McGraw-Hill ESSENTIAL DICTIONARY OF HEALTH CARE

A Practical Reference for Physicians and Nurses

Lee Hyde

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Lee Hyde, M.D.

McGraw-Hill Book Company

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1 2 3 4 5 6 7 8 9 0 DOC DOC 8 9 4 3 2 1 0 9 8

ISBN 0-07-031614-7

This book was set in Century Schoolbook by McGraw-Hill Book Company Publishing Center in cooperation with Monotype Composition Company.
The editors were Deborah Glazer and Mariapaz Ramos-Englis.
The production supervisor was Elaine Gardenier.
The text was designed by Carol Woolverton and the cover was designed by Edward Schultheis.
R. R. Donnelley & Sons was printer and binder.

Library of Congress Cataloguing-in-Publication Data

Hyde, Lee, date.
The McGraw-Hill essential dictionary of health care: a practical reference for physicians and nurses.

Bibliography: p.
Includes index.
1. Medical care—Dictionaries. 2. Health planning—Dictionaries. I. Title. [DNLM: 1. Health Services—dictionaries. W 13 H994m]
RA423.H93 1988 362.1'03'21 87-32497
ISBN 0-07-031614-7

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A Practical Reference
for Physicians and Nurses

"Ya' gotta serve somebody."
—Bob Dylan

To those I serve
and
to those who raised
and taught me to do it

Foreword

In a world of high technology and highly evolved bureaucracies, we have come increasingly to depend, in our businesses and professions, on machines, whether those made of steel and microprocessing chips or those fashioned out of human institutions. We have mechanized our transactions, our communications, our interactions. And we have changed our language to express and to accommodate our new relationships.

New words enter our personal and professional lives to capture meaning, to give form to our discoveries, to fill needs created by an expanding universe. The language is dynamic, and those words that are not mere passing fancy help write human history.

The proliferation of technology, of concepts, and of words is overwhelming if it is not organized. Our highways organize our transportation, our laws organize our social institutions, and our dictionaries organize our words and thoughts.

In the field of health care, this proliferation is manifest—for technology, concepts, and words are joined in a crucial endeavor. In the matter of health care, language must be purposeful, useful, and crystal clear. We have medical technology that offers unprecedented opportunities for remedy, rehabilitation, and relief; we have a health care establishment that is vast, powerful, and complex.

The machinery of this enterprise—the sophisticated life-saving devices, the financial inner workings, the social relations, the regulating mechanisms—is under the direction of a cast of players, from administrators and physicians to lawmakers and patients. To direct this en-

terprise wisely, to keep the machinery tuned and adjustable, and to achieve efficiency and equity, we require a firm grasp on the words and the terms, the acronyms and the abbreviations that serve as our tools. In this way, we can make sure that we understand each other and that we can proceed to shared goals.

No matter what our stake in the health care enterprise, we are constantly being guided—by our peers and by our knowledge. In this process, a dictionary of health care, embodying the values and concepts that have made it necessary to affix the label "modern" to health care, is an essential guide. We refer to it in order to refresh our memories, to reacquaint ourselves with words that we have temporarily lost, and to educate ourselves in new or unfamiliar territory. We may want to refer to it before we make important, perhaps even life-and-death, decisions. We should refer to it when we begin to feel overrun by cliches and jargon. It is to this end that *this* dictionary is written.

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Preface

This is a collection of words. My grandfather collected stamps; I have collected the words, concepts, peculiar recurrent phrases, common and obscure acronyms, and good names for useful ideas from my life as a physician. The collection, a dictionary, is intended for use by anyone interested or involved in efforts to maintain health, including clinicians, managers, and lay people, whether members of Congressional committees concerned with health, consumer members of health program governing boards, or patients. As any good stamp collector knows the history of each stamp in his collection, I know the "history" of my words. I have included references that provide additional, more encyclopedic information about the particular concepts and an annotated bibliography of additional sources. References are generally available, which justify and give the primary sources for the definitions.

The dictionary should be of particular use to clinicians.

Historically, doctors, nurses, and other clinicians knew everybody in the business. The number of other clinicians and managers in one's own town was small enough that one might know all of them. There were no insurance companies, out of town managers, or interested government officials. But, during the last several decades, as the effort to maintain a healthy population has grown in knowledge, technology, size, and complexity, the medical community has also become deeply divided. The internists have never met the neonatologists, let alone a Blue Cross executive or an industrial hygienist. The administrators of the community and profit-making hospitals rarely talk to each other,

although both are talking to the health maintenance organization people; none of them understand the psychiatrist.

