BY WILLIAM G. WILKOFF, M.D.

LETTERS FROM MAINE

The Short List

I have always prided myself on being a business-savvy and efficient practitioner. In fact, I'm a little bummed that the editor didn't choose me to write the Efficient Pediatrician Practices column that you will find near the back of each issue.

But to be honest, I don't think I could do nearly as good a job at collecting and presenting tips about running a pediatric office as Dr. Charles A. Scott is doing. His advice has the ring of common sense and is realistically doable.

Nonetheless, I can't resist the urge to share a few of my thoughts on coding and the advantages of creating one's personal bite-sized menu of diagnoses. Being a "think small" kind of guy, I have always striven to keep my list of codes and hence diagnoses as short as possible. Six or eight pretty much cover it.

Regardless of how complex the patients' problems may sound when one listens to their parents, I try to distill things into something simple such as "viral illness" or "fever."

Keeping my diagnostic list as short as possible makes it easier for our staff members, who are already working at the limits of their capabilities.

I notice that my partners who enjoy splitting hairs and dredging up unusual diagnoses spend way too much time with the front office people trying to get the coding correct.

If the physician has written the diagnosis legibly, he or she has probably misspelled it. Even if the physician is lucky enough to have spelled it correctly, the receptionist may not know in which organ system to begin her search for the appropriate code.

I know that some practices have an exhaustive and intimidating list of "common" diagnoses and codes printed on their billing sheets. This usually creates a document that looks something like a page out of the phone book and is even harder to navigate.

Another issue is that at least half of my patients reach the checkout desk before I have gathered enough information to render an accurate and specific diagnosis. Rarely, I may be waiting for some lab work, but more than likely I'm just plain waiting. I'm pretty sure I know what the child doesn't have, and I've asked the parents to join me in a friendly game of wait-and-see until I call the next day.

I suspect my short-list approach to coding creates the impression that my patient mix is of low complexity. My numbers may make it look as though my professional life is rather boring. And I'm sure it would make in-office research projects fruitless. But, you and I know that it's the patients and not the diagnoses that make pediatrics interesting.

However, there are days when I wonder if my life might be easier if I expanded my diagnostic list just a bit. If I included "teething," then I could hustle those parents of fussy infants and low-grade fevers out of the office more quickly. No need to make those time-consuming follow-up calls the next day.

Imagine how easy things would be if I could sign out all the cranky 2-month-olds as having "colic." No more extended interviews to find out whether a new mother is depressed or sleep-deprived or both.

If I could move "sinusitis" from my seldom-used list to my short list, then scores of toddlers with green and yellow snot would be on the fast track out of the office and off to the pharmacy for antibiotics. "Growing pains" could become another giant wastebasket into which I could efficiently toss those annoying and sometimes mysterious cases of extremity aches.

But, I know the grand old masters of pediatrics who trained me would be spinning in their graves. I'm sure they would prefer that I stick to my current game plan. I think they would approve of my philosophy that no diagnosis is always better than the wrong one. ■

DR. WILKOFF *practices general pediatrics in a multispecialty group practice in Brunswick, Maine. Write to Dr. Wilkoff at our editorial offices (pdnews@elsevier.com).*