requisitions, future appointment requests, or directions for inpatient admission to the hospital. The clinic clerk: (1) reviews the record entry and requisitions, (2) arranges for appointments, (3) provides instructions for ancillary services, and (4) arranges for escorting the patient to the inpatient admission office as is appropriate to the case. Upon completion of a routine clinic visit, the unit record is returned to the Medical Records Department.<sup>13</sup>

#### Walk-in patient procedures

A walk-in patient to the clinics is screened by an experienced "triage nurse" who determines the patient's problem and refers him to the appropriate clinic.<sup>14</sup> Walk-in problems relating to the specialty of general medicine are referred by the "triage nurse" to the Admitting Clinic. The Admitting Clinic is a general, acute-illness screening clinic under the

supervision of the General Medical Service operating daily from 7:00 A.M. to 10:00 P.M.<sup>15</sup> The Admitting Clinic is staffed by one staff physician and three to four medical house officers. Acute episodic care is provided and the patient can be referred to either the General Medical Clinic or to the subspecialty clinics for long term following or specific evaluation as is appropriate.

An attempt is made at this point to provide a degree of continuity of care by having the patient followed in the General Medical Clinic by a specific house officer who will be remaining within the Department of Medicine for a reasonable period of time. The degree of continuity of care is handicapped by the frequent rotational schedules of the house officers which moves them into the subspecialty areas and limits the time available to return to the General Medical Clinic to follow "their patients."<sup>16</sup>

Patients presenting themselves to the emergency center are similarly screened within that facility by an experienced nurse for either immediate care for an emergency condition, delayed care for an acute episodic condition, or are referred to the Admitting Clinic during the hours of 7:00 A.M. to 10:00 P.M. After these hours, walk-in patients are treated

in the emergency center for all conditions.<sup>17</sup>

### Summary

Summarizing the current organizational structure and operations of the outpatient clinics, the major disadvantages include parallel organizational structures, multiple professional lines of authority, limitations of personnel and facilities, extremely heavy work loads, congested clinic waiting areas, and some difficulty of patient entry into the system. All of these problems contribute to a fragmented and depersonalized approach to care which was described by Dr. Leonard S. Rosenfeld as follows:

The highly fragmented clinic structures of the outpatient departments of many hospitals, together with the all too frequent lack of assignment of the clinic outpatient to one physician for ongoing surveillance, tends to promote a fragmented and depersonalized approach to care which can be extremely frustrating to the patient.<sup>18</sup>

Fragmented clinic structures such as this reflect a high degree of medical specialization. The vertical organizational structure of the hospital's medical staff is also difficult to change. In a comprehensive study conducted by the University of California's School of Public Health, hospitals surveyed indicated that the majority of patients came to the central outpatient department for their basic primary health services; yet, the average number of separate clinics among

these hospitals varied from 58 to 127.<sup>19</sup>

### Feasibility of Establishing the System

#### General

The feasibility of establishing a primary care physician system in the clinics of Ben Taub Hospital is dependent upon multiple factors which have been addressed peripherally in preceding sections of this thesis. The more significant and relevant factors impinging upon the feasibility will be further discussed in this section.

#### Delineation of the goal

The extent and limits of the feasibility must be clearly defined. With a service population in excess of 300,000 people making twelve hundred clinic visits a day, it is virtually impossible to implement a system providing total comprehensive care to all patients. This assumes that all patients desire it, are in need of it, and are acceptable to the practitioners; assumptions which, in themselves, are fallacious. A lesser number than total patient enrollment would realistically have to be accepted. The actual number of total patients who would benefit from a primary care physician system would be dependent upon institutional commitments, capabilities, and resources. Based upon the author's

observations and analysis, fewer than 5 per cent of the total target population could be integrated into such a system within existing resources. Based upon the literature, this is not surprising, as even model programs in the most innovative hospitals have achieved only 8 to 10 per cent enrollment in comprehensive care programs under similar circumstances.<sup>20</sup>

#### Institutional philosophy

The philosophy of the institution, in this case Baylor College of Medicine, is critical to the successful implementation of a primary care physician system. It involves the degree of institutional commitment to the concepts of family-centered comprehensive health care. Freilich points out that the establishment of similar programs in other hospitals has not been successful until the board of trustees or related policy-making bodies have been committed to the concept. As a corollary, a viable ambulatory care committee must be established at a high enough level in the organizational hierarchy to exert influence in bringing about desired changes which are consistent with modern concepts of ambulatory care delivery.<sup>21</sup>

Individual Baylor College of Medicine, historically and traditionally, has been a surgically oriented institution. Its

goals and philosophy, established by its famous surgical founders, has made the institution one of the leading surgical care centers in the world. The commitment to furthering surgical care may be a pre-eminent factor against developing a favorable philosophy toward comprehensive ambulatory care. Dr. John Deitrick of Cornell University Medical College characterized outpatient clinics very well when he called them the step-children of the hospital, serving in a subordinate position as screening services to provide the most interesting Patients for the ward services.<sup>22</sup> This comment, to a large extent, applies to the clinics of Ben Taub Hospital and their relationship to the surgical inpatient service.

This can be argued as being desirable, for undoubtedly there is a role in medical education for schools with a strong orientation and commitment to predominately one branch of medical care. However, until an institution develops a philosophy of, and a commitment to, the concept of primary family-centered comprehensive health care, individual efforts of lower organizational elements to implement such a program will at best be a token effort and most likely doomed to failure.

#### Individual physician philosophy

Physicians in training within such an institution will

similarly have varying loyalties to a general versus a specialty approach to the practice of medicine. Specialty-oriented institutions tend to attract interns and residents, based upon the prestige and strength of that specialty. Potential house officers gravitate to such an institution to develop skills in very highly specialized areas of medicine to the exclusion of general, broader training. Many physicians within highly specialized training programs will have little interest in diseases, organs, or systems which do not fit the criteria of their pursued specialty.

#### Organization

The organizational structure for the delivery of ambulatory services is vital to the implementation of a primary care physician system. A universal recommendation from the experiences of other hospitals in implementing similar programs involves the reorganization of clinic services into a department of ambulatory care. The chief or director of the newly created service is granted status and authority equal to that of the chief of any of the other specialty services. As a part of this reorganization, emergency services, specialty clinics, and general clinics are brought under the supervision of a single individual who has the authority to

command resources and to extract responsibility directly from those within the department.<sup>23</sup> Only in this manner can the director establish policy and allocate resources to benefit from certain economies of scale, quality, and system.

Current organization for the delivery of ambulatory care at Ben Taub Hospital is basically an administrative structure designed to facilitate the support functions of the system. Functionally, two separate organizations exist: the emergency center and the outpatient clinics, both under the supervision of separate nursing directors and joined in the organizational hierarchy to an assistant administrator. Professionally, the activities are supervised by the Outpatient and Emergency Room Committee, chaired by the Deputy Chief of General Surgery Service and consisting of the Assistant Chiefs for Outpatient Services from the respective clinical specialties. The emergency center is under the personal supervision of the chairman of the above committee, operating under the title of the Director of Emergency Services. The nearest parallel counterpart within the outpatient clinics is the Director of Outpatient Medical Clinics who is responsible for the ambulatory care of patients with diseases relating to the specialty of internal medicine. The Director of Outpatient

Medical Clinics is one step removed from the Chief of the Medical Service and two steps removed from the Chairman of the Department of Medicine, Baylor College of Medicine.

The feasibility of successfully establishing any level of a primary physician system must take these organizational relationships into consideration. Successful implementation will be determined by clear organizational lines of authority and responsibility with loyalty to a central authority figure instead of vertical loyalty to the chiefs of multiple specialty services.

#### Personnel

Within the existing staffing of nursing and administrative support personnel for the clinics, establishment of any program, other than a token program is not feasible. A program of the type desired by Ben Taub Hospital requires a health team of from three to five people, exclusive of physicians, to support one thousand to fifteen hundred enrolled patients.<sup>24</sup> This does not consider general support personnel. Obtaining this level of personnel staffing is not currently realistic nor will it be in the future for Ben Taub Hospital. The detailed staffing required for various levels of patients enrolled should be further studied prior to implementing a

primary care physician system.

