DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

PHONE: (202) 690-6870 FAX: (202) 401-7321

Date:

From: Lisa Rovin

To: Jennifer Klein

Phone: (202) 690- _____
(202) 690-6870
FAX: (202) 401-7321

Phone: _____

Fax: _____

Number of Pages (Including Cover): 6

Comments:

TO: Jennifer Klein
FROM: Lisa Rovin
RE: Status of Health Professionals Research
DATE: February 9, 1994

Since I will be out next week, I thought you'd like a status report on our efforts re the lawful scope of practice of health professionals. Two provisions of the Health Security Act (HSA) raise "scope of practice" questions:

> The HSA includes as covered benefits "health professional services," defined as "services that are lawfully provided by a physician." Such services are covered benefits when provided by a physician or by another person legally authorized to provide such services in the state in which the services are rendered. You asked us to look at state medical practice acts, to determine what services are "lawfully provided by a physician" and thus covered by the HSA.
>
> The HSA provides that States may not, "through licensure or otherwise, restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals. You asked us to review state practice acts to learn how states restrict the practice of health professionals, and what limits might be applied if a state's law is preempted.

Status of Research and Analysis

Scope of Practice of Physicians.
We have reviewed the medical practice acts in roughly 18 states. A summary is attached. Although we are obtaining the practice act statutes and regulations for the remaining states, it is unlikely that this additional information will change the attached preliminary summary.

Scope of Practice of Other Health Professionals
We are obtaining nurse practitioners and pharmacists practice acts and implementing regulations from all states. We should be receiving these materials shortly, and will be analyzing this information in-house.

We are drafting a Scope of Work to obtain an analysis of the scope of practice of other health professionals. Our current list includes physician's assistants, chiropractors, acupuncturists, audiologists, psychologists, physical therapists, respiratory therapists. We need to discuss whether dental hygienists, other types of therapists, social workers, etc., should also be included, and agree on a final list. Due to the need for development and approval of a Scope of Work, the results of this research could not be expected for 6 - 8 weeks. However, the Scope would be designed so that early deliverables will provide significant information to get us started.

TO: Jennifer Klein
FROM: Lisa Rovin
RE: "Services lawfully provided by a physician:" Preliminary Conclusions[1]
DATE: February 9, 1994

The following is background you should have for our meeting tomorrow. It will give you a feel for how broad and encompassing state medical practice acts are, and also for the kinds of standards that effectively limit physician practice. Note that the actual standard of medical practice among doctors is not as broad as licencure would allow. This raises a number of issues relevant to §§ 1112 and 1161 of the HSA, and to where we go from here.

Summary

State licensure laws do not provide effective standards for defining covered professional services. The practice of medicine is defined both broadly and indeterminately, to include any intervention or treatment intended to diagnose or treat human ailments. (See Part A, below)

As a practical matter, effective limits on lawful physician behavior stem not from definitions of the practice of medicine, but from normative sources such as malpractice standards, the need to maintain hospital staff privileges, and the (albeit tiny) threat of disciplinary action by the state licensure board. While these standards may appear too indeterminate to rely on for coverage boundaries, they in fact define a scope of practice more narrow than the formal definitions of "the practice of medicine." They each reduce to a standard that may our best starting point, and which in any event we will be unable to avoid: the accepted standard of medical practice in a community (or nationally). (See Part B, below) Lets discuss this tomorrow.

Section § 1141 of the HSA, excluding items and services "not medically necessary or appropriate" and implementing regulations which would define "medically necessary and appropriate" to exclude experimental treatments not covered under § 1128 may be a more effective source of boundaries on covered services. For example, the regulation could define a treatment outside standard practice as "experimental" or "not appropriate."

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[1] This is not a formal legal opinion. General counsel has not been involved in this analysis.

Part A: Summary of State Licensure and Practice Acts

In every state we have examined, the "practice of medicine" is a broad and indeterminate concept. The definitions are typically found in the statutes prohibiting the practice of medicine without a license and the case law interpreting them. In short, any intervention intended to diagnose or treat human ailments may be the practice of medicine. A few examples:

California:

> "Any person, who practices or attempts to practice, or who advertises or holds himself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other mental or physical condition or any person, without having at the time of so doing a valid, unrevoked certificate as provided in this chapter, or without being authorized or perform such act pursuant to a certificate obtain in accordance with some other provision of law, is guilty of a misdemeanor."

Connecticut:

> "No person shall, for compensation, gain or reward, received or expected, diagnose, treat, operate for or prescribe for any injury, deformity, ailment or disease, actual or imaginary, of another person, nor practice surgery, until he has obtained such a license ..."

New York:

> "The practice of the profession of medicine is defined as diagnosing, treating, operating or prescribing for any human disease, pain, injury deformity or physician condition."

North Dakota:

> Any one who "holds himself out to the public as being engaged within this state in the diagnosis or treatment of disease or injuries of human beings" is practicing medicine.

Louisiana:

> The practice of medicine includes interventions "whether physical or psychic, or of what other nature, or any other agency or means ..."

Some statutes except from the unlawful practice of medicine certain activities, such as the practice of other professions (i.e., the practice of dentistry by a licensed dentist is not the unlawful practice of medicine), healing by spiritual means, the gratuitous rendering of emergency services, and treatment within a family. These exceptions do not narrow the definition of medical services. Rather, they define circumstances under which the licensure requirement will not apply to medical services.

