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Patient Profile: A Comprehensive Study of the Reasons for Visit As Well As the Sex and Age Distributions of Patients Seen in a Kankakee General Practicioner's Office Between the Months of May and July

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PATIENT PROFILE: A COMPREHENSIVE STUDY OF THE REASONS FOR VISIT

AS WELL AS THE SEX AND AGE DISTRIBUTIONS OF PATIENTS

SEEN IN A KANKAKEE GENERAL PRACTITIONER'S OFFICE

BETWEEN THE MONTHS OF MAY AND JULY

By

Jennifer A. Kershaw

Honors Capstone Project

Submitted to the Faculty of

Olivet Nazarene University

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in

Biology
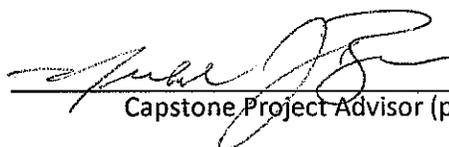
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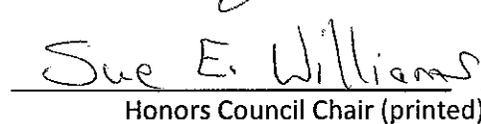
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ACKNOWLEDGEMENTS

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ABSTRACT

The goal of this project was to examine the patients that a general practitioner (GP) sees in a given time period and to chart their characteristics in order to better understand the mosaic of patients seen in such a practice. Comprising this profile are answers to the following questions: Are females or males seen more frequently in the GP's office? What is the distribution of ages seen most frequently? What are the most common presenting symptoms? Data was collected via survey from the office of Dr. Rodney Alford in Kankakee, IL between May 10, 2010 and July 10th, 2010. When weighing decisions regarding specialty training, medical students often have little personal knowledge of medical practice environments upon which to make sound decisions. The goal of this study is to provide additional data for this decision making process. Such data might also guide topic selection for certification exams at the end of training for new practitioners as well as postgraduate continuing medical education courses for established physicians. This study was limited by small sample size, low survey participation and failure of participants to answer questions in context. However, the following observations seem instructive and are generally similar to available national data on age, ethnicity and presenting symptoms. These observations are that the most common reason for visit is check-ups, the most commonly seen age group is 61 years old and older, and females are seen more frequently than males.

INTRODUCTION

A general practitioner, also known as a family practitioner, is a physician that sees many types of patients. These patients range in age from newborns to senior citizens, from pediatrics to geriatrics (Santiago, 2010). After four years of medical school a three-year residency is required to achieve Board Certification in Family Practice (McGaha, et. al., 2007). This type of physician then generally practices in an office (clinical) setting, with office hours four to five days of the week. General practitioners (GPs) sometimes also have patients in nursing homes which they visit on their "day off."

According to Santiago (2010), and consistent with my observation, "During office hours, a family physician may see anywhere from 22-25 patients per day on average, with some doctors seeing up to 30 patients daily." Furthermore, GPs may have nights when they are on call for patients being admitted to the hospital, and often make rounds in the hospital when they have had an established patient admitted. In fact, according to Leawood (2005), "more than 80 percent of family physicians choose to have hospital privileges." Common office visits "may include immunizations, yearly physicals, colds and flu, common skin issues or 'lumps and bumps,' and a wide variety of patients with chronic issues such as hypertension, allergies, or diabetes" (Santiago, 2010). According to Leawood (2005) "most family physicians (82 percent) perform skin and nail procedures; 35 percent regularly perform colposcopy; and 35 percent perform flexible sigmoidoscopy." Leawood goes on to say that "family physicians receive training in a variety of procedures, including joint injections, paracentesis, thoracentesis, intubation and advanced life support, ultrasonography, stress testing, colonoscopy, esophagogastroduodenoscopy, vasectomy, tubal ligation, cervical cancer treatment, pulmonary function testing, and maternity care."