With respect to physician staffing, institutions which have implemented the concept, staff at a level of one full-time physician per eight hundred to fifteen hundred enrolled patients.<sup>25</sup> Vorzimer and Katz, from their experiences at Beth Israel Hospital, New York, found that ten to fifteen patients a week, who were enrolled in their comprehensive care program, could be seen by the team's public health nurse alone.<sup>26</sup> In situations where house staff officers are utilized to provide this service, splitting their time with inpatient duties, the number of patients which can be provided comprehensive care ranges significantly less at two hundred to four hundred enrolled patients per physician.<sup>27</sup>

The question of physician staffing involves one of the productivity and utilization of physician time, which becomes even more complex in an educational setting. Based upon observations within the clinics of Ben Taub Hospital, it would appear that greater physician and ancillary personnel productivity might be realized in several specialty clinics. Further study of personnel utilization and productivity would be required prior to establishing a primary care physician system.

the physician is apt to be more conservative in his referral

## Facilities

The outpatient clinics at Ben Taub Hospital, like those of Michael Reese Hospital in Chicago, are primarily single, disease-oriented specialty clinics. No one physician assumes overall responsibility for the patient's well-being and coordinates the various procedures, medications, or plan of treatment. As a result, the continuity of care for a patient is lost when, depending upon a particular ailment, a different physician becomes responsible for care. A common technique in other programs has been the deliberate reduction of subspecialty clinics in favor of general clinics in the basic specialties of medicine, pediatrics, and surgery.<sup>28</sup> Vorzimer and Katz observed a significant reduction of patients in medical subspecialty clinics who were being followed in the comprehensive care program for on-going care. The cardiac clinic alone experienced over a 30 per cent reduction in visits. They attributed this to the observation that when a patient is referred to a specialty clinic from an acute episodic screening clinic, the patient invariably gets a maximum evaluation irrespective of the extent of his problem. If the patient is known to a physician in a comprehensive system, the physician is apt to be more conservative in his referral

pattern.<sup>29</sup>

Within the Ben Taub Hospital clinics, waiting areas are continually congested from 6:00 A.M. until 6:00 P.M. The first floor waiting area and the pediatric clinic waiting areas are congested until 11:00 P.M. The general clinics in medicine, surgery, and pediatrics are utilized to the maximum extent possible throughout the daily working hours. Space utilization of some of the subspecialty clinic areas is related to the period of the clinics and remains available as potentially utilizable space during nonclinic hours. As some clinics are scheduled only several days a week, a fair amount of additional space could theoretically be shared by compatible services.

From strictly a facility and space aspect, the establishment of a limited comprehensive primary care physician system appears feasible. Overall clinic space appears adequate but would require a sharing of facilities and close scheduling coordination between the various general and subspecialty services. Further detailed study of space utilization requirements and scheduling coordination would be mandatory before a primary physician system could be established.

### Patient control

Patient control within a primary physician system would be essential. This would involve identification of all patients enrolled in the program, identification of the patient with a personal physician, the utilization of a problem-oriented unit medical record, and a means to provide continuity of care after routine clinic hours. Schemes have been developed to control these factors and methods described by Vorzimer, Katz, and Sandlow are notable models.<sup>30</sup>

Ben Taub Hospital employs a unit medical record system and the problem-oriented approach is utilized exclusively by the Department of Medicine and, to a lesser extent, by the other services. This type of record forms the core of, and facilitates, a comprehensive, primary care physician system. From the standpoint of the medical record, the establishment of a primary physician system is feasible.

### Summary

Summarizing the feasibility of establishing a primary care consultant physician system, one must consider: (1) a clear definition of the goals; (2) institutional and individual philosophy and commitment to the concept; (3) organizational structure; (4) personnel and facility limitations; and

(5) elements of patient control. the clinics of Ben Taub

Hospital is comparatively a model system. In spite of its

heavy patient load and Methods for Resolving  
the Problem there is effective

General client patient movement and disposition. A large

measure Methods for resolving the problem must satisfy the criteria and limitations established for the study, and, at the same time, take advantage of the particular strengths of Ben Taub Hospital. As a variety of factors affect each of the possible methods for resolving the problem, the resulting best method becomes a complex mixture of the strengths of various approaches. No single, all inclusive, best method can be developed at this time, but the realistic approach will contain features of all considerations and will be a spectrum of the application of methods to resolve the problem based upon existing resource levels. limited program enroll-

Method one an 10 per cent of the target population would re-

quire a Method one is to make no changes and to continue with the present system of ambulatory care delivery. Based upon the author's personal observations and experiences with similar institutions such as Detroit Medical Center, Detroit Receiving Hospital, Wayne County General Hospital, San Francisco General Hospital, and Los Angeles County Hospital,

the organization and operation of the clinics of Ben Taub Hospital is comparatively a model system. In spite of its heavy patient load and limited resources, there is effective and efficient patient movement and disposition. A large measure of this success can be attributed to the hospital's policy of open-clinics and the dedication of the personnel staffing the services.

In view of: (1) the sizable service population; (2) a large daily work load; (3) the institution's philosophy towards medical education; (4) the small number of patients who could be enrolled in such a system; and (5) the resource constraints of a county hospital system in facilities, personnel, and equipment, one would have to conclude that method one is the only realistic, practical, and pragmatic approach to the problem. To establish even a limited program enrolling less than 10 per cent of the target population would require a quantum jump in resources.

The continuation of the present system of outpatient care is an advantage considering the breadth of services offered. The centralization of ambulatory care within the hospital allows easier access by physicians to other physicians for consultations concerning problematic areas of

diagnosis and plans of management. The plethora of specialty services and the extensive diagnostic and therapeutic equipment in the hospital enhances the spectrum of care available to the clinic patient.

Additionally, the advantages of method one are that it: (1) requires no additional commitments of resources; (2) can be accommodated within the existing organization; and (3) operates from a proven base of experience. The current system accomplishes the purpose of providing excellent teaching cases for inpatient services, providing patients a high level of quality care, and being consistent with current organizational philosophy.

The disadvantages of not implementing a primary care physician system concerns the continuity and comprehensiveness of care. Also, the disadvantages are that administrative problems arising from the present system which prompted the study are not resolved. One would have to assume that establishing a new system would resolve the current problems. This is a fallacious assumption and fails to take into the account the probability that another system may create more and different problems.

Method two

Method two is to continue the present system of ambulatory care delivery, but to utilize the General Medical Clinic as the nucleus for establishing a limited, informal, primary care physician program. This approach would build on the strength of the present system, because it appears that only the medical service has the interest and capability to implement even a limited primary care physician system within existing or minimally expanded organizational concepts and resources. Additionally, since some attempts of continuity of care by the medical service has been in progress for a period of time, it appears the General Medical Clinic is the logical area to explore and expand.

Dr. Leslie J. Sandlow, Director of Ambulatory Care, Michael Reese Hospital and Medical Center, achieved continuity of care by assigning medical residents to the clinics throughout their full residency period. Each resident devoted three afternoons a week to the general medical clinic, caring for patients who were assigned specifically to him for the duration of the residency. The physician was responsible for the comprehensive, coordinated care of "their patients" on a 24-hour-a-day, 7-day-a-week basis. If the patient needed to

be admitted to the hospital, the resident remained his medical counsel during the period of hospitalization.<sup>31</sup>

Within the current system at Ben Taub Hospital, patients are channeled into the medical outpatient services from several sources but predominately, initially, from the Admitting Clinic. At this point, the patient could be identified as a potential candidate for enrollment in a comprehensive care program. The medical outpatient services consist of a General Medical Clinic that meets every weekday afternoon from 1:00 P.M. to 5:00 P.M. and eleven medical specialty clinics that meet one morning each week.

All interns assigned to the medical services of Ben Taub Hospital work one afternoon a week in the General Medical Clinic, and all medical residents in the Baylor medical residency program work one afternoon each week in the clinic. Additionally, one staff physician is available in the clinic to consult with the intern or resident, as needed. The subspecialty clinics are staffed only by those interns, residents, and fellows assigned to the particular subspecialty. Fellows do not work in the General Medical Clinic. The assignments to the General Medical Clinic are made by the Director of the Medical Outpatient Clinics and each house officer is

expected to be in the clinic promptly at 1:00 P.M. on his scheduled afternoon irrespective of current service rotation demands.

An attempt is made to restrict the maximum number of patients seen per clinic session by house officers to eight for an intern, and twelve for each resident. Patients being discharged from the medical inpatient service are appointed to return to the clinic on the assigned day of the house officer who cared for them on the ward. Patients being followed in the clinic by a specific house officer are appointed to return on the day the house officer is assigned to the clinic. New patients are assigned at the discretion of the administrative assistant for the clinic.<sup>32</sup>

The Department of Medicine, Baylor College of Medicine presently has enrolled fifty-two interns and residents in general medicine and forty-one fellows in various subspecialties of medicine. The normal training program for general medicine is one year internship and two years residency. Fellowships usually entail two additional years. There is some individual variation in the process. Training is conducted at five major hospitals affiliated with Baylor College of Medicine in the Texas Medical Center, Harris County

Hospital District, and the Veterans Administration Hospital System. Within the hospital, training is further divided between general and specialty services; and inpatient versus outpatient duties.

On a given afternoon in the General Medical Clinics of Ben Taub Hospital, ten to fifteen house officers will be available to see between eighty and one hundred new and returning patients. New patients represent about 10 per cent of the total and are weighted three times as much as an old patient for residency work load scheduling. As mentioned, the house officers staffing the clinic that afternoon come from other hospitals and services, and the coordination required for staffing under these arrangements is a major problem for the Director of Outpatient Medical Clinics. The adage that a man cannot successfully serve two masters is clearly illustrated in the house officers' dilemma between the demands of the clinic director and the demands of the chief of their present rotational service.