State licensure requirements restrict who can practice medicine, not what services licensed physicians can render. Further, every licensed physician may lawfully provide any service within the umbrella definition of medical practice. State licensure law does not prohibit a psychiatrist from performing brain surgery or a brain surgeon from rendering psychiatric therapy.

Case law interpreting these statutes typically involves a challenge to a service rendered by a nonphysician practitioner, not by a physician practitioner. These are consumer protection statutes, and the courts treat them as such: any person purporting to diagnose or heal, by whatever means, must have a medical license or meet a statutory exception.

Some state licensure laws include provisions listing grounds for medical board disciplinary action against a physician. Some of these include failure to exercise "sound medical practice" or "failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease." Again, note that these standards do not limit the definition of medical practice, but rather define unsuitable medical practice.

Part B: Practical Limits on Physicians' Practice

This is not to say that there are no legal boundaries to the practice of medicine. There are such boundaries, but they arise from other sources, primarily:

- the threat of a malpractice action.
- the threat of license revocation.
- the threat of an informed consent action.
- the desire/need to obtain board certification.
- the need to obtain hospital staff privileges.

Threat of a malpractice action.

In most cases, a malpractice actions holds a physician to the standard of practice in the local medical community. The physician must practice medicine with the same skill and in the same manner as other local physicians. In some cases, a national standard may be applied.

Threat of license revocation.

The state licensure board is typically composed of physicians who practice in that state. Courts have found that state constitutions prohibit medical boards from placing certain limits on professional practice (i.e., a Florida court held that the Florida constitution prohibited the state medical board from suspending the license of a physician who prescribed vitamin therapy for coronary artery disease).

Threat of an informed consent action.

Informed consent rules limits what a physician must tell a patient, but not what a physician may do once the risks are disclosed. There are three legal standard in use today in informed actions. Some states use a standard identical to the malpractice standard: the physician must inform the patient of those risks which the reasonable physician would tell a patient. Other states use a "reasonable patient" standard: the physician must inform the patient of those risks which a reasonable patient would want to know. A few states have promulgated in regulations a list of risks which must be disclosed, according to the type of intervention.

Desire/need to obtain board certification.

Board certification is obtained by passing examinations developed and scored by other physicians in the same speciality.

Need to obtain hospital staff privileges.

Staff privilege decisions are typically made by a committee dominated by physicians who practice at the hospital. The hospital administration also has representatives on the committee.

Thus, each of these limits on medical services relates back to the services other physicians render, and the standard of medical practice in the community and/or nationally. In short, physicians can do what other physicians do.[2] They are limited by other like professionals, and their own professionalism as inculcated during training. As one court noted, "[t]he hallmark of the professional is knowing the limits of one's professional knowledge." Even physicians who venture beyond the standard of practice of their peers are unlikely to be deemed "not practicing medicine;" rather, they will be accused of "malpracticing" medicine.

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[2] This circularity applies not only to these normative standards, but also to licensure standards. Professional services are those which can only be rendered pursuant to a license. To obtain a license to practice medicine, the applicant must typically be a graduate of an accredited school of medicine, and may also be required to pass one or more examinations. Thus, under these state rules, physicians may render the services they are trained to render.

What services are physicians trained to render? The medical school curricula and certification examinations are (for the most part) determined by boards of physicians. That is, medical students are trained to render those services that other physicians render.

Closing Note:
It seems inevitable that a standard for benefits coverage will in some way incorporate community or national medical practice standards. Thus, in defining coverage standards, we also need to think about how to combine reliance on existing medical practice with the use of outcomes research to change practice patterns.

QUESTION:

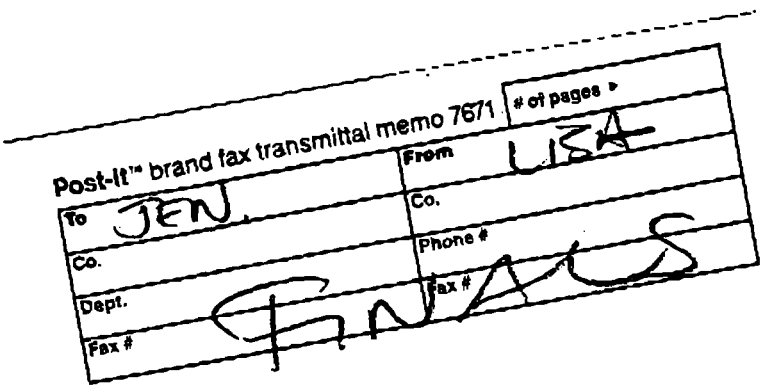
Does the Federal government intend to enter into the regulation of professional practice and pre-empt state practice acts as appears to be the intent of section 1161 - override of restrictive state practice laws?

ANSWER:

- No. Definition and regulation of state professional practice acts is and will continue to be a state function. The intent of this provision is to prevent states from inappropriately limiting the practice of certain professionals beyond what is justified by their skills and training. For example, not all states grant nurse practitioners and other nurses in advanced practice prescriptive privileges.

- It is anticipated that the current way in which professional practice acts are modified, notably through state legislative initiatives, will continue.

- The Federal government will not be developing or promulgating standards for professional practice acts. There are however provisions in the Health Security Act for the Department of Health and Human Services to develop and encourage the adoption by states of model professional practices statutes for advanced certain professions, including advanced practice nurses and physician assistants (section 3071(e)(1)I; page 539).



QUESTION:

Will all health professionals be able to contract with plans? Can health plans exclude providers the way they do now? What reasons can they give for this exclusion?

