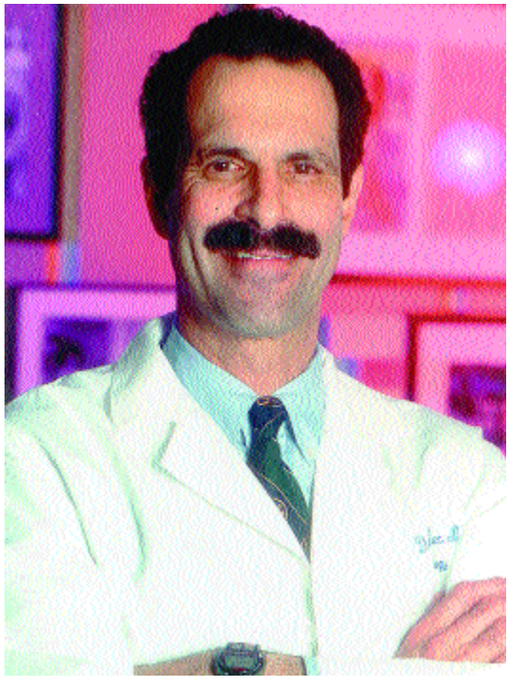
BY TAREN GROM

PHYSICIANS check-up

Physicians are experiencing **terrific pressure** to deliver high-quality patient care in an increasingly **competitive and regulated environment**.



Daniel Hier, M.D. For every hour of direct patient-care time, there's another hour of back-room time. We've got to make ourselves more efficient in terms of time spent seeing the patient, as well as making the back room more efficient. I think physician productivity is one of the biggest challenges we face.

Physicians are being squeezed from all sides, whether they are in private practice, part of a physician group, or based in academia. Overall, physicians claim managed care, back-office functions, regulations, and myriad other variables limit their time, bottom lines, and, not least, their ability to deliver consistent patient care. Physicians say they must become more adept at weeding through red tape, communicating with each other and other partner groups, and developing ways to enhance patient care through reducing medical errors and improving diagnosis.

Diagnosing the condition

DERMAN. Insurance and reimbursement are two big challenges. Part of the problem is that reimbursement rates have dropped, thus physicians need to see more patients, more efficiently, in the same period of time to cover overhead. This is true even in an academic environment. The days of external support for the clinical-practice component of a hospital linked to a medical school are gone. Physicians have to carry their own weight by way of a patient base. We work in an inner-city environment and it requires a tremendous commitment, given Medicaid reimbursement rates, to attend to under-served populations. Therefore physicians often need to modify their base of patients so that they can pay their bills. Additionally, with so many different insurers and managed-care plans, the cost of

having administrative support just to handle reimbursement takes away what little profit margin there may be from the bottom line. If physicians were to develop a system for cost containment, it would likely not be a managed-care system; it would probably be a PPO system with some risk taken on the part of clinicians.

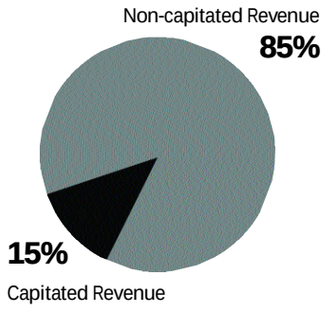
LIVINGSTON. There is a medical liability crisis right now. Our liability insurance went from about $70,000 to about $160,000. The insurance companies that we were with went bankrupt, and finding another one was difficult. Other specialties are incurring huge increases, but not to the extent that Ob-Gyns have experienced. There are complicated reasons for the increases, mostly due to insurance company issues. The medical insurance companies can't increase their reimbursement to the physician. Consequently, we now are having our patients pay us out of pocket, and they are reimbursed by their insurance company. The reimbursements that we were receiving from the insurance companies didn't cover our costs, which were going up hugely, particularly the malpractice insurance. The bottom line is as a participating provider, the reimbursements from the insurance companies were not enough to cover our expenses. The option was to perform lots and lots of births and not spend as much time with our patients, which we found to be unsatisfying. Our other choice was to become a nonparticipating provider, so that we could charge what we charge and presumably we would have less business. We are now in a position to see if this will work. Our other choice was to move out of New Jersey or go out of business. We don't know if our current patients will pay out of pocket or not. The law provides for continuity of care, thus we can't change midstream. The preliminary reaction has been mixed. Some of our patients have a straight HMO, and don't have an out-of-network benefit. It's very difficult for them to pay the whole amount, because their insurance company won't reimburse them at all. Their choice is to get another insurance company. I would estimate that about one-third of patients are not willing to pay out-of-network prices for standard Ob-Gyn services. Patients are stuck in the same way we are, thinking that they had insurance.

UDWIN. For most practices, there are enough patients out there. Managed care has been cutting back on what it contributes to office revenue, so the provider must make up the difference by increasing patient volume. This creates additional strain on an already very busy office environment.

STERN. The nature of the beast these days is that the best care is being provided by specialty-care centers, par-

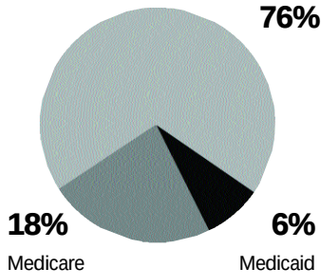
REVENUE SOURCES

Percentage of