At best, the present system can only provide some degree of continuity of care to about 150 patients per physician per year. This is based on ten patient-visit-time units a week for forty-eight weeks and three visits per

patient per year. Assuming fifty house officers available for the program one afternoon a week, only about 7,500 patients a year could be enrolled in a comprehensive care program. This represents 2.5 per cent of the total active medical records of patients maintained in the clinics.

By utilizing and expanding upon the medical clinic nucleus, a limited primary care physician system could theoretically be established for adult patients. If house officers were assigned for additional clinic hours and fellows were brought into the program, a greater number of patients could be enrolled. Presumably the patient load would increase in the general clinic and decrease in the specialty clinics as more patients were diverted from subspecialty clinics and followed by their primary physician in the general clinic. This has been the experience of institutions adopting this method.<sup>33</sup> However, the increase in patients enrolled would not be a linear function of the number of additional physician-clinic-days made available. Diminishing returns would quickly set in without facility and equipment expansion and the addition of nursing and ancillary personnel. Perhaps reallocation of existing resources would be possible, to some extent, as clinic work loads shifted from specialty to general

clinics.

The advantages of this approach would be those related to improved continuity of care under a comprehensive system and would be of primary benefit to patients and house staff who are interested in long-term follow-up and primary care of patients.

The disadvantage is that it is difficult to see any large-scale benefits to the hospital administrator as the number of patients enrolled would be too small to achieve any fiscal or administrative economies of scale. The group of patients enrolled in the program might be happier and complain less, but the presence of a unique, special-interest group might create more administrative problems for the management than would be solved through establishment of a new system.

If method one is unacceptable, method two is considered to be the only realistic approach within the current operating constraints. Applying method two, a primary care physician system could be feasible on a limited scale with only minor modifications to the organizational structure and internal operations of the Department of Medicine, Baylor College of Medicine. At the present time, such

a change does not appear to be acceptable to current residency-training philosophy which emphasizes the practice of specialty medicine.

### Method three

Method three would include major conceptual, organizational, operational, and resource changes and commitments based upon issues raised within the section of this thesis dealing with the feasibility aspects of establishing a primary care physician system. In view of the current realities operating in the Harris County Hospital District and Baylor College of Medicine, implementing any of these approaches is not practical or feasible at the present time or in the immediate future. For example, such theoretical and innovative approaches as: (1) reorganizing the emergency and outpatient services under a chief of ambulatory care; (2) establishing a family practice module within the hospital to function as a comprehensive care unit; (3) infusing a cadre of full-time physicians to staff the General Medical Clinic and serve as the stabilizing influence for a primary care system; or (4) developing a team approach which utilizes an internist, pediatrician, nursing, and administrative support personnel to deliver comprehensive family-centered

primary care are concepts which other institutions have adopted but are not within the resource capabilities of Ben Taub Hospital at the present time.

To explore these approaches any further is beyond the scope of this thesis but could be the starting point for additional studies in the future.

### Summary

Ben Taub General Hospital, a 475-bed, acute-care facility affiliated with Baylor College of Medicine, provides community care to over 300,000 residents of the city of Houston and Harris County, Texas. The outpatient clinics, receiving 22,000 patients a month, consists of sixty-two general and specialty clinics providing ambulatory patient care for virtually all phases of medicine and surgery.

The current organizational structure, staffing, and operation of the clinics, necessary to support a daily influx of twelve hundred patient visits, was examined and analyzed. Major disadvantages included parallel organizational structures, multiple professional lines of authority, limitations of personnel and facilities, extremely heavy work loads, congested clinic waiting areas, and some difficulty of patient entry into the system.

Based upon inherent problems within the present system, the feasibility of establishing a primary care physician system was explored. It was concluded that the establishment of such a system must consider: (1) a clear delineation of the goals; (2) institutional and individual philosophy consistent with the concept; (3) organizational structure; (4) personnel and facility limitations; and (5) elements of patient control.

In considering approaches to the solution of the problem, three methods were provided. The first method was to continue the present system of ambulatory care delivery. The major advantages of the current system were that it was in existence, was functional, and operated from a proven base of experience. The primary disadvantage of method one was that it did not resolve the continuity of care issue nor the administrative problems of the present system.

Method two was to continue the present system, but to utilize the General Medical Clinic as the nucleus for establishing a limited, informal, primary care physician system. The advantages were those related to improved continuity of care for patients and physicians associated with the program. The major disadvantage was that the number of patients

which could be enrolled into such a program would be too small to achieve any fiscal or administrative economies of scale.

Method three, an idealized conceptual model taken from the literature, was considered to be an impractical and unfeasible approach at the present time in view of the current realities operating within the Harris County Hospital District and Baylor College of Medicine.

#### Footnotes

<sup>1</sup>Report of the Secretary's Advisory Committee on Hospital Effectiveness (Washington, D.C.: Government Printing Office, 1968), p. 33.

<sup>2</sup>Anne R. Somers, Health Care in Transition: Directions for the Future (Chicago: Hospital Research and Educational Trust, 1971), p. 101.

<sup>3</sup>Harris County Hospital District, Outpatient Clinic Procedure Manual, p. ii.

<sup>4</sup>Interview with Richard Giles, Administrative Director, Medical Records, Ben Taub General Hospital, Houston, Texas, March 5, 1975.

<sup>5</sup>Harris County Hospital District, Houston, Texas, "Patient Services Summary, January, 1975," Houston, January 31, 1975. (Mimeographed Report.)

<sup>6</sup>Harris County Hospital District, Medical Staff Roster: Harris County Hospital District (Houston: Harris County Hospital District, 1974), p. 6.

<sup>7</sup>Harris County Hospital District, Emergency Center Policy Manual (Houston: Harris County Hospital District, 1974), p. 1.

<sup>8</sup>Interview with Mary Benkoski, RN, Director, Outpatient Clinics, Ben Taub General Hospital, Houston, Texas, March 4, 1975.

<sup>9</sup>Harris County Hospital District, Outpatient Clinic Procedure Manual, pp. 1-2.

<sup>10</sup>Harris County Hospital District, Hospital District Policy Manual (Houston: Harris County Hospital District, 1971), p. M-5.

<sup>11</sup>Harris County Hospital District, Outpatient Clinic Procedure Manual, pp. 4-5.

<sup>12</sup>This opinion was derived from the following people: interview with N. J. Vaughn, Administrator, Harris County Hospital District, Houston, Texas, March 3, 1975; interview with Dan Alderman, Associate Administrator, Ben Taub General Hospital, Houston, Texas, March 3, 1975; interview with Don Archer, Assistant Administrator, Ben Taub General Hospital, Houston, Texas, March 4, 1975; Benkowski interview; Davis interview.

<sup>13</sup>Harris County Hospital District, Outpatient Clinic Procedure Manual, pp. 7-8.

<sup>14</sup>Interview with Mrs. Edna Pearson, RN, Director, Screening Clinic, Ben Taub General Hospital, Houston, Texas, March 3, 1975.

<sup>15</sup>Harris County Hospital District, Outpatient Department Clinics' Schedules (Houston: Harris County Hospital District, 1974), p. 3.

<sup>16</sup>Davis interview, March 3, 1975.

<sup>17</sup>Interview with Alan MacDonald, Administrative Coordinator, Ben Taub General Hospital, Houston, Texas, March 4, 1975.

<sup>18</sup>Leonard S. Rosenfeld, Ambulatory Care: Planning and Organization (New York: Health and Hospital Planning Council of Southern New York, Inc., February, 1971), p. 32.

- <sup>19</sup>Ibid., p. 34.
- <sup>20</sup>Vorzimer and Katz, pp. 76-81.
- <sup>21</sup>Freilich, pp. 52-55.
- <sup>22</sup>Deitrick, pp. 710-11.
- <sup>23</sup>American Hospital Association, Reshaping, p. 7.
- <sup>24</sup>Gibson, p. 1188; Silver, Cherkasky, and Axelrod, pp. 785-91.
- <sup>25</sup>American Hospital Association, Reshaping, p. 54.
- <sup>26</sup>Vorzimer and Katz, pp. 76-81.
- <sup>27</sup>Beloff and Weinerman, pp. 383-89.
- <sup>28</sup>Brown and Alexander, pp. 1661-65.
- <sup>29</sup>Vorzimer and Katz, pp. 76-81.
- <sup>30</sup>Sandlow, pp. 55-56; Vorzimer and Katz, pp. 76-81.
- <sup>31</sup>Sandlow, pp. 55-56.
- <sup>32</sup>Harris County Hospital District, Medical Housestaff Manual (Houston: Harris County Hospital District, 1974), p. 4.
- <sup>33</sup>American Hospital Association, Reshaping, pp. 29-55.

## CHAPTER III

### CONCLUSIONS AND RECOMMENDATIONS

#### Conclusions

It is concluded that:

1. Based upon a consideration of the factors relevant to the problem, the establishment of an effective primary care physician system, enrolling a majority of eligible patients, is not currently feasible in the outpatient clinics of Ben Taub General Hospital within the existing organizational structure; institutional philosophy; and personnel, facility, and equipment resources.