ANSWER:

- The comprehensive benefits package in the Health Security Act does not specify classes of providers, rather it provides coverage for a range of services. Health professional services are defined to include those services that are lawfully provided by a physician, or those services which could be performed by a physician and which are provided by another person who is legally authorized to provide those services in the state.

- Increasingly today, insurers are entering into contracts with employers that restrict their employee's choices of health providers. As a result, health providers are either being locked out of plan contracting arrangements or forced to accept contracts that significantly alter their preferred practice style just to maintain their patient base.

- The Health Security Act dramatically alters this balance of power by putting the choice in the *individual's* hand, not the employers. As individuals evaluate the plan options provided through their alliance, they will be able to contact their physician, find out which plan he/she participates in, and select that plan. This puts providers in a far better position to negotiate effectively with plans.

- Health plans are specifically prohibited from discriminating against providers on the basis of "race, national origin, sex, language, age, or disability of the provider" or on the basis of "the socio-economic status, disability, health status, or anticipated need for health services of a patient of the provider".

- Health plans may exclude providers on the basis of business necessity except in cases of intentional discrimination as described above.

- A fee for service plan must cover all items and services in the comprehensive benefit package that are furnished by any lawful health care provider of the enrollee's choice subject to only 3 reasonable requirements:

  - utilization review;
  - prior approval for specified services (which does not permit use of a gatekeeper mechanism for access to non primary health care services); and
  - exclusion of providers on the basis of poor quality of care.

QUESTION:

What recourse will a patient have if a health plan denies coverage for a particular treatment or service?

ANSWER:

- Health plans must provide access to all medically necessary or appropriate items or services specified in the comprehensive benefit package.

- Decisions about what is medically necessary or appropriate are best left up to a health care provider and a patient and the Health Security Act does not get in the way of these decisions.

- Currently, when a patient needs a service that a plan chooses not to cover, the patient is left to argue with the plan with often little recourse. The Health Security Act changes this balance of power by establishing numerous consumer protection provisions that allow for appeals of plan decisions, at the plan, alliance, and state levels.

  At the plan level:

  - First, plans must have in place procedures to handle claims for payment or provision of benefits and must respond within 30 days and if the claim is denied the plan must notify them of the reasons for denial. If the plan does not meet these timelines, the claim is deemed approved.

  - In situations where there is need for an urgent response, plans must provide for expedited review within 24 hours.

  - For claims that are denied, there is opportunity for the claimant to re-submit the claim for reconsideration and again the plan must decide within 30 days. This review must be done by a different person than handled the first claim and must include review by a qualified physician if it involves medical issues.

  At the alliance level:

  - States must establish complaint review offices for each regional alliances to handle claims from enrollees residing in each regional alliance area, whether they are enrolled in that regional alliance or a corporate alliance.

  - Complainants to these review offices may choose to either seek remedies in a court of jurisdiction, go through an Early Resolution Program (specified in the Act), or proceed with a hearing in the complaint review office.

  Finally, the Secretary of Labor will establish a Federal Health Plan Review Board to review any appeals of decisions made by the alliance hearing officer.

Jennifer

CHIROPRACTORS

Q: Are chiropractic services covered under the HSA comprehensive benefit package?

A: A broad range of medically necessary or appropriate services are specified in the Act including hospital care, clinical preventive services, mental home health care, mental illness and substance abuse services, and services of health professionsal. The Act does not specify particular items or services within the broad categories, nor does it identify specific providers of services. The Act defines health professional services to include those services that are lawfully provided by a physician and which are provided by another person who is legally authorized to provide those services in the state. For example, physician services include treatment for lower back pain. Typically, chiropractors are also legally authorized to provide this treatment. It is expected that improved competition among health plans will create new incentives for effective use of providers. This, in turn, will increase the competitiveness of alternative practitioners. Plans will be free to use any mix of providers to meet the needs of their enrollees.

cheryl and jennifer

do we want to use the specific back pain example?

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JAN 14 1994

NOTE TO JUDY FEDER

Cheryl asked me to find out for you whether or not hemophilia treatment centers funded under Title V of the Social Security Act (Maternal and Child Health Services Block Grant) would be certified automatically as "essential community providers" under the Health Security Act. The answer appears to be yes and no.

Section 1582(a) of the Health Security Act identifies categories of providers that are automatically certified as essential community providers, and it includes among those categories:

> "Maternal and Child Health Providers--A public or private nonprofit entity that provides prenatal care, pediatric care, or ambulatory services to children, including children with special health care needs, and that receives funding for such care or services under title V of the Social Security Act."

Since grants for comprehensive hemophilia diagnostic treatment centers are authorized and funded under Title V, those centers that serve children would be automatically certified as essential community providers. However, there are some hemophilia diagnostic treatment centers that serve exclusively adults. Thus, even though they receive funding under Title V, they do not satisfy the other condition specified in the Act--providing services to children.

I talked to Sara Rosenbaum, who drafted this language, and she was very surprised to learn that there are Title V centers out there that do not serve children. She was not aware of this when she drafted the language, and she agreed that it does not appear as if adult centers funded under Title V would be automatically certified under the current language of the Act.

Tom

Tom Hertz, ASPE/HP

Sounds correct
~~Ellen~~ Share with
Jean Ward

Brookside Obstetrics & Gynecology Associates P.C.