There is a serious lack of information available to the public on the types of illnesses and patient characteristics that a general practitioner sees the most. Because the physician's office is a place of confidentiality, there are certain restrictions in place for access to patient information. In addition, when

a study involves people in any way, researchers must first receive approval from the Institutional Review Board (IRB). These restrictions create an interesting state of dynamic tension between protecting patient confidentiality and acquiring thorough and reliable scientific data. This study will focus on the office of the general practitioner and attempt to create a comprehensive patient profile that provides the most common patient characteristics a GP sees on a regular basis. Comprising this profile should be answers to the following questions: Are females or males seen more frequently in the GP's office? What is the distribution of ages seen the most frequently? What are the most common reasons for visit?

REVIEW OF LITERATURE

Research has been done exploring the most common reasons for office visits to private practices (U.S. Census Bureau, 2008); however, data specific to the general practitioner's office is very limited, which is why it was important to study. One study was done on the frequency of adults visiting a family doctor due to the common cold (McIsaac, 1998). In this study, patients that had reported having a cold, or upper respiratory tract infection, in the last two weeks were surveyed on whether they had made a visit to their doctor, along with questions involving their use of over the counter medications and personal characteristics. The findings showed that only 14% of those studied had visited a doctor, while the remaining 76% had simply self-cared with over the counter medications. The study was done because of the belief that people all too often visit the doctor for colds even though they are self-limited issues for which doctors often cannot do much to help treat. This study showed that in reality, most adults do not seek medical help for a cold, though severity of symptoms and other factors can influence this decision. This study is beneficial for physicians when evaluating patient tendencies in dealing with certain illnesses; however, for the purpose of this study, simply tracking one illness does not give an overall picture of the patient base a general physician treats. All it might suggest is that fewer people come in with complaints of the common cold than may be assumed.

Many articles have been written which journal a week in the office of a family doctor, thus providing examples of different reasons for visit. One such example is an article by Paul Gross, M.D. (2005). Dr. Gross has written a number of articles on some of the patients he encounters during a week in family practice. His articles give invaluable insight for a pre-medical student, as they provide a glimpse into his practice and the types of patients that he sees. The limitations of such articles are their incompleteness. Gross writes them as reflections of his days. In his evaluations of the patients that came through that week are attributions and assumptions of his own, and as the diary is not a scientific log of

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all the patients that he saw, but rather a personal recollection, only some of the cases are given attention. Even if he were to give a complete log of the week from a scientific standpoint, one week just simply is not a long enough period of time to provide a comprehensive view of the scope of practice of a general practitioner.

Another study serving to influence this one looked specifically at patients visiting a doctor for one type of injury and charted their characteristics. Adeyinka O. Ashaye (2009) compiled a comprehensive study of "all consecutive patients with eye injury in children and adolescents who were ≤18 years of age and who were admitted to UCH, Ibadan, Nigeria, between January 2004 and June 2005, an 18-month period." The information obtained from the patients or their parents included "age, sex, agent of injury (stick or stone, etc.), activity at the time of injury and place of injury. Other information collected was the time between injury and presentation, and if any other treatment was received prior to presentation" (Ashaye, 2009). Though Ashaye's study was done in Nigeria and specifically on patients suffering from eye injuries, the approach seemed very thorough, and appeared as though if applied to a general practice, similar results could be obtained just by adding a question inquiring of the reason for visit, as that varies in the general practice setting. This study will follow the example set by Ashaye (2009) in order to provide a comprehensive view of the age, sex, and reason for visit most commonly seen by a general practitioner

METHODS

The study was conducted on patients visiting the office of Dr. Rodney Alford, M.D. in Kankakee, IL. Surveys were created and placed on clipboards in each of the examination rooms. A large poster was placed behind the stacks of surveys that simply said in black box letters, "Would you like to take a survey while you wait?" Next to the survey was a manila envelope marked "completed surveys" for patients to place their surveys after completion, as well as a few pens with which to complete them. The survey was completely anonymous, and to preserve anonymity and remove any fear of being exploited, at least one ploy survey completed by the researcher was present in each manila envelope at all times. Patients were not otherwise persuaded, encouraged, or verbally invited to complete the survey. At the top of each survey was the following introduction:

"Hi. My name is Jennifer and I'm a pre-medical student at Olivet Nazarene University. I'm collecting information on patients visiting general practitioners' offices. The goal of this study is to help medical students and doctors in the field of General Practice to be more effective doctors. This directly affects patients, as their quality of care could be increased. Below is a quick survey that is completely anonymous that would help me complete this research. Notice the survey does not ask for your name. Please only provide the information that is asked of you. If interested, please fill one out and place it in the envelope when finished. The envelope is for your confidentiality. Please place your completed survey there rather than hand it to someone. You may choose to discontinue or withdraw from the survey at any time without consequence. Note that there is a contact number at the bottom if you have any questions or concerns. "

NOTE: If patient needs assistance, assistance may be given them.

A bit further down, right above the survey questions is an explanation of how and to whom the research is beneficial. It reads as follows:

Questionnaire

The information collected from this questionnaire will allow medical students to be more informed as they attempt to choose a specialty. It will also allow new General Practitioners to prepare for the ages and illnesses they are most likely to see in the office, as well as help current practitioners to see what type of medicine they are in most need of refreshing.

*Please do not provide any information other than what is asked of you. Please only fill out one survey per patient per visit.

Initially, the goal of the project was to shadow the physician during all office visits and collect data firsthand, utilizing patients' charts while complying with HIPPA laws and other privacy restrictions in place. When attempting to obtain IRB approval, it became clear that such a method would not be permissible for undergraduate research, and it would have more barriers than could be surpassed for the scope of the project. In order to adhere to said restrictions, a survey was created as a less intrusive manner of data collection.

A complete copy of the survey utilized can be found in Appendix A. It simply includes five questions. The first asks for the patient's age, the next for their sex, and the third for their ethnicity. The fourth asks "What symptoms are you here to talk to the doctor about today (i.e. cough, stomach aches, a cut/wound)?" and the fifth asks "Approximately how long did you wait after first experiencing symptoms before coming in today?" No other information was asked of the patient. These questions were chosen in order to obtain a basic profile of the patients coming into Dr. Alford's practice. If women were seen more than men, or patients coming in due to the common cold were more numerous than

any other, such findings were noted. In addition, any correlations between sex and symptoms or ethnicity and symptoms were noted as well. The final question was meant to see if a link was present between sex or ethnicity and the amount of time the patient endured his or her condition before seeking medical attention. Any findings that might have indicated that one sex typically waits longer to seek medical help than the other or that one ethnicity waits longer than another would have been of special interest and have been explored in more depth to discover what possible explanations might exist to support such findings. With these questions, a new general practitioner or pre-medical student would have a good idea of what they are most likely to encounter in a general practice. As stated in the survey, such information would be invaluable to the new physician or pre-medical student, and could also benefit the established physician, as he would be able to see what topics he is in most need of refreshing. Ultimately, the result in any case is better patient care, which is the end goal for all involved.

Besides the posters placed in the office, no other information or encouragement was given to the patients to fill out a survey, so as to avoid causing any distress or undue pressure in what might be for some an already stressful or embarrassing situation. The surveys were present in the examination room for three months: from May 10th, 2010 to July 10th, 2010. During this time, Dr. Alford's office had 1,448 patient visits. At the end of the time period, surveys were collected and analyzed using SPSS, a data analysis program. This program allows for the entry of data and for specific tests and analyses to be run quickly in order to make conclusions about trends and patterns present in the data.