2. A limited, modified system, utilizing the General Medical Clinic as the nucleus of a primary care physician system is feasible. However, the number of patients which could be cared for in such a program, given present organization and operations, would be so small that any impact to improve overall clinic operations would be insignificant in view of total service population and daily work load.

3. Establishing a limited comprehensive care system would be of benefit to individual patients and physicians but from an administrative standpoint, formalizing such a

system at this time would prove to be cost ineffective and would, in all probability, create more and different problems than are currently encountered with the present system.

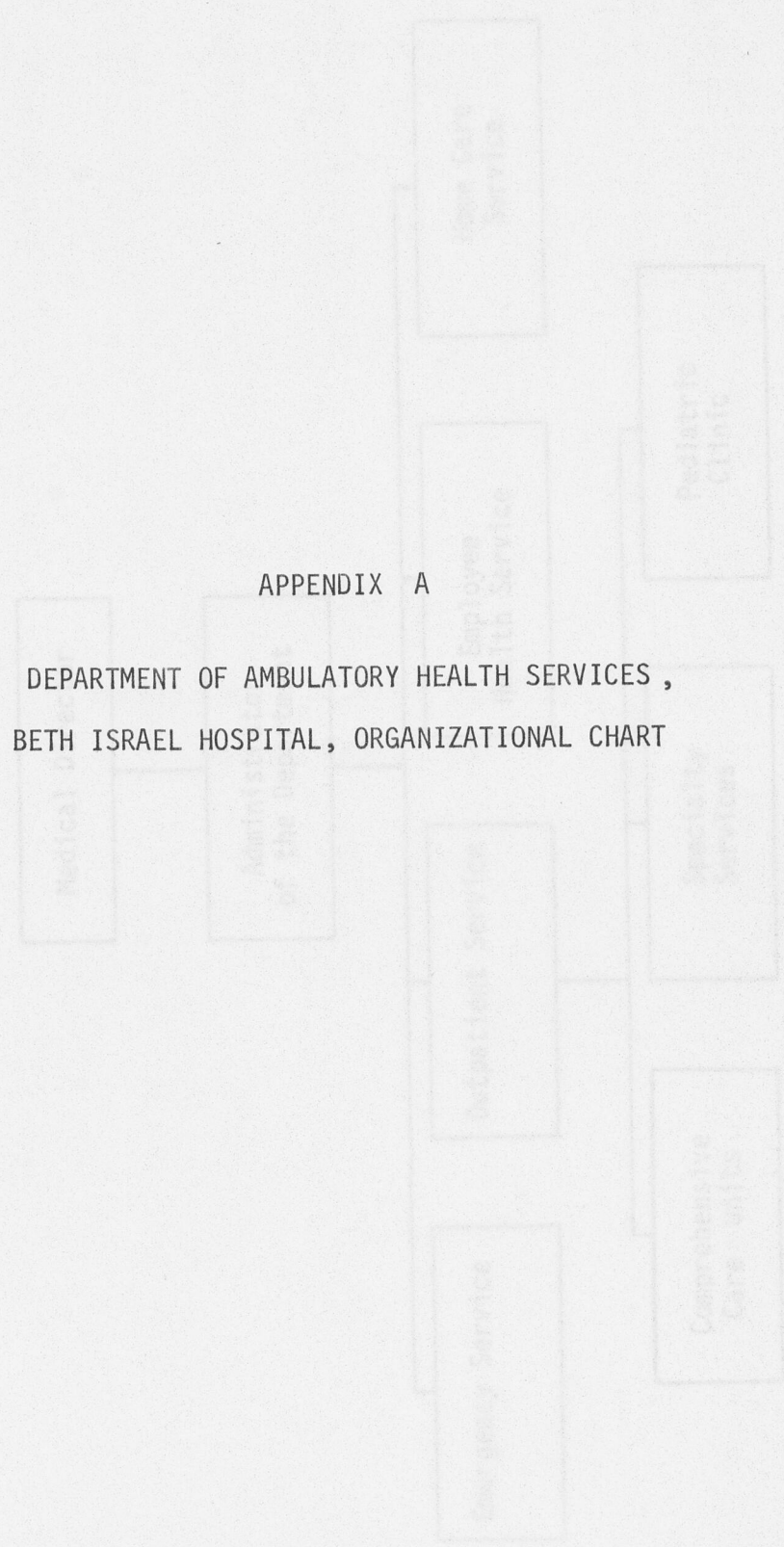
#### Recommendations

In view of the conclusions reached above, the following recommendations are made:

1. Recommend the present system for delivery of ambulatory care be continued with no major changes.

2. Recommend the approach as discussed in method two for implementing a limited, comprehensive primary care physician system in the future, which utilizes the General Medical Clinic as the nucleus of such a system, be further considered and studied.