The most fundamental division separates the clinicians, the physicians, nurses, and other people engaged in direct patient care, from the managers, the hospital administrators, policymakers, insurers, and people who run the system that makes care possible. This book is intended to help bridge the divide, to make it possible for the clinician to understand the manager.

Each division of the health system has its own language. As knowledge and practice become more specialized, so does each division's dialect. If clinicians are to be effective in their caring efforts, to be as good as they would like to be, they must speak the language the managers speak. Actually they don't have to speak it, to actually say those things, but they better understand it. By trying to reduce the language of administrators, insurers, lawyers, and such to plain English I hope to make this possible. While English is spoken herein, this is not watered down; an attempt has been made to define terms with precise and complete definitions reflecting full professional meaning. Discourse has been added to show the terms in use, give examples and alternative or official definitions, and emphasize issues and nuances. In case the managers read this as well, and for the amusement of the clinicians, I have included some of the jargon of clinical medicine leaving out the worst, as (lexicographers say "as" rather than "for example" or "such as," it is briefer) Texas catheter and nun's cap, although I have never met a manager who knew their meaning.

The dictionary defines primarily the language, specialized vocabulary, and jargon of the practice and management of health care, without covering the clinical and technical language used in the direct delivery of services. (The latter is left to the standard medical dictionaries: good sources include *Blakiston's*, 1979; *Dorland's*, 1986; *Friel*, 1985; *Landau*, 1986, and *Stedman's*, 1983.) Alternatively put, the vocabulary defined is that of the institutional and organizational form of health care, rather than of its clinical content. The dictionary's scope is the terminology people working in health care use during, and as a specialized part of, their work. There is naturally some overlap between this work, standard medical dictionaries, and glossaries of other disciplines with which health and its care interact. Where terms are well covered in other works, the treatment here is fairly brief and generic, since the focus is on the language unique to health care.

Some of the terms are truly unique to the health field, as slang, which is included. Some are borrowed from or overlap with those of other disciplines (law, economics, sociology, psychology, insurance, finance, and management, for instance). The former are given greater coverage than the latter, particularly where good dictionaries in the

related fields are cited. Coverage of other disciplines focuses on concepts that are particularly generic, useful, commonly misunderstood, or in common use in the health field.

Coverage is limited only by the author's limitations of time, energy, resources, and ability to find contributors to share the load. These limits must explain why some programs, laws, and subjects are included or better covered in preference to others. The same limits also certainly explain any errors; they are not made intentionally. Corrections will be much appreciated. Besides, errors are a lexicographer's way of proving he or she is human. (Throughout the text where male pronouns appear, it should be understood that their use is for convenience and the intention is that their meaning be universal.).

Coverage is also generally and preferentially exhaustive (although brief definitions with cross-references may be used for large families of related terms and other minor variants). Historical events and entities are included, and specialized or infrequently used terms are covered, particularly where they have distinct or useful meanings.

Each definition in the McGraw-Hill Essential Dictionary of Health Care starts with a formal statement of the term's meaning. Except for the initial article, most definitions are given in a form that will replace the term defined in use in a sentence. Multiple meanings are numbered. Terms defined within a larger definition are preceded by an asterisk (*) where they are actually defined.

Wherever it is helpful to the reader, definitions contain discourse on the concepts they define. This goes beyond simple definition to examples, exclusions, limitations, suggestions on usage, cross-references, and so forth. Terms are defined as they are used by most workers in the field. This is in preference to defining them as may have been done in law or by other formal means, or as they ought to be used according to researchers, lexicographers, or other pedants. Where "official" or "proper" definitions are known, particularly by competent bodies or recognized organizations, they may be quoted or cited in addition to the definition given.

Cross-references are given in italics to generic terms in the family of concepts to which a term belongs, as "see *malpractice*" in the case of "good samaritan law," and where otherwise less than obvious or likely to be useful. A list of defined related terms will typically be found in the Conspectus at the location given in a definition. References are included, not for source or justification of a definition (often available from the author), but for further expansion on the term. They locate the kind of material the reader would seek in an encyclopedia or text rather than in a dictionary.