As the survey questions were fill-in-the-blank, responses had to first be categorized before they could be analyzed. This was done with the help of Dr. Michael Pyle, M.D., the professor mentor for this project. Symptoms were placed into one of ten created categories: skin condition, psychological/social, respiratory disease, diabetes, check-up/wellness check, genito-urinary tract disease, surgery-related problems, musculoskeletal problems, gastrointestinal problems, or multiple minor complaints. Ages

were broken into five year increments. Ethnicities were divided into White/Caucasian, Black/African

American, Hispanic, or other. Each variable could then be given a numerical value (i.e. 1 signifying male,

2 signifying female for sex) and then entered into the SPSS program. Totals, frequencies, and

percentages were then determined by the program.

RESULTS

Before interpreting the results, it is important to note that only a total of 92 people completed

the survey. Of the 1,448 patients that were seen in Dr. Alford's office during the study, this number only

accounts for 6.4% participation; thus, all results obtained are questionable. The tables that follow show

the frequency totals for the different categories explored by the survey. Females were seen nearly 3

times as often as males in Dr. Alford's office, as shown in Table 1. Table 2 shows the most frequently

seen age group during this time period, at 28.3%, were aged 61 or older. Table 3 shows Caucasians as

the most frequently reported ethnicity at 47.8%, followed by African Americans at 39.1%. Finally, the

most commonly reported reasons for visit, as shown in Table 4, fell under the category of "check-

up/wellness check." These findings raise interesting questions, which will be explored in the next

section. Other data can be found in Appendix B, but the above data was found to be most significant.

Table 1 – Age

Age	Frequency	Percent
0-5	2	2.2
6-10	3	3.3
11-15	7	7.6
16-20	5	5.4
21-25	2	2.2
26-30	2	2.2
31-35	6	6.5
36-40	6	6.5
41-45	6	6.5
46-50	9	9.8
51-55	7	7.6
56-60	11	12.0
61 or older	26	28.3

Table 2 - Gender

Sex	Frequency	Percent
Male	24	26.1
Female	68	73.9

Table 3 – Ethnicity

Ethnicity	Frequency	Percent
White/Caucasian	44	47.8
Black/African American	36	39.1
Hispanic	2	2.2
No Response	7	7.6
Other	2	2.2

Table 4 – Symptoms

Symptoms	Frequency	Percent
Pain	6	6.5
Skin Condition	5	5.4
Psychological/Social	6	6.5
Respiratory Disease	17	18.5
Diabetes	7	7.6
Check Up/Wellness Check	30	32.6
Genito-Urinary Tract Disease	4	4.3
Surgery-Related Problems	2	2.2
Musculoskeletal Problem	8	8.7
Gastrointestinal	4	4.3
Multiple Minor Complaints	3	3.3

DISCUSSION

Symptoms most frequently seen in a general practitioner's office is the first datum to discuss. A study was done by the Department of Family Medicine at Case Western Reserve University where 266 randomly selected office visits to 37 family physicians were monitored. The results showed that in 73% of the visits, the physician and the patient addressed more than one problem (Flocke 2001). In categorizing the symptoms listed on surveys, some surveys had more than one listed, and some had so many listed that a category had to be created for those listing 'multiple minor complaints.' This category, however, did not prove to be the most common. The most common symptom category in this survey was "Check-Up/Wellness Check," making up 32.6 percent of all who completed the survey. This information, again, must be read with the understanding that the percentage might be skewed. Patients may simply have been most comfortable with the idea of filling out a survey if they were just coming in for a check-up. Patients in this category were likely to be experiencing less anxiety than those coming in with new symptoms or issues, and may have even been proud of the fact that their visit was one in good health, leading to a desire for that status to be documented, even if anonymously. Data from this survey was compared to an ongoing publication by Paul Gross called "Diary from a Week in Practice" (2005) that lists a few symptoms he sees patients presenting with in the office setting. With the exception of Diabetes, none of the symptoms he mentioned were represented in the results of this survey. This may be explained by an embarrassment factor; even though these surveys are anonymous, it is possible that a man coming in for erectile dysfunction, one of the symptoms mentioned in the diary, would be too self-conscious to fill out a survey which asks him to write down his symptoms. The hope was that in making the surveys completely and thoroughly anonymous that any anxiety which might prevent a person from filling out a survey indicating their symptoms would be eliminated, but the results do not

seem to support that: with ninety-two surveys completed in a time period in which 1,448 patients were seen in the office, the data collected only represents a 6.4% sample.