DEPARTMENT OF AMBULATORY HEALTH SERVICES, BETH ISRAEL HOSPITAL  
ORGANIZATIONAL CHART

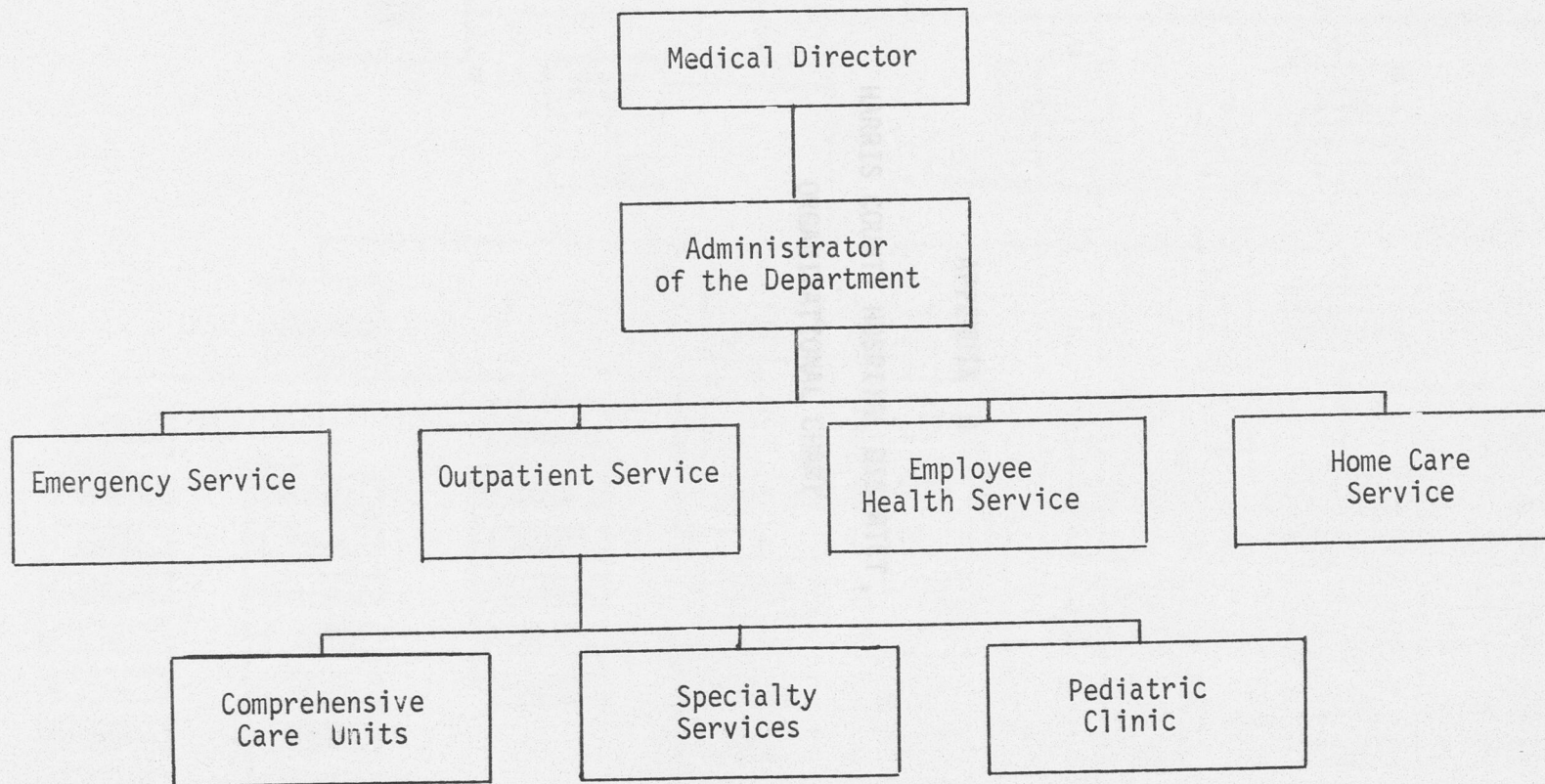


APPENDIX A

DEPARTMENT OF AMBULATORY HEALTH SERVICES,  
BETH ISRAEL HOSPITAL, ORGANIZATIONAL CHART

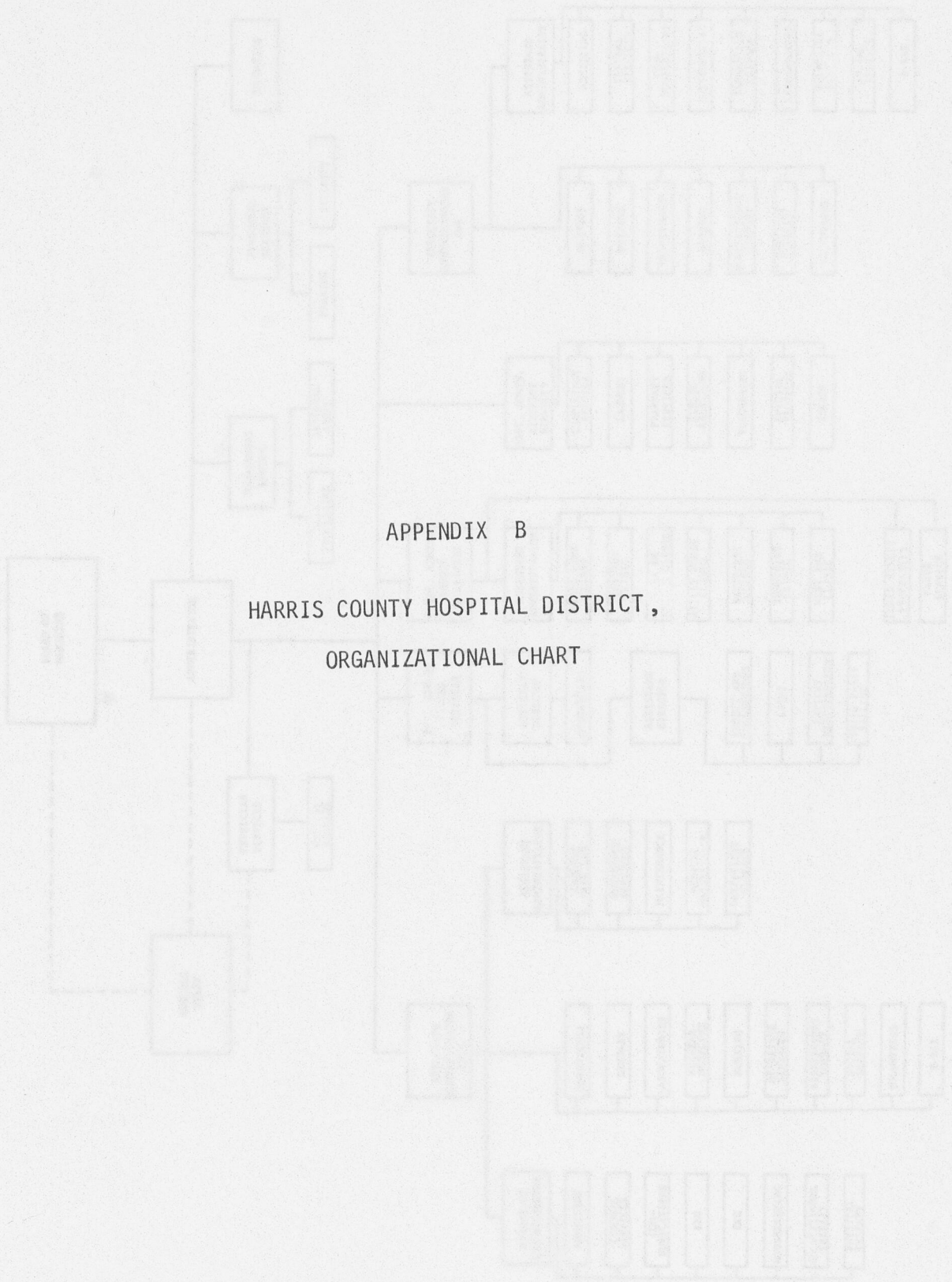
Source: American Hospital Association, *Assessing Ambulatory Care Programs*, Chicago: American Hospital Association, 1973, p. 97.

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ORGANIZATIONAL CHART



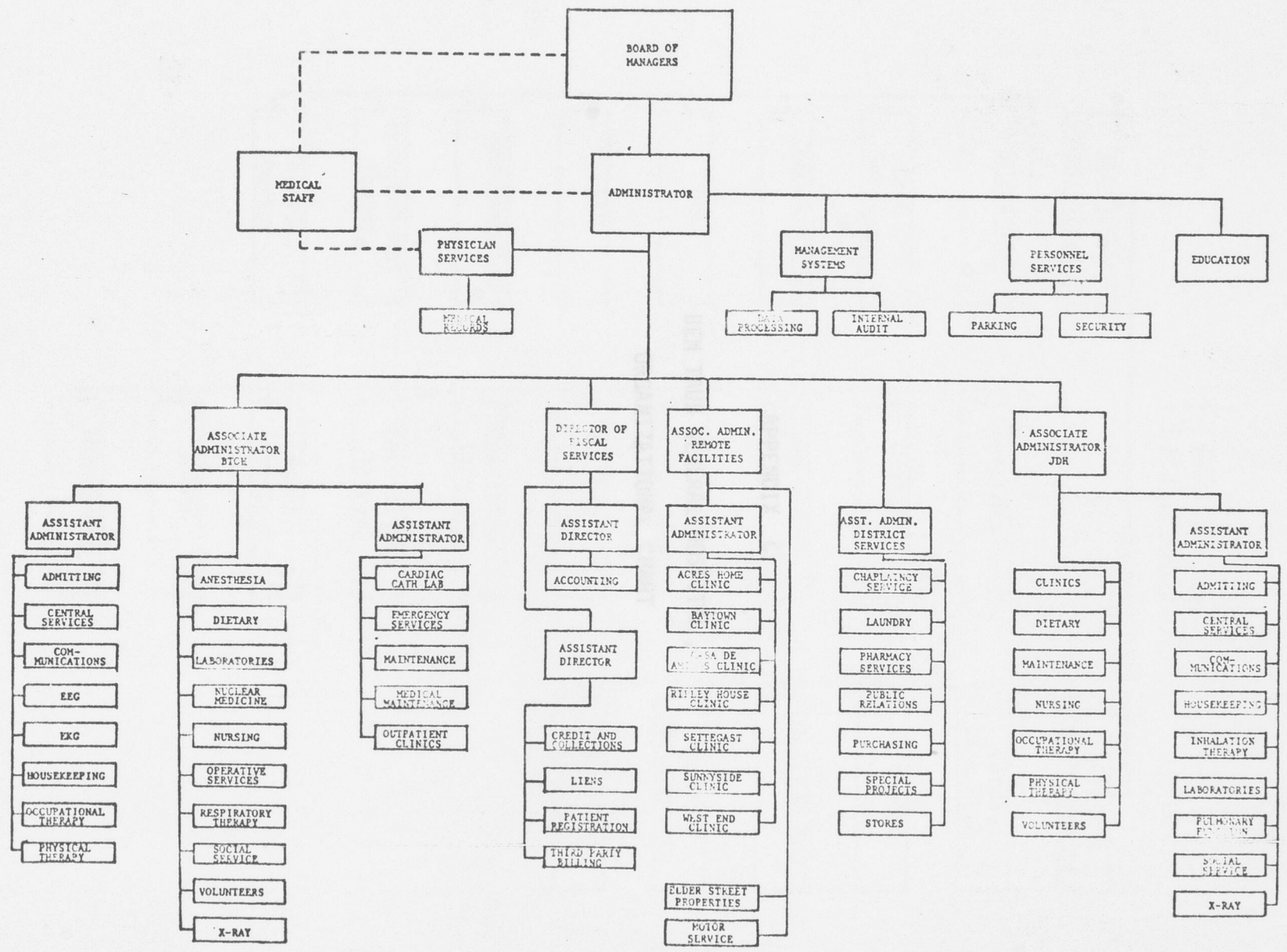
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Source: American Hospital Association. Reshaping Ambulatory Care Programs.  
Chicago: American Hospital Association, 1973, p.35.