No effort is made to cover the pronunciation or etymology of the terms defined except in the unusual circumstance that the term is reg-

ularly mispronounced or an understanding of its origin is necessary to understand its meaning.

Many of the great array of acronyms and abbreviations encountered in health care are listed in their own section with their full meanings given so they may be found in the vocabulary, where most are defined. Finally, an annotated bibliography is supplied. It gives references on the language of medicine, about lexicography, concerning medical writing and resources, and to numerous other glossaries and encyclopedias related to health and health care. The bibliography is indexed by subject using the Conspectus. In the interests of brevity, citations in the Conspectus and text are given, as in anthropology, with only the principal author's last name and the year of publication.

In addition to defining the vocabulary, the dictionary uses several means to help the reader organize, map, and connect the covered vocabulary. Some have already been described: the cross-references within the text that suggest related terms, guide the reader to more generic or basic concepts and indicate useful if not obvious connections, references cited to more exhaustive material suitable to an encyclopedia or text, and the indexed bibliography of additional sources.

The most important organizing tool is the Conspectus. The terms in a specialized vocabulary like that of health care naturally have their own hierarchy and structure. Many of the terms form families of related concepts and these families are related to each other in ways that can be loosely but helpfully described with an outline or taxonomy. An attempt was made in the dictionary's first edition (*Discursive, 1976*) to describe these families for the reader's use, but it was inconsistently and inadequately done (*Viseltear, 1977*). In this edition the families of related concepts are listed more carefully, along with lists of the members of the families, in an outline locating the various families in relationship to each other in health care. This takes the form of a subject outline, known as the Conspectus, which lists essentially all the terms defined in the dictionary. Conspectus locations in each term's definition guide the reader to its family and place in the taxonomy and thus allow an understanding of the term's role and place in health care. The mapping of a language, attempted in the Conspectus, is more difficult than might have been expected, as I am sure the authors of MeSH and other indices are aware. Critical feedback on this part of the effort would be particularly appreciated.

This volume does not contain my whole collection. A fair amount of incomplete, uncertain, peripheral, and obscure material has been left out but is available from the author.

Stamp collectors trade through newsletters and collector's magazines; we shall have to trade through correspondence. I would appreciate any comments or contributions from users of this vocabulary.

Write me

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I shall attempt to respond, perhaps with a new definition in a new edition. Please provide complete references and information about new material: for a program or organization, an address, the year founded (and ended, if no longer in existence), a statement of purpose(s), a size indicator (budget, membership, whatever), and a reference to a history, an independent evaluation, or major products; for people, their birth and death years, nationality, profession, and contributions; and for plain concepts, one good reference enlarging on the subject and the actual text of any official, legal, or technical definitions with proper citations.

Writing this has helped me understand health and health care, what I am doing as a physician, and the health system in which I do it. I hope it serves you similarly.

Thank you.

Lee Hyde

Acknowledgments

Acknowledging help with a dictionary may be done by telling its story.

My conscious interest in health care began with public health while doing anthropological field work in Africa during college, for which I thank the National Science Foundation and Harvard Department of Anthropology. In medical school my concern for health policy was nurtured by a generally receptive faculty and, particularly, Deans Fred Robbins and Jack Caughey. Medical school and internship were followed by my years as a *yellow beret.* These were especially exciting because of a large group of powerful peers — Brian Biles, Rick Carlson, Merle Cunningham, Joe Fortuna, George Goldberg, Bob Graham, Dave Kindig, Fitz Mullen, Patrick O'Donoghue, Budd Shenkin, Bill Waters, Pete West — a wonderful group (no offense intended to anyone omitted).

Suddenly I went to Capitol Hill, where I particularly appreciate those who gave and taught me my job — Harley Staggers, Paul Rogers, James Menger, David Meade, Steve Lawton. There I took an incredible crash course in law, health policy, and the U.S. health system and community. I find a lot of parallels between defining terms and legal drafting.