The next datum to explore is the age range most frequently seen. According to the Statistical Abstract of the United States (2009), 15% of visits to a typical practice are from children. The percentage of those aged 15 & under who visited the office and filled out a survey was 13%. Those percentages are very similar. The most commonly seen age group during the three month period was those aged 61 or older, which comprised 28.3% of all patients seen. No other significant findings involve age.

In regards to gender, an overwhelming 73.9% of the patients seen were females compared to just 26.1% male. This is nearly a 3:1 ratio of women to men coming to the doctor's office. However, the US Census Data listed in the Statistical Abstract of the United States (2009) says that in 2006, males made 368.7 million visits to physician offices compared to females' 533.3 million visits, which is nearly a 1.5:1 ratio for female to male visits. The discrepancy between those two ratios may be partially attributed to the fact that women may simply be more likely to fill out surveys than men, which could give a skewed impression of the patient gender breakdown normally seen in a general practice.

Another finding worth noting involves the breakdown in ethnicities represented by the data. Self-reported ethnicities were 47.8% White/Caucasian, 39.1% Black/African American, and 2.2% Hispanic. If one compares this to the breakdown of ethnicities found in Kankakee, IL, according to U.S. Census data from 2000, it is clear that the percentages are not very different. Of those that live in Kankakee, IL, 53.5% are White, 38.9% are Black, and 8.7% are Hispanic. Although the breakdown is representative of the city population, the percentages do not line up with the normal visit frequency for each of the ethnicities. According to the US Census data from 2006 (2008), there were 764.6 million visits made to physician's offices by Whites, compared to only 87.0 million visits made by Blacks/African Americans. This means that Whites made 8.8 times more visits than Blacks in that year. The sample

collected from Dr. Alford's office does not have such a discrepancy between white and black visits. This might be explained by the role of ethnicity in physician trust. A study published by Cooper-Patrick et al and referenced in an article by M.P. Doescher on physician style and trust (2000) found that "African American patients rated their visits with physicians as less participatory than whites." That same study found that "African American patients who visit African American physicians rated their physicians' decision-making styles as more participatory." The study suggests that patients who see their physician as more participatory also feel more trusting of the care they receive from that physician. As Dr. Rodney Alford is an African American man, it is likely that the greater representation of black patient visits to his office is due to African American patients feeling more secure in the hands of an African American physician, making them likely to seek healthcare more frequently at this office than the national average would suggest.

A few things could have led to low survey participation. First of all, with no prompting by the researcher, the only people represented in this survey are those that were intrinsically motivated to fill out a survey. Also, if someone was unable to read and did not have another individual with them in the examination room, they would have been oblivious to the poster about the survey, and thus would not be represented in the results. Another unforeseen shortcoming in the survey was the wording chosen on some of the questions. Initially the survey included five questions, but due to many misunderstanding the final question, the answers to that question were not useable. Also, some respondents did not list ethnicity, which might simply reflect unfamiliarity with the term as compared to a term like 'race.' This could be a cause for skewed data.

The design of this study had apparent limitations that certainly affected the results. Because of the requirements for IRB approval and the restrictions set by physician offices and hospitals for healthcare confidentiality, the study could not be performed as originally planned. Instead of a

collection of objective, thorough scientific data, subjective, incomplete data was obtained, which

significantly impacted the results of the study. The survey was clearly an ineffective data collection tool,

as only 6% of the patients that came through the office during the time frame studied completed a

survey, thus making the results largely inconclusive and unreliable.