OBSTETRICS, GYNECOLOGY & INFERTILITY

Michael J. Langan, M.D.
Ben Duncan Ramaley, M.D.
S. Wear Culvahouse, M.D.
Elizabeth M. Gelberg, M.D.
Donna J. Hagberg, M.D.

To All Our Patients:

The U.S. Senate Finance Committee has proposed that Obstetrics and Gynecology be deleted from primary care designation. Other State Legislatures are also taking similar action to exclude this field of medicine from such classification. If this proposal is passed, then a woman would have to be examined by her internist or family practitioner before being referred for pap smears, menstrual cramps, birth control, obstetrical visits or even breast exams. This proposal would greatly restrict a woman's access to the only medical speciality that specifically deals with women's health. As this proposal discriminates against women by restricting their access to medical care, we urge you to call or write your respective Senators and Representatives listed below and voice your concerns. Obstetrics and Gynecology must retain its' primary care designation.

For Connecticut:

The Honorable Representative Christopher Shays
House Budget Committee
888 Washington Blvd
Stamford, Ct 06901 Phone #357-8277

The Honorable Senator Joseph Lieberman
1 Commercial Plaza, 21st Floor
Hartford, Ct 06103 Phone #1-800-225-5605

The Honorable Senator Christoper Dodd
Putnam Park, 100 Great Meadow Road
Wethersfield, Ct 06109 Phone #240-3470

For New York:

The Honorable Senator Suzi Oppenheimer
16 School Street
Rye, NY 10580 Phone #914-921-0221

The Honorable Senator Nicholas Spano
1 Executive Blvd
Yonkers, NY 10701 Phone #914-969-5194

(over)

THE OBSTETRICIAN-GYNECOLOGIST: PRIMARY CARE PHYSICIAN

The specialty of obstetrics and gynecology is devoted to the health care of women throughout their lifetime. Primary-preventive health care is integral to services provided by obstetrician-gynecologists. These include periodic health screening, evaluation and counseling about health/risk behaviors and immunization. Family planning, sexual counseling, instruction in breast self-examination, health education, instruction in health promotion, hypertension and cardiovascular surveillance, osteoporosis counseling, sexually transmitted diseases counseling, and identification of domestic violence are many of the primary-preventive services in the well-patient encounter with the obstetrician-gynecologist. One of the most significant preventive health services provided by obstetrician-gynecologists is prenatal care and risk assessment prior to and during pregnancy.

For many women, their obstetrician-gynecologist serves as their primary physician. As the health care delivery system undergoes major changes, it is imperative that women's direct access to their obstetrician-gynecologist not be limited by Congress' failure to classify obstetrician-gynecologists as primary care.

- Significant numbers of women view their obstetrician-gynecologist as their primary or only physician. For many women, the obstetrician-gynecologist is often the only physician they see regularly during their reproductive years. According to recent surveys conducted by ACOG, more than half of women in a national sample considered their obstetrician-gynecologist to be the principal physician providing their medical care.

- Family planning is a critical preventive health care service for women. According to the National Center for Health Statistics (NCHS) visit survey data, three-fourths of all office visits for family planning purposes in 1989 and 1990 were to obstetrician-gynecologists.

- According to NCHS data, the second most frequently cited purpose of patient visits to obstetrician-gynecologists in 1989 and 1990 was for a general medical exam, accounting for seven million visits annually.

- In 1987, more than 53% of women ages 15 and older who saw an obstetrician-gynecologist did so for the purpose of having a general checkup. Obtaining a general checkup was a more frequently cited reason for seeing an obstetrician-gynecologist than it was for seeing either family physicians or internists.

- Prenatal care is an essential primary care service for pregnant women. Every year, approximately 80% of maternity care services in the U.S. are provided by obstetrician-gynecologists.

- According to a survey of employee attitudes toward health plan design, 68% of women responded that they would be unwilling to change their obstetrician-

gynecologist to save money. This percentage was significantly higher than the employers' responses concerning their willingness to change other primary care physicians.

- Data from various sources consistently support the primary care services provided by obstetrician-gynecologists, particularly in terms of inquiry and counseling in relation to preventive risk behaviors -- the true aim of prevention. In 1992, under contract from the HHS Office of Disease Prevention and Health Promotion, ACOG conducted a randomized survey of obstetrician-gynecologists. The survey found that a large proportion (more than 40%) of patients cared for by obstetrician-gynecologists receive a wide variety of preventive care services. Of obstetrician-gynecologists who provide primary care,
    - 85% reported that they routinely queried about family planning/preconception care;
    - 71% routinely queried about sexual practices and counseled about STDs including HIV infection;
    - 71% routinely queried about smoking, 55% about alcohol and 53% about illicit drug/medication use;
    - about half queried about diet (51%) and exercise (48%) and one third queried about work related health risks;
    - 40% queried about emotional/behavioral function.

- Obstetrician-gynecologists refer their patients less frequently than other primary care specialties, thus avoiding costly and time-consuming referrals to specialists. According to a 1991 study of physician referral rates, obstetrician-gynecologists had the lowest referral rate at 4%, as compared with referral rates of 7.3% for general internists, and 8.4% for general/family practitioners.

- The NCHS visit survey found that more than two-thirds (69.5%) of all visits to obstetrician-gynecologists were by established patients of the physician who were returning for care of their condition. In contrast, only 4.7% of patient visits resulted from referrals from another physician.