The dictionary itself began in 1975 when the U.S. House of Representatives Committee on Interstate and Foreign Commerce and, particularly, its Subcommittee on Health and the Environment were studying national

health insurance. As the Committee's professional staff member for health, I undertook a glossary of terms relevant to the debate. This produced the first edition, which the Committee published as a staff background document, *The Discursive Dictionary of Health Care*, in February 1976. The acknowledgment printed then is repeated here, but it does not tell the whole story. Most of the organizations cited actually had all the work done by individuals whose names were omitted because of personal preference, organizational policy, or courtesy. These people are remembered with appreciation, many did lots of good work. Karen Nelson was the best office mate I've ever had and the only person I've known who understood Title XIX of the Social Security Act. If Anne Jordan hadn't been professionally trained as a secretary, I'm not sure I'd have ever found or finished anything. Anne also began the second edition by cutting up the first and taping each word on its own 5x8 index card (*Safire, 1978*, prefers 5x7 cards?!).

The 5x8 card file, known as "old words," grew to three twelve-inch boxes that were gradually edited at home, of course, but also at my mother's basement desk, Barb and Dale Schumacher's Rockburn Institute, Camp Sequin on the Maine Coast, Gloria O'Dell's place in Silver Lake, Pinewoods Folk Camp, and a number of other such kind, comfortable, and memorable places.

During most of the preparation of the second edition I made my professional home in the Department of Family Medicine of East Tennessee State University's Quillen-Dishner College of Medicine, i.e., in the beautiful Tennessee mountains. The Department's various chairmen, particularly David Doane, faculty, and staff have provided invaluable time and friendship for the effort. James Mitchell and Craig Haire worked well as medical student research fellows both in the library and at the word processor keyboards. Dawn Connor, Debbie Norton, Kim Griffith, and Vivian Love deciphered the incredibly elaborate editorial scrawling on large shares of the 5x8 cards, turning old words into a manuscript known as "new words." The 5x8's are gone now; I've moved on to a remarkably handy portable pc and software.

From time to time I've sought help from a group of friends that I've thought of as an "Editorial Board." Especially diligent and helpful among these have been Joe Newhouse, John Dirk, Dan Pettengill, Art Viseltear, and David Willis. McGraw-Hill's "Washington Health Letters" newsletters have been a long-time major source, and former editor of the newsletters, Jerry Brazda, has for years been a particular friend and supporter. Stephanie Tames, Deborah Glazer, Mariapaz Ramos-Englis, Elaine Gardenier, and Jim Fullerton of the McGraw-Hill staff have been very supportive and responsive.

Gail Hyde-Pike has proofread more than anyone, helped particularly with the family medicine vocabulary, and, finally, given her study to housing the effort.

Kate and Zack Hyde learned to alphabetize and file at early ages, and Kate proved she was ready for college by making most of McGraw-Hill's editorial changes while her father was being a doctor. (Caleb, True, and Leah certainly face similar fates as they grow.) Jane Hyde enjoyed more requests to "read a good definition" and related enthusiasm than anyone. At least lexicographers are well known to be harmless and are usually friendly.

Enduring thanks go to the people who have given generously of their time for writing definitions, suggesting terms, locating existing glossaries, and criticizing the various drafts of the 1976 edition of the dictionary. All of their efforts are still much appreciated. Particular appreciation is due to the staff of the Congressional Research Service of the Library of Congress: Ira Raskin, John Gallicchio, and other staff of the National Center for Health Services Research; Dan Pettingill of the Aetna Life & Casualty Company; Catherine Lyon, Joe Newhouse, and other staff of the Rand Corporation; Irv Wolkstein and Steve Sieverts of the American Hospital Association; Joe Manes of the House Committee on the Budget; David Banta of the Office of Technology Assessment; Jane Murnaghan and Kerr White of the Department of Health Care Organization of the School of Hygiene and Public Health of the Johns Hopkins University; Steve Summers of the Association of American Medical Colleges; Edwin Tuller and other staff of the Blue Cross Association; Linda Horton and other staff of the Food and Drug Administration; Ruth Johnson and other staff of the Bureau of Health Manpower of the Health Resources Administration; the staff of Spectrum Research, Inc.; the staff of the Health Policy Program of the University of California, San Francisco; Ruth Hanft and other staff of the Institute of Medicine of the National Academy of Sciences; the staff of the American Medical Association; and the staff of the Office of the Assistant Secretary for planning of HEW. Special thanks also go to Anne Jordan, Susan Tomasky, and Bill Burns of the Committee staff for doing much of the real work. Without the assistance of these and other people the job simply would never have been done. The responsibility for the results of course remains with the Committee professional staff, who would like to add to Samuel Johnson's explanation of errors in his dictionary, "Ignorance, sir, ignorance!", only "and laziness."

Thank you, everyone. Thank you.

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