There is obviously a dynamic tension in research between protecting the rights of the

participants and obtaining good scientific results that one must consider when undertaking a research

project. It is important that we protect the rights of the individual, but at what point does that

protection overrun the rights of others? If the study focuses too much on patient rights at the expense

of inconclusive results, then no conclusions can be drawn from the research. If the research cannot be

completed and provide meaningful, reliable results, then the people affected in the end are those we

are working so hard to protect in the first place. Without good scientific data about the patients seen in

this setting, new family practitioners and established family practitioners are unable to provide the best

patient care possible. Therefore, the patient is not as well cared for, and the attempt to protect them in

the first place is for naught.

Unfortunately, the results of this study suffered greatly from the rigorous restrictions of the

environment the study was set to explore. If the study were to be done again in the future, chart review

would definitely be a more effective means of data collection. Such a collection method would require

much greater authorization from both the IRB and the healthcare field, as well as a researcher with

greater authority than an uncertified undergraduate student, and thus was beyond the scope of this

project; but if such authorization could be granted for another study, more thorough data could be

compiled, and a more complete sample could be obtained.

This researcher hopes that in the future, a researcher in a more privileged position will pick up

where this study left off, and work to truly create a reliable, thorough patient profile for the field of

general practice. Pre-medical students and new graduates ready to start work as a general practitioner need to know what they will encounter in this setting. They need to have reliable data to reference in order to prepare as thoroughly as possible for the patient characteristics they are most likely to encounter. Such data should also be published so that general practitioners can compare the patients seen in their practices with those around the country. It is truly disappointing that this study cannot fully provide such data, as this researcher believes that the publication of that information would lead to better patient care, which should be the goal of every physician and physician-to-be. In conclusion, the data sample collected by this study was simply too small to make any serious conclusions; however, some similarities to available national data were seen in age, sex, ethnicity, and presenting symptoms.

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APPENDIX A – Survey

Below is the survey used in the office of Dr. Rodney Alford.

"Hi. My name is Jennifer and I'm a pre-medical student at Olivet Nazarene University. I'm collecting information on patients visiting general practitioners' offices. The goal of this study is to help medical students and doctors in the field of General Practice to be more effective doctors. This directly affects patients, as their quality of care could be increased. Below is a quick survey that is completely anonymous that would help me complete this research. Notice the survey does not ask for your name. Please only provide the information that is asked of you. If interested, please fill one out and place it in the envelope when finished. The envelope is for your confidentiality. Please place your completed survey there rather than hand it to someone. You may choose to discontinue or withdraw from the survey at any time without consequence. Note that there is a contact number at the bottom if you have any questions or concerns. "

NOTE: If patient needs assistance, assistance may be given them.

Questionnaire

The information collected from this questionnaire will allow medical students to be more informed as they attempt to choose a specialty. It will also allow new General Practitioners to prepare for the ages and illnesses they are most likely to see in the office, as well as help current practitioners to see what type of medicine they are in most need of refreshing.

*Please do not provide any information other than what is asked of you. Please only fill out one survey per patient per visit.

1) Age _____
2) Sex _____
3) Ethnicity_____
4) What symptoms are you here to talk to the doctor about today (i.e. cough, stomach aches, a cut/wound)?
_____
_____
_____
_____
5) Approximately how long did you wait after first experiencing symptoms before coming in today?
_____

Questions? Comments? Contact Dr. Michael Pyle, Professor of Biology at Olivet Nazarene University. Phone: (815) 939-5377 Mailing Address: ONU Box 6047, One University Ave., Bourbonnais, IL 60914

APPENDIX B - Additional Data Tables

Below are the tables that were concluded to have insignificant findings.