JULY 1993

OBSTETRICIAN-GYNECOLOGISTS -- PRIMARY CARE PHYSICIANS

QUESTIONS AND ANSWERS

Why it is important that the specialty be classified as primary care:

Q. Why should obstetrics/gynecology be classified as a primary care specialty?

A. For the majority of women aged 15-44, their obstetrician-gynecologist is the primary or only physician they see. Failure to classify obstetrics/gynecology as a primary care specialty will mean that women will be denied direct access to obstetrician-gynecologists. In other words, women would be able to see the physicians they prefer only on a referral basis.

Q. What effect will the lack of designation of obstetrician-gynecologists as primary care physicians have on the health care of women?

A. Without this designation, the educational process will be impacted through a graduate medical education reimbursement proposal that could result in fewer physicians trained in our specialty. This in turn would result in not only fewer primary care physicians, but also a smaller number of obstetrician-gynecologists to serve patients and work with nurse practitioners and certified nurse-midwives, creating diminished quality of care for women.

Q. Why are we considered primary care physicians?

A. Our specialty is the most unique of all of medicine. We cover the spectrum from obstetrician-gynecologists who practice primary care through limited generalists in obstetrics/gynecology to sub-specialists, some of whom provide primary care. We might be considered a mutation between medicine and surgery with some aspects of pediatrics.

acog
The American College of Obstetricians and Gynecologists
409 12th Street, SW, Washington, DC 20024-2188
(202) 638-5577
FAX (202) 488-3985

Q. Is it cost effective for obstetrician-gynecologists to be primary care physicians?

A. Commonly, the patients we serve are cared for in a primary-preventive mode, elevated to a specialist mode when surgical or more sophisticated obstetric/gynecologic services are needed, then returned to the primary-preventive mode without costly referral.

Q. Will all obstetrician-gynecologists be obligated to practice primary care if the specialty is classified as primary care?

A. No! Individual obstetrician-gynecologists may continue in a consultant/specialist capacity. Many pediatricians and internists are specialists although their respective specialties have been traditionally defined as primary care.

Q. As a primary care physician, would I still be able to do surgery?

A. Yes. Being a primary care physician means that you provide preventive health care services to your patients, such as cholesterol screening, counseling about smoking prevention, or counseling about prevention of sexually transmitted diseases. Focusing your practice on providing primary-preventive care would not preclude you from performing surgical procedures.

Q. If obstetrics/gynecology is classified as primary care, does this mean that I would no longer be a specialist?

A. No! The specialty's designation as primary care would not alter your status, only the ability of patients to come to you first. For example, pediatrics has been consistently defined as a primary care specialty. This is also true of internal medicine.

Q. What if I don't want to be a primary care physician for my patients?

A. That's fine, as long as your patients understand that they can see another physician for their primary care. Again, just because the specialty is classified as primary care does not mean that all obstetrician-gynecologists are obligated to become primary care physicians.

Q. If I am a primary care physician, would I have to take care of men?

A. No! In the case of obstetrics/gynecology, the scope of primary care relates only to women. If the specialty is classified as primary care, those obstetrician-gynecologists deciding to practice primary care would continue to provide preventive health care services to women.

Q. What happens to residency programs if obstetrics/gynecology is not designated primary care?

A. In all likelihood, non-primary care specialties will lose residency slots in the next several decades. In fact, Congress and several state legislatures are considering legislation that would increase funding to primary care residency positions, while decreasing funds below cost to all other positions. Failure to classify obstetrics/gynecology as primary care would result in drastically reduced numbers of obstetrician-gynecologists trained and available to serve women's health care needs. Ultimately, the provision of much obstetric/gynecologic care would have to be assumed by physicians with substantially less training in these services than obstetrician-gynecologists.

Q. Will the specialty change if we are not classified as primary care?

A. Yes. If obstetrician-gynecologists are not authorized to practice as primary care physicians, women will be forced first to see other physicians or providers and would then be able to see their obstetrician-gynecologist only if referred by the "gatekeeper" physician. Thus, obstetrician-gynecologists would be relegated to practicing exclusively on a referral basis and would have no choice in deciding whether they wished to provide primary-preventive health care services. More important, women would have no choice in accessing directly the physician they prefer.

Q. Who will determine who cares for our patients if we are not designated primary care physicians?

A. General/family physicians or internists! Third-party payers are already making that decision for many obstetrician-gynecologists and their patients. Across the country, obstetrician-gynecologists are being told by insurance companies that they cannot serve as a woman's primary care physician. Equally ominous are the actions of federal and state governments to establish a primary care policy that excludes obstetrician-gynecologists from federal and state programs and health care reform.

Q. *How can I help on this issue?*

A. Meet with your legislators to discuss your role as a primary care physician. (This document and the attached fact sheet should help you.) Discuss this issue with your patients and encourage them to communicate with lawmakers. Many of your patients will quickly recognize the importance of this issue to them, and will be easily persuaded to call or write letters to lawmakers. Inform the Department of Government Relations about your meetings. (Fax (202) 488-3985; Phone (202) 863-2509) Look for information in the September newsletter that will help you communicate with and enlist your patients' support.

Q. Why the urgency when Congress hasn't acted on health care reform?

A. Current plans that will dictate all future patterns of care are being formulated now; and some legislation, like the medical education bill mentioned earlier, are being enacted now. It will be difficult -- if not impossible -- to change these plans if we are not included initially.

