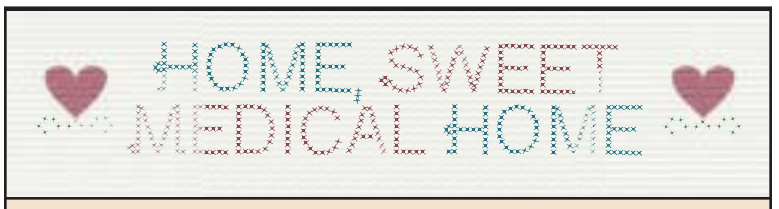

So Often, It's a Matter of Trust

BY LINDA S. NIELD, M.D.

"Do you need some help in there?" yelled Mr. B through the closed door. "Thank you for your concern, sir, but it's okay," I answered, as I opened the door and saw a familiar gentleman. He looked at the angry mother beside me in the exam room and instantly snapped, "Why don't you just listen to the doctor and put your child in the hospital?"

The child is 2-year-old Zachary who has multiple medical problems. His recurrent central line infections have resulted in many trips to various urgent-care centers and many hospitalizations.

Having met Zachary and his mother, Pam, for the first time tonight, I quickly realize that Pam is tired of all of this. Zachary has had fever and chills for the past 24 hours, and Pam insists that "he just needs a vancomycin prescription." Since I know very little about Zachary, I spend several minutes trying to extract the history from the frustrated mother who has told her son's story too many times to doctors who know nothing about him. Since tonight's chief complaint is worrisome and Zachary appears quite ill, I recommend admission. The mother becomes irate. She hollers at me, "You don't know what you're talking about! Dr. R gave him antibiotics at home last time! He's not going in the hospital again!"

Mr. B, the father of another patient in the clinic that night, heard the loud yelling and was concerned for my safety. He has known me for years as his son Sammy's pediatrician, and he just does not understand why this mother will not trust my judgment. My attempts to defuse the situation are unsuccessful and Pam abruptly leaves the clinic with febrile Zachary.

This not-so-unusual situation illustrates a contrast between the patient who has an established medical home and one who does not. Mutual concern, respect, and trust are evident with Sammy B's father. Lack of a medical home leads to frustration for all involved and fosters a lack of parental trust that can result in life-threatening consequences for the most vulnerable.

Congratulations to our contest winner, Dr. Nield of West Virginia University in Morgantown!

LETTERS FROM MAINE

Carts and Horses

BY WILLIAM G. WILKOFF, M.D.

I was about to enter an exam room to see my 30th patient of the day. "Dr. Wilkoff, her rapid strep test is negative." Meredith is our newest PPS (patient placement specialist, a job category I invented several years ago), and she thought she was being helpful. But no one had told her that while one or two of my colleagues have asked their assistants to swab the throats of anyone complaining of sore throat, I prefer to do it myself *after* I have seen the patient.

There was nothing to be gained by holding my breath and turning purple. The water was over the dam. But now what was I going to do? The whole rhythm of this office visit would be thrown off. Like most people, I thrive on routine. When I am busy, routines and habits (good, bad, or ugly) help maintain my efficiency and sanity.

Of course, I have never sat down and written a script for my typical office visits, but over the years a standard plot pattern has evolved … a plot into which I weave as much drama as the scenario will allow. Each one-act play begins with an introduction during which I make a little small talk about the weather or comment on how well or poorly the Patriots or the Red Sox are doing.

Shifting to a more serious and thoughtful persona, I begin taking a history, scribbling illegibly, and sketching the painful body part. In most situations I am 94% confident that I know the diagnosis and have already begun developing my plan by the time I've heard the story. However, to build and maintain the suspense, I continue to contort my face to reflect curiosity and concern, and then I examine the patient.

In most cases I pause at the end of the exam and announce, "Let me do some more writing, and then we can talk about what might be going on and what we should do about it." Occasionally, I add the apology that if I don't write things down immediately they will be forgotten. This is true, of course, but the real reason for this 60-second pause for documentation is that it will add even more suspense to the visit.

Hopefully, by the time I am ready to reveal my diagnosis, the patient is squirming with anticipation and will be more likely to accept without question my diagnosis of a simple URI requiring no specific treatment.

It is only in rare cases that my history and physical examination have not solidified the diagnosis. Then and only then is it time for some lab work. This may be an "old school" approach, but I think it is a tradition that serves us all well and not just because it can hype up the drama in a visit and make one feel professorial. Doing the lab work first devalues the two other components of a good clinical evaluation.

One need only look at a typical medical bill to see that the system already places a higher value on diagnostic studies (meaning lab and x-ray) than it does on a good history and physical. If we continue to request lab work and imaging studies before we have examined the patient, we will perpetuate this inequity.

Of course, there is always cost. Not infrequently the patient's chief complaint is so vague or so mangled by the person at the front desk that a routinely ordered preexamination lab or x-ray is unnecessary and makes no sense. I'm sure some of you must deal with orthopedists who demand MRIs before they examine certain patients. We're not talking the chump change of a rapid strep test here.

Finally, knowing the lab work before one examines the patient eliminates the intellectual gamesmanship that keeps me going. Looking at 50 sore throats a week can be a bit mind numbing. Guessing whether the rapid strep test is going to be positive or negative helps keep my head in the game. ■

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

LETTERS

Slow, Low Pay for Vaccines Hurts

I am a solo pediatric practitioner in Canton, Mich., taking the plunge after many years in hospital practice. About the numerous articles discussing universal immunization: None of us in the trenches needs any convincing about the advisability of immunizing children completely. What we *do* need help with is being reimbursed for it.

The single largest component of my annual expenses is vaccine cost: an amazing 35%-40% of the total. That does not include storage costs, backup generators, staff costs, medical waste collection, data entry into the immunization registry, and billing expenses. Neither does it include time discussing with parents, time fighting screaming/biting children, and worker's compensation premiums in case a staff member is injured in the struggle. Most insurance barely covers the cost of the vaccine, let alone the rest of it.

Pharmaceutical giants like Wyeth and Merck & Co. use their monopolies to increase the price of products such as Prevnar and Varivax, knowing that we have no other sources for these vaccines. It takes a minimum of a few months for insurance companies to increase reimbursement to cover increased cost. Guess who eats the difference.

As the economy declines, there is a new problem: parents who get children immunized and cannot meet deductibles. These families do not meet the criteria for state-sponsored vaccines because of partial insurance coverage. I could spend years waiting for payment on these vaccines; I have 90 days to pay my invoices.

I have tried addressing these obstacles through physician groups, through purchasing groups, and even by having a conversation with a representative from an AAP task force on insurance reimbursement practices. Let me repeat: What we need is strong lobbying in Congress so that I can run a viable business. I already know my job and how to do it well. Just help me be paid for it.

Meera Raghunathan, M.D.
Canton, Mich.

LETTERS

Letters in response to articles in PEDIATRIC NEWS and its supplements should include your name and address, affiliation, and conflicts of interest in regard to the topic discussed. Letters may be edited for space and clarity.

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