Table B5 - Symptoms and Gender Crosstab

Count		Gender		
		Male	Female	Total
Symptoms	Pain	1	5	6
	Skin Condition	0	5	5
	Psychological/Social	1	5	6
	Respiratory Disease	6	11	17
	Diabetes	0	7	7
	Check Up/Wellness Check	9	21	30
	Genito-Urinary Tract Disease	1	3	4
	Surgery-Related Problems	0	2	2
	Musculoskeletal Problem	3	5	8
	Gastrointestinal	3	1	4
	Multiple Minor Complaints	0	3	3
	Total	24	68	92

Table B6 - Symptoms and Gender Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	13.044[a]	10	.221
Likelihood Ratio	16.487	10	.087
Linear-by-Linear Association	1.799	1	.180
N of Valid Cases	92		

a. 17 cells (77.3%) have expected count less than 5. The minimum expected count is .52.

Table B7 - Symptoms and Gender Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Phi	.377	.221
	Cramer's V	.377	.221
	N of Valid Cases	92	

Table B8 - Symptoms and Age Crosstab

Symptoms	Age													Total
	0-5	6-10	11-15	16-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61 or older	
Pain	0	0	0	0	0	1	0	0	1	1	1	0	2	6
Skin Condition	0	0	1	1	1	0	0	0	0	0	1	1	0	5
Psychological/Social	0	0	1	0	0	0	1	1	1	1	1	0	0	6
Respiratory Disease	0	1	2	2	0	1	2	2	0	0	0	2	5	17
Diabetes	0	0	0	0	0	0	0	0	0	2	0	1	4	7
Check Up/Wellness Check	2	2	1	0	1	0	2	1	1	4	3	5	8	30
Genito-Urinary Tract Disease	0	0	0	1	0	0	0	1	0	0	0	0	2	4
Surgery-Related Problems	0	0	0	0	0	0	0	0	0	0	0	1	1	2
Musculoskeletal Problem	0	0	0	0	0	0	1	1	1	1	1	1	2	8
Gastrointestinal	0	0	2	1	0	0	0	0	0	0	0	0	1	4
Multiple Minor Complaints	0	0	0	0	0	0	0	0	2	0	0	0	1	3
Total	2	3	7	5	2	2	6	6	6	9	7	11	26	92

Table B9 - Symptoms and Age Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.083E2	120	.769
Likelihood Ratio	101.784	120	.884
Linear-by-Linear Association	.319	1	.573
N of Valid Cases	92		

a. 142 cells (99.3%) have expected count less than 5. The minimum expected count is .04.

Table B10 - Symptoms and Age Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Phi	1.085	.769
	Cramer's V	.343	.769
	N of Valid Cases	92	

Table B11 - Symptoms and Ethnicity Crosstab

Count

		Ethnicity					
		White/Caucasian	Black/African American	Hispanic	No Response	Other	Total
Symptoms	Pain	2	3	0	1	0	6
	Skin Condition	1	4	0	0	0	5
	Psychological/Social	4	2	0	0	0	6
	Respiratory Disease	9	4	0	2	1	16
	Diabetes	2	3	0	1	1	7
	Check Up/Wellness Check	16	12	1	1	0	30
	Genito-Urinary Tract Disease	2	2	0	0	0	4
	Surgery-Related Problems	1	1	0	0	0	2
	Musculoskeletal Problem	3	4	0	1	0	8
	Gastrointestinal	2	1	1	0	0	4
	Multiple Minor Complaints	2	0	0	1	0	3
	Total	44	36	2	7	2	91

Table B12 - Symptoms and Ethnicity Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	32.720[a]	40	.786
Likelihood Ratio	27.444	40	.934
Linear-by-Linear Association	.040	1	.841
N of Valid Cases	91		

a. 51 cells (92.7%) have expected count less than 5. The minimum expected count is .04.

Table B13 - Symptoms and Ethnicity Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Phi	.600	.786
	Cramer's V	.300	.786
	N of Valid Cases	91	