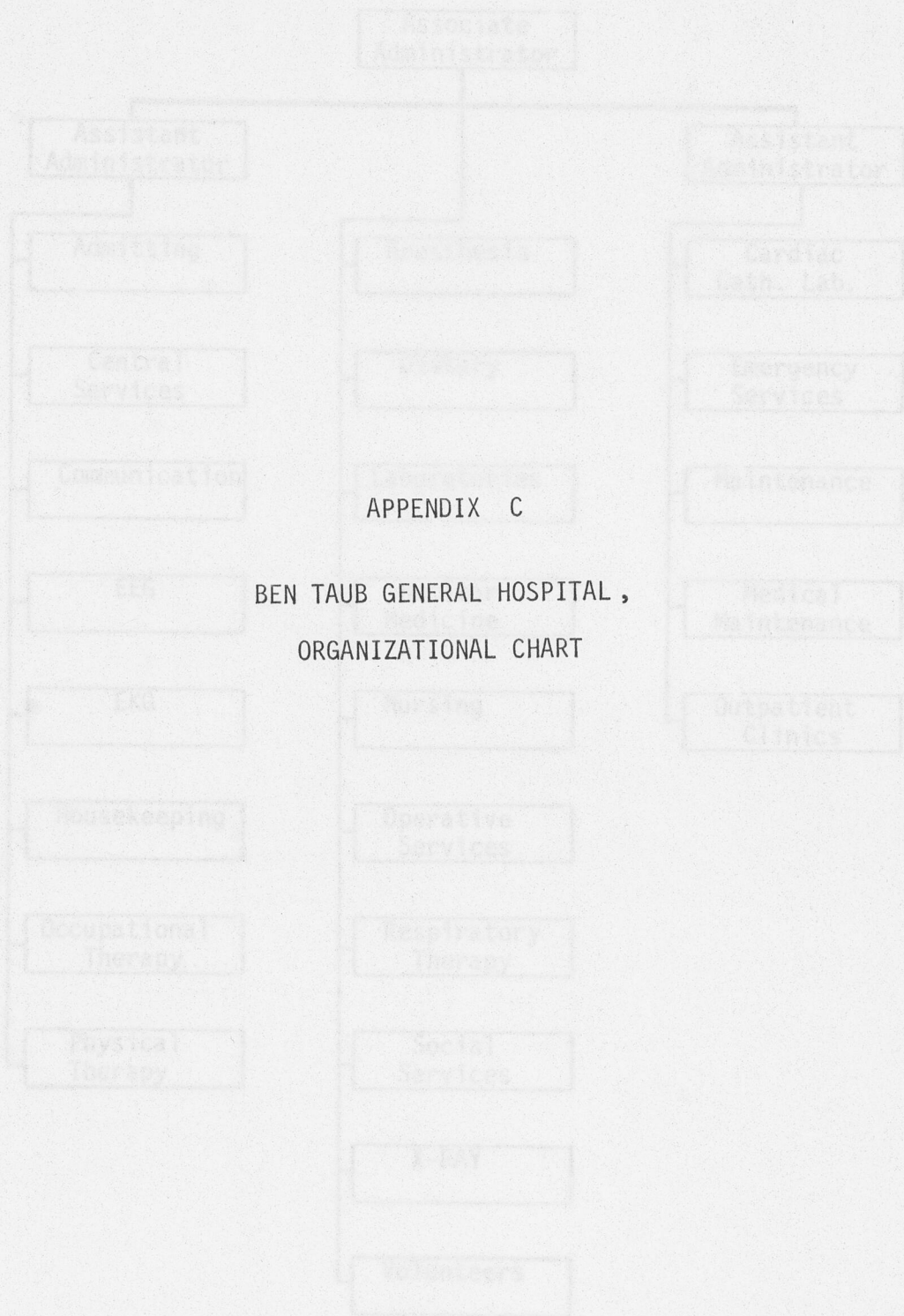


APPENDIX B

HARRIS COUNTY HOSPITAL DISTRICT,  
ORGANIZATIONAL CHART



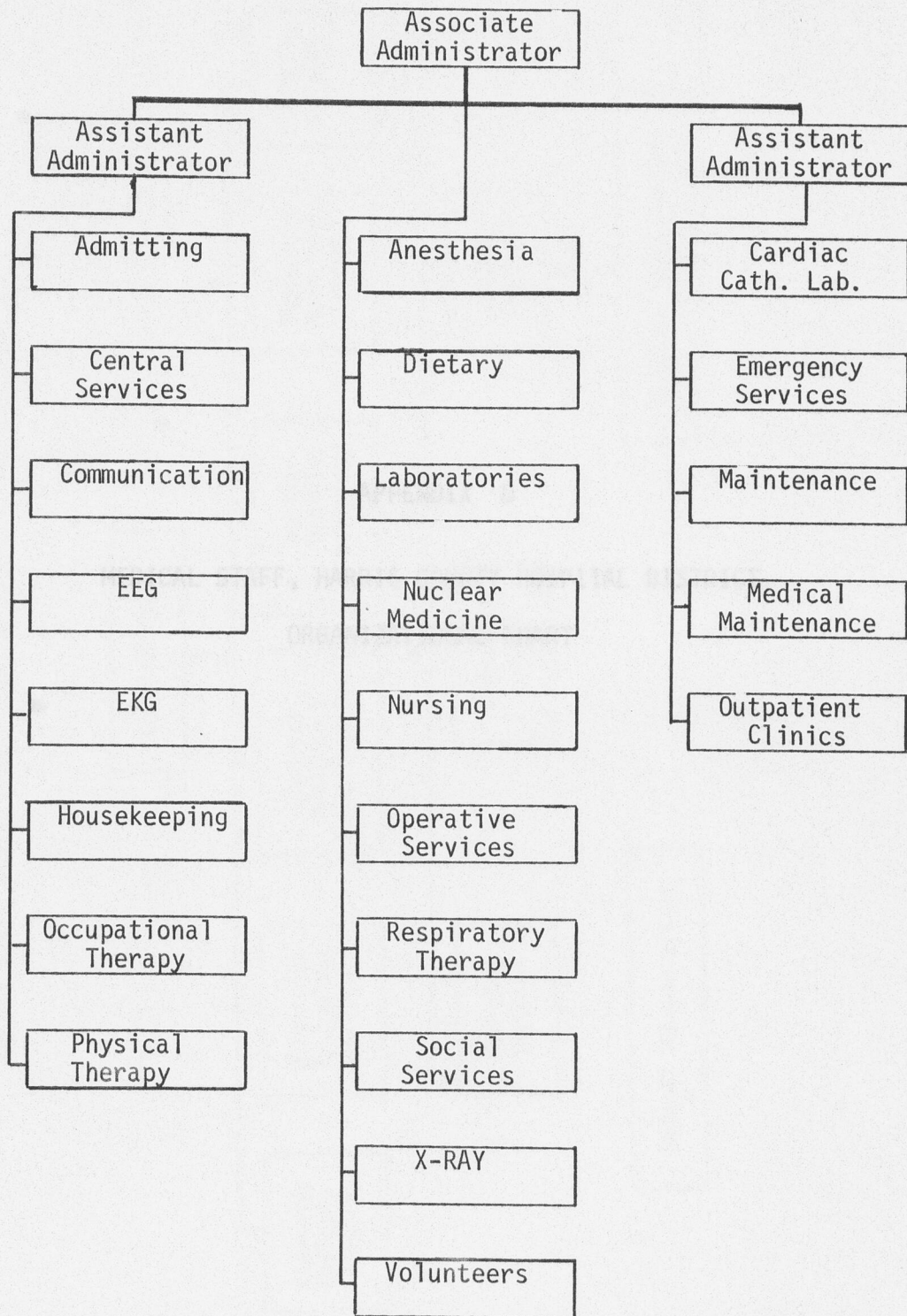
BEN TAUB GENERAL HOSPITAL, ORGANIZATIONAL CHART



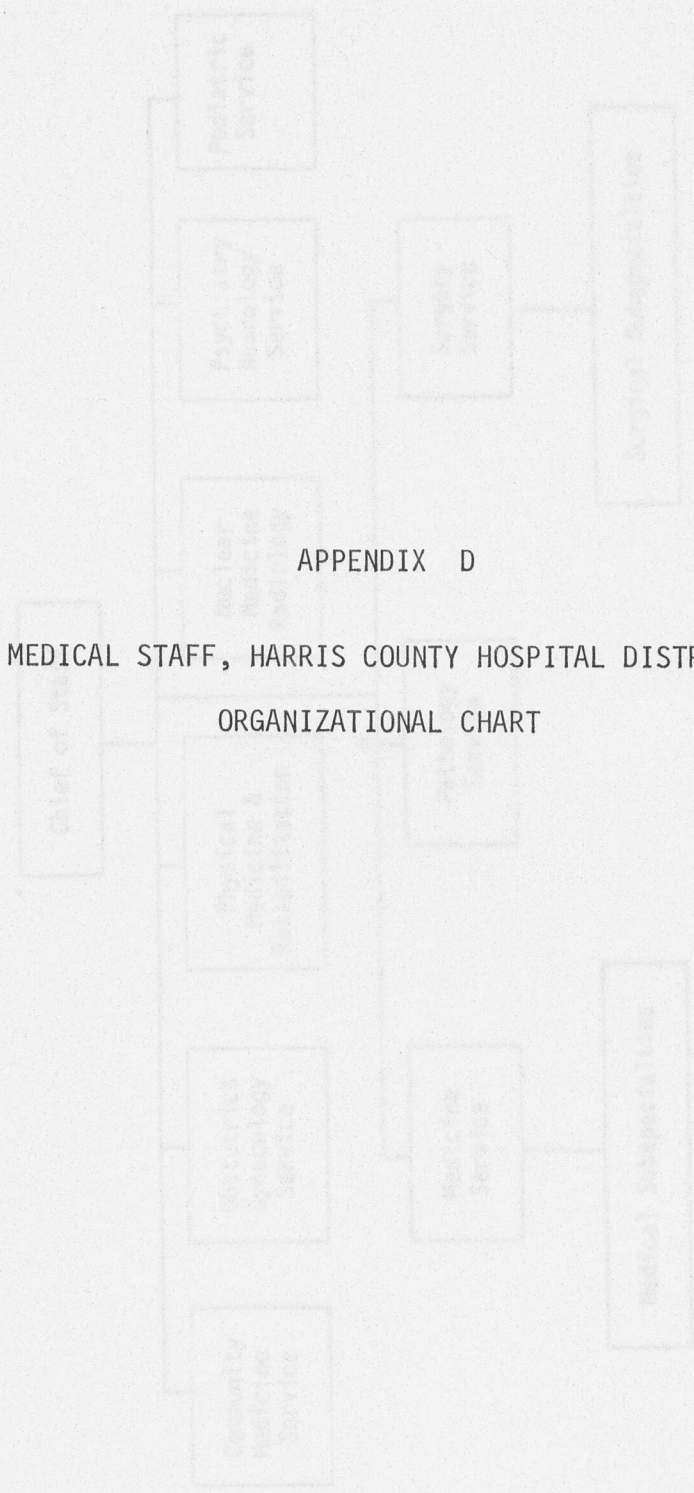
APPENDIX C

BEN TAUB GENERAL HOSPITAL ,  
ORGANIZATIONAL CHART

BEN TAUB GENERAL HOSPITAL, ORGANIZATIONAL CHART

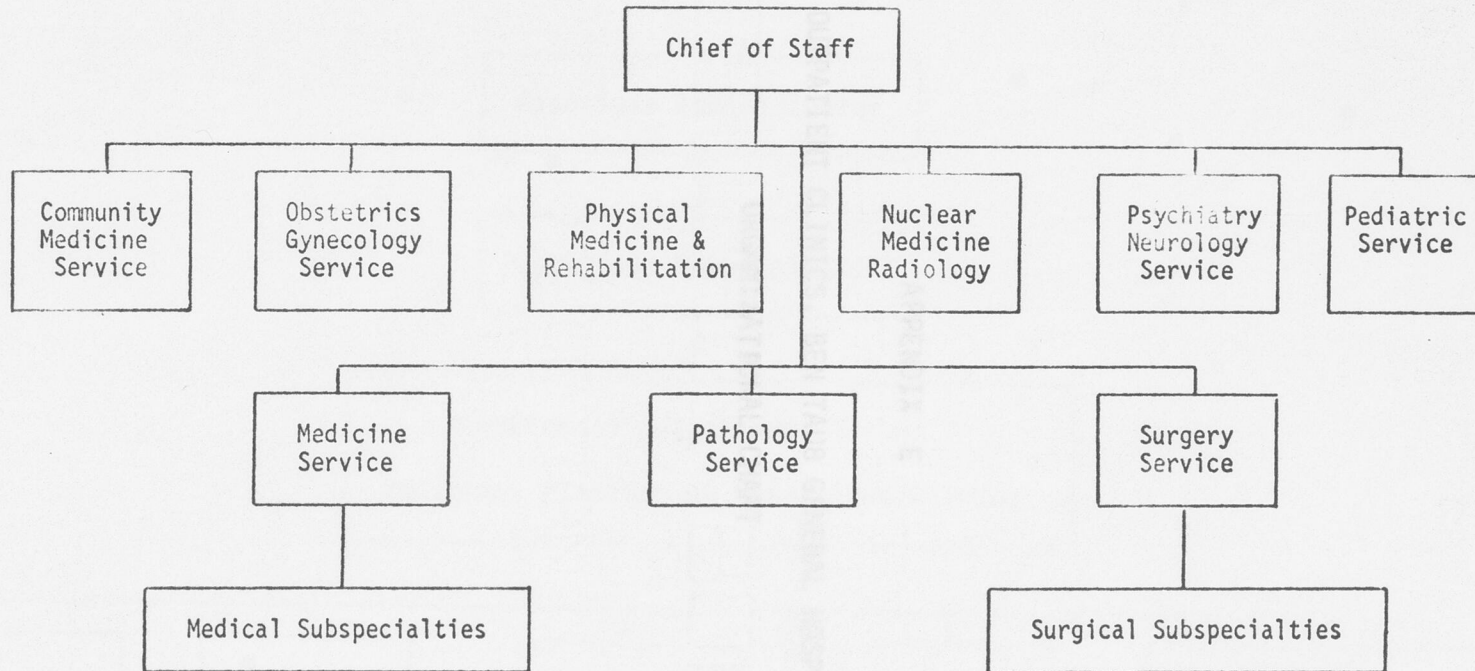


MEDICAL STAFF, HARRIS COUNTY HOSPITAL DISTRICT, ORGANIZATIONAL CHART



APPENDIX D  
MEDICAL STAFF, HARRIS COUNTY HOSPITAL DISTRICT,  
ORGANIZATIONAL CHART

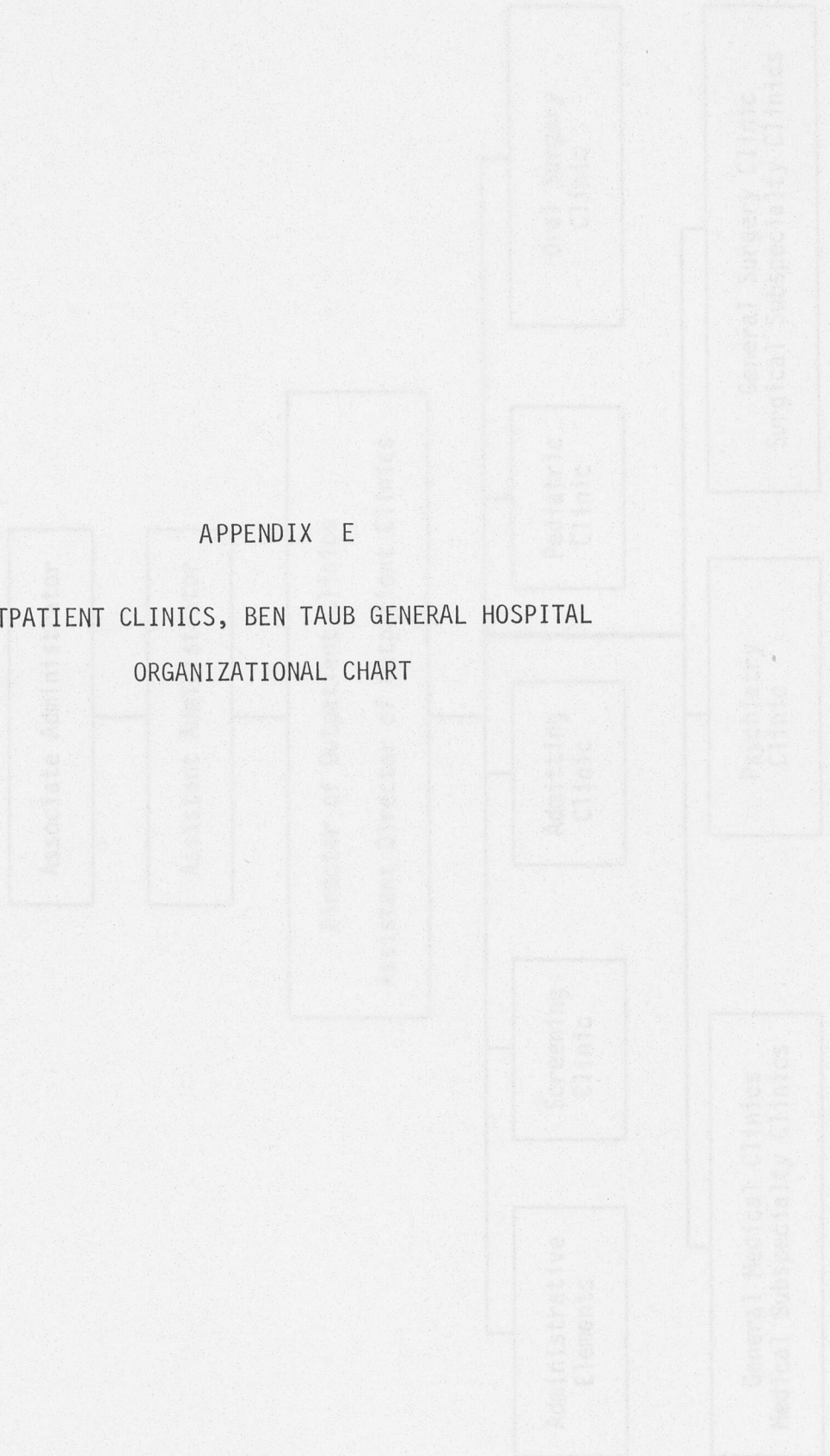
MEDICAL STAFF, HARRIS COUNTY HOSPITAL DISTRICT, ORGANIZATIONAL CHART



OUTPATIENT CLINICS, BEN TAUB GENERAL HOSPITAL

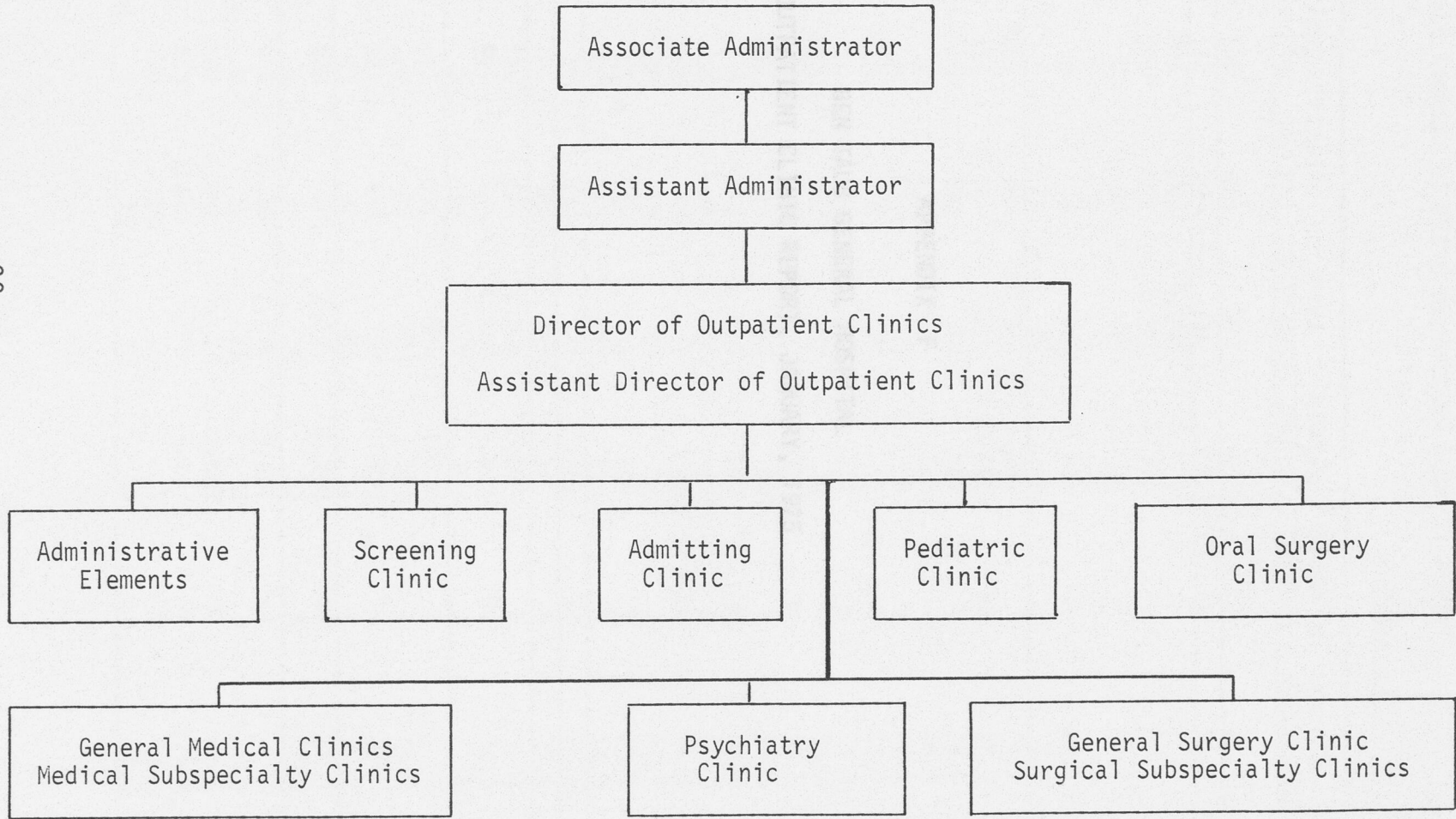
ORGANIZATIONAL CHART

APPENDIX E  
OUTPATIENT CLINICS, BEN TAUB GENERAL HOSPITAL  
ORGANIZATIONAL CHART



OUTPATIENT CLINICS, BEN TAUB GENERAL HOSPITAL  
ORGANIZATIONAL CHART

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HARRIS COUNTY HOSPITAL DISTRICT  
BEN TAUB GENERAL HOSPITAL OUTPATIENT CLINICS REPORT

January 1975

CLINIC	PATIENT VISITS		TOTAL ATTENDANCE	JANUARY 1974	NUMBER OF CLINICS	AVERAGE ATTENDANCE
	New Pts.	Old Pts.				
DENTAL	364	418	782	809	19	41.2
DERMATOLOGY	347	395	742	811	22	33.7
GYNECOLOGY	604	964	1,568	1,674		
General	598	772	1,370	1,500	18	76.1
Dysplasia	0	92	92	51	6	15.3
Hot Flash	0	0	0	31	0	X
Tumor	0	86	86	73	3	28.7
Vulvar	6	14	20	19	4	5.0
MEDICINE	427	6,360	6,787	6,580	X	X
Admitting	135	3,341	3,476	3,457	22	158.0
Allergy	16	300	316	255	4	79.0
Cardiac	1	177	178	166	4	44.5
Chemotherapy	8	121	129	99	8	16.1
Chest	13	53	66	57	5	13.2
Diabetic	10	93	103	133	5	20.6
Endocrinology	25	102	127	75	5	25.4
General	129	1,601	1,730	1,711	22	78.6
G.I.	14	69	83	82	4	20.8
Hematology	9	112	121	100	9	13.4
Hypertensive	2	48	50	49	4	12.5
Adolescent	14	33	47	44	11	4.3
Renal	10	79	89	86	4	22.3
Rheumatic	13	128	141	149	9	15.7
Podiatry	28	103	131	114	9	14.6
NEUROLOGY	33	300	333	381	13	25.6
NEUROSURGERY	66	82	148	121	5	29.6
OPHTHALMOLOGY	395	805	1,200	1,033	X	X
General	395	805	1,200	1,033	22	54.5
Optical	0	318	318	304	X	X
ORTHOPEDIC	443	551	994	1,028	X	X
Crippled Child	89	87	176	195	4	44.0
General	321	416	737	799	14	52.6
Hand	33	48	81	34	4	20.3
OTOLARYNGOLOGY	528	543	1,071	1,204	22	48.7
Tumor	0	16	16	17	1	16.0
PEDIATRIC	642	4,718	5,360	5,491	X	X
Cardiac	0	12	12	74	4	3.0
Acute Care	168	1,247	1,415	2,187	31	45.6
General	474	3,407	3,881	3,133	22	176.4
Neurology	0	15	15	9	2	7.5
Special Problems	0	37	37	88	12	3.1

HARRIS COUNTY HOSPITAL DISTRICT  
BEN TAUB GENERAL HOSPITAL OUTPATIENT CLINICS REPORT

January 1975

CLINIC	PATIENT VISITS		TOTAL ATTENDANCE	JANUARY 1974	NUMBER OF CLINICS	AVERAGE ATTENDANCE
	New Pts.	Old Pts.				
PHYSICAL MED.	126	334	460	442	22	20.9
Amputee	2	4	6	0	1	6.0
PLASTIC	133	303	436	445	19	22.9
Tumor	0	5	5	0	1	5.0
PSYCHIATRY	74	739	813	741	22	37.0
Alcoholism	2	10	12	18	3	4.0
RADIOTHERAPY	0	88	88	41	X	X
SURGERY	980	641	1,621	1,760	X	X
"Blue"	115	164	279	474	8	34.9
Chest	12	14	26	7	4	6.5
"Green"	127	115	242	211	9	26.9
Suture	147	39	186	169	22	8.5
Minor Surgery	6	7	13	6	5	2.6
Proctology	35	28	63	40	4	15.8
"Red"	157	94	251	536	8	31.4
Screening	309	109	418	367	18	23.2
Tumor	33	25	58	50	4	14.5
Ped. Surg.	39	46	85	0	4	21.3
UROLOGY	384	728	1,112	1,216	X	X
General	0	525	525	615	18	29.2
G.U. New	152	0	152	139	18	8.4
G.U. Stone	0	6	6	7	4	1.5
Pediatric	13	38	51	68	7	7.3
Tumor	0	22	22	22	9	2.4
Cysto	219	137	356	365	22	16.2
<b>TOTALS</b>	<b>5,550</b>	<b>18,328</b>	<b>23,878</b>	<b>24,138</b>		
<b>EMERGENCY CENTER</b>			<b>7,623</b>			
<b>TOTAL OUTPATIENT CLINICS AND EMERGENCY CENTER VISITS</b>			<b>31,501</b>			

ADMINISTRATIVE SERVICES: OUTPATIENT CLINICS & EMERGENCY CENTER

New patients interviewed	1,078	Ineligible Referrals	83	Medicare	2,317
Reinvestigations	<u>3,974</u>	Ineligible Referrals	<u>67</u>	Medicaid	<u>2,885</u>
Totals	5,052		150		5,202

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## BIOGRAPHICAL SKETCH

ABSTRACT

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