Questions you may be asked by your legislator:

Q. What types of primary care services do obstetrician-gynecologists provide?

A. Obstetrician-gynecologists provide a wide array of preventive and primary care services to women. Prenatal care represents a major component of primary care for women; more than 80% of all prenatal/maternity care in the U.S. is provided by obstetrician-gynecologists every year. Other preventive-primary care services include family planning, general medical examinations, instruction in breast self-examination, screening and treatment for sexually transmitted diseases, identification of domestic violence, screening for breast and cervical cancer, hypertension and cardiovascular surveillance, osteoporosis prevention, and counseling about sexual practices and sexual dysfunction, as well as healthy lifestyles counseling.

Q. Do women commonly see obstetrician-gynecologists for primary care services?

A. Yes. Continuity of care is a fundamental aspect of primary care that is common to the majority of obstetrician-gynecologists' relationships with their patients. The obstetrician-gynecologist is often the only physician that many women see regularly during their reproductive years. ACOG surveys have found that more than 50% of women in a national sample considered their obstetrician-gynecologist

to be the principal physician providing their medical care. Many women see no other physician except by referral and the obstetrician-gynecologist may be their only entry into the health care system. A recent survey found that more than half of women (53%) age 15 and older who saw an obstetrician-gynecologist did so for the purpose of having a general medical checkup. Obstetrician-gynecologists frequently maintain a woman's permanent medical record for much of her lifetime.

Q. Do women prefer to see obstetrician-gynecologists over general/family physicians and internists for preventive-primary care services?

A. Yes. More than 53% of women ages 15 and older who saw an obstetrician-gynecologist in 1987 (most recent data) did so for the purpose of having a general checkup. Obtaining a general checkup was a more frequently cited reason for seeing an obstetrician-gynecologist than it was for seeing either family physicians or internists. Surveys of office visits by women to obstetrician-gynecologists show that women overwhelmingly choose to see obstetrician-gynecologists over general physicians and internists for the following: normal pregnancy, menopausal and postmenopausal health concerns, contraceptive management, postpartum care and examination; and infertility.

Also, according to a survey conducted by an employee benefits consultant, 68% of women responded that they would be unwilling to give up their obstetrician-gynecologist to save money. This percentage was significantly higher than the employees' responses regarding their willingness to change other primary care physicians.

Q. If obstetrics/gynecology is classified as a primary care specialty, would all obstetrician-gynecologists provide primary care?

A. No. While the majority of obstetrician-gynecologists describe themselves and their practices as primary care, some obstetrician-gynecologists will continue to specialize in infertility, oncology, or maternal-fetal medicine. This is desirable. Pediatrics and internal medicine traditionally have been considered primary care specialties, yet not all pediatricians and internists are primary care physicians, nor should they be.

Q. Don't current federal and state health care policies define obstetrics/gynecology as primary care?

A. Yes and no. Federal and state policies are inconsistent. The National Health Service Corps, for example, which provides scholarships to primary care physicians

serving in underserved areas, includes obstetrician-gynecologists in that classification. The Primary Care Loan program -- formerly the Health Profession Student Loan program, a key federal funding source of student loans -- does not define obstetrics/gynecology as primary care.

Likewise, some states such as California and Florida classify obstetrics/gynecology as primary care, whereas others such as Kansas and Minnesota do not; still other states such as North Carolina are deliberating legislation relating to health care reform and primary care. It is imperative that obstetrics/gynecology be designated primary care so that women's access to their obstetrician-gynecologist is not impeded and state government support for obstetrics/gynecology residency programs is not eroded.

Q. What would happen if obstetrics/gynecology was not classified as primary care?

A. If federal and state policies fail to classify obstetrics/gynecology as primary care, women will only be allowed to see their obstetrician-gynecologist upon referral from a general practitioner or internist. One of the most critical aspects of an obstetrics/gynecology practice, particularly maternity care, is continuity of care -- which is a fundamental element of primary care. Because women do not use general/family physicians and internists for their primary care as they do obstetrician-gynecologists, women will not access the health care system in a timely or efficient manner. In fact, only obstetrician-gynecologists are trained to provide comprehensive primary care for women; their rates of referral are the lowest of all specialties, at 4%.

OBSTETRICIAN-GYNECOLOGISTS -- PRIMARY CARE PHYSICIANS

QUESTIONS AND ANSWERS

Why it is important that the specialty be classified as primary care:

Q. Why should obstetrics/gynecology be classified as a primary care specialty?

A. For the majority of women aged 15-44, their obstetrician-gynecologist is the primary or only physician they see. Failure to classify obstetrics/gynecology as a primary care specialty will mean that women will be denied direct access to obstetrician-gynecologists. In other words, women would be able to see the physicians they prefer only on a referral basis.

Q. What effect will the lack of designation of obstetrician-gynecologists as primary care physicians have on the health care of women?

A. Without this designation, the educational process will be impacted through a graduate medical education reimbursement proposal that could result in fewer physicians trained in our specialty. This in turn would result in not only fewer primary care physicians, but also a smaller number of obstetrician-gynecologists to serve patients and work with nurse practitioners and certified nurse-midwives, creating diminished quality of care for women.

Q. Why are we considered primary care physicians?

A. Our specialty is the most unique of all of medicine. We cover the spectrum from obstetrician-gynecologists who practice primary care through limited generalists in obstetrics/gynecology to sub-specialists, some of whom provide primary care. We might be considered a mutation between medicine and surgery with some aspects of pediatrics.

acog
The American College of Obstetricians and Gynecologists
409 12th Street, SW, Washington, DC 20024-2188
(202) 638-5577
FAX (202) 488-3985

Q. Is it cost effective for obstetrician-gynecologists to be primary care physicians?

A. Commonly, the patients we serve are cared for in a primary-preventive mode, elevated to a specialist mode when surgical or more sophisticated obstetric/gynecologic services are needed, then returned to the primary-preventive mode without costly referral.

Q. Will all obstetrician-gynecologists be obligated to practice primary care if the specialty is classified as primary care?

A. No! Individual obstetrician-gynecologists may continue in a consultant/specialist capacity. Many pediatricians and internists are specialists although their respective specialties have been traditionally defined as primary care.

Q. As a primary care physician, would I still be able to do surgery?

A. Yes. Being a primary care physician means that you provide preventive health care services to your patients, such as cholesterol screening, counseling about smoking prevention, or counseling about prevention of sexually transmitted diseases. Focusing your practice on providing primary-preventive care would not preclude you from performing surgical procedures.

Q. If obstetrics/gynecology is classified as primary care, does this mean that I would no longer be a specialist?

A. No! The specialty's designation as primary care would not alter your status, only the ability of patients to come to you first. For example, pediatrics has been consistently defined as a primary care specialty. This is also true of internal medicine.

Q. What if I don't want to be a primary care physician for my patients?

A. That's fine, as long as your patients understand that they can see another physician for their primary care. Again, just because the specialty is classified as primary care does not mean that all obstetrician-gynecologists are obligated to become primary care physicians.

Q. If I am a primary care physician, would I have to take care of men?

A. No! In the case of obstetrics/gynecology, the scope of primary care relates only to women. If the specialty is classified as primary care, those obstetrician-gynecologists deciding to practice primary care would continue to provide preventive health care services to women.

Q. What happens to residency programs if obstetrics/gynecology is not designated primary care?

A. In all likelihood, non-primary care specialties will lose residency slots in the next several decades. In fact, Congress and several state legislatures are considering legislation that would increase funding to primary care residency positions, while decreasing funds below cost to all other positions. Failure to classify obstetrics/gynecology as primary care would result in drastically reduced numbers of obstetrician-gynecologists trained and available to serve women's health care needs. Ultimately, the provision of much obstetric/gynecologic care would have to be assumed by physicians with substantially less training in these services than obstetrician-gynecologists.

Q. Will the specialty change if we are not classified as primary care?

A. Yes. If obstetrician-gynecologists are not authorized to practice as primary care physicians, women will be forced first to see other physicians or providers and would then be able to see their obstetrician-gynecologist only if referred by the "gatekeeper" physician. Thus, obstetrician-gynecologists would be relegated to practicing exclusively on a referral basis and would have no choice in deciding whether they wished to provide primary-preventive health care services. More important, women would have no choice in accessing directly the physician they prefer.

Q. Who will determine who cares for our patients if we are not designated primary care physicians?

A. General/family physicians or internists! Third-party payers are already making that decision for many obstetrician-gynecologists and their patients. Across the country, obstetrician-gynecologists are being told by insurance companies that they cannot serve as a woman's primary care physician. Equally ominous are the actions of federal and state governments to establish a primary care policy that excludes obstetrician-gynecologists from federal and state programs and health care reform.

Q. How can I help on this issue?

A. Meet with your legislators to discuss your role as a primary care physician. (This document and the attached fact sheet should help you.) Discuss this issue with your patients and encourage them to communicate with lawmakers. Many of your patients will quickly recognize the importance of this issue to them, and will be easily persuaded to call or write letters to lawmakers. Inform the Department of Government Relations about your meetings. (Fax (202) 488-3985; Phone (202) 863-2509) Look for information in the September newsletter that will help you communicate with and enlist your patients' support.

Q. Why the urgency when Congress hasn't acted on health care reform?

A. Current plans that will dictate all future patterns of care are being formulated now; and some legislation, like the medical education bill mentioned earlier, are being enacted now. It will be difficult -- if not impossible -- to change these plans if we are not included initially.

Questions you may be asked by your legislator:

Q. What types of primary care services do obstetrician-gynecologists provide?

A. Obstetrician-gynecologists provide a wide array of preventive and primary care services to women. Prenatal care represents a major component of primary care for women; more than 80% of all prenatal/maternity care in the U.S. is provided by obstetrician-gynecologists every year. Other preventive-primary care services include family planning, general medical examinations, instruction in breast self-examination, screening and treatment for sexually transmitted diseases, identification of domestic violence, screening for breast and cervical cancer, hypertension and cardiovascular surveillance, osteoporosis prevention, and counseling about sexual practices and sexual dysfunction, as well as healthy lifestyles counseling.

Q. Do women commonly see obstetrician-gynecologists for primary care services?

A. Yes. Continuity of care is a fundamental aspect of primary care that is common to the majority of obstetrician-gynecologists' relationships with their patients. The obstetrician-gynecologist is often the only physician that many women see regularly during their reproductive years. ACOG surveys have found that more than 50% of women in a national sample considered their obstetrician-gynecologist

to be the principal physician providing their medical care. Many women see no other physician except by referral and the obstetrician-gynecologist may be their only entry into the health care system. A recent survey found that more than half of women (53%) age 15 and older who saw an obstetrician-gynecologist did so for the purpose of having a general medical checkup. Obstetrician-gynecologists frequently maintain a woman's permanent medical record for much of her lifetime.

Q. Do women prefer to see obstetrician-gynecologists over general/family physicians and internists for preventive-primary care services?

A. Yes. More than 53% of women ages 15 and older who saw an obstetrician-gynecologist in 1987 (most recent data) did so for the purpose of having a general checkup. Obtaining a general checkup was a more frequently cited reason for seeing an obstetrician-gynecologist than it was for seeing either family physicians or internists. Surveys of office visits by women to obstetrician-gynecologists show that women overwhelmingly choose to see obstetrician-gynecologists over general physicians and internists for the following: normal pregnancy, menopausal and postmenopausal health concerns, contraceptive management, postpartum care and examination; and infertility.

Also, according to a survey conducted by an employee benefits consultant, 68% of women responded that they would be unwilling to give up their obstetrician-gynecologist to save money. This percentage was significantly higher than the employees' responses regarding their willingness to change other primary care physicians.

Q. If obstetrics/gynecology is classified as a primary care specialty, would all obstetrician-gynecologists provide primary care?

A. No. While the majority of obstetrician-gynecologists describe themselves and their practices as primary care, some obstetrician-gynecologists will continue to specialize in infertility, oncology, or maternal-fetal medicine. This is desirable. Pediatrics and internal medicine traditionally have been considered primary care specialties, yet not all pediatricians and internists are primary care physicians, nor should they be.

Q. Don't current federal and state health care policies define obstetrics/gynecology as primary care?

A. Yes and no. Federal and state policies are inconsistent. The National Health Service Corps, for example, which provides scholarships to primary care physicians

serving in underserved areas, includes obstetrician-gynecologists in that classification. The Primary Care Loan program -- formerly the Health Profession Student Loan program, a key federal funding source of student loans -- does not define obstetrics/gynecology as primary care.

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THE OBSTETRICIAN-GYNECOLOGIST: PRIMARY CARE PHYSICIAN

The specialty of obstetrics and gynecology is devoted to the health care of women throughout their lifetime. Primary-preventive health care is integral to services provided by obstetrician-gynecologists. These include periodic health screening, evaluation and counseling about health/risk behaviors and immunization. Family planning, sexual counseling, instruction in breast self-examination, health education, instruction in health promotion, hypertension and cardiovascular surveillance, osteoporosis counseling, sexually transmitted diseases counseling, and identification of domestic violence are many of the primary-preventive services in the well-patient encounter with the obstetrician-gynecologist. One of the most significant preventive health services provided by obstetrician-gynecologists is prenatal care and risk assessment prior to and during pregnancy.

For many women, their obstetrician-gynecologist serves as their primary physician. As the health care delivery system undergoes major changes, it is imperative that women's direct access to their obstetrician-gynecologist not be limited by Congress' failure to classify obstetrician-gynecologists as primary care.

- Significant numbers of women view their obstetrician-gynecologist as their primary or only physician. For many women, the obstetrician-gynecologist is often the only physician they see regularly during their reproductive years. According to recent surveys conducted by ACOG, more than half of women in a national sample considered their obstetrician-gynecologist to be the principal physician providing their medical care.

- Family planning is a critical preventive health care service for women. According to the National Center for Health Statistics (NCHS) visit survey data, three-fourths of all office visits for family planning purposes in 1989 and 1990 were to obstetrician-gynecologists.

- According to NCHS data, the second most frequently cited purpose of patient visits to obstetrician-gynecologists in 1989 and 1990 was for a general medical exam, accounting for seven million visits annually.

- In 1987, more than 53% of women ages 15 and older who saw an obstetrician-gynecologist did so for the purpose of having a general checkup. Obtaining a general checkup was a more frequently cited reason for seeing an obstetrician-gynecologist than it was for seeing either family physicians or internists.

- Prenatal care is an essential primary care service for pregnant women. Every year, approximately 80% of maternity care services in the U.S. are provided by obstetrician-gynecologists.

- According to a survey of employee attitudes toward health plan design, 68% of women responded that they would be unwilling to change their obstetrician-

gynecologist to save money. This percentage was significantly higher than the employees' responses concerning their willingness to change other primary care physicians.

- Data from various sources consistently support the primary care services provided by obstetrician-gynecologists, particularly in terms of inquiry and counseling in relation to preventive risk behaviors -- the true aim of prevention. In 1992, under contract from the HHS Office of Disease Prevention and Health Promotion, ACOG conducted a randomized survey of obstetrician-gynecologists. The survey found that a large proportion (more than 40%) of patients cared for by obstetrician-gynecologists receive a wide variety of preventive care services. Of obstetrician-gynecologists who provide primary care,
    - 85% reported that they routinely queried about family planning/preconception care;
    - 71% routinely queried about sexual practices and counseled about STDs including HIV infection;
    - 71% routinely queried about smoking, 55% about alcohol and 53% about illicit drug/medication use;
    - about half queried about diet (51%) and exercise (48%) and one third queried about work related health risks;
    - 40% queried about emotional/behavioral function.

- Obstetrician-gynecologists refer their patients less frequently than other primary care specialties, thus avoiding costly and time-consuming referrals to specialists. According to a 1991 study of physician referral rates, obstetrician-gynecologists had the lowest referral rate at 4%, as compared with referral rates of 7.3% for general internists, and 8.4% for general/family practitioners.

- The NCHS visit survey found that more than two-thirds (69.5%) of all visits to obstetrician-gynecologists were by established patients of the physician who were returning for care of their condition. In contrast, only 4.7% of patient visits resulted from referrals from another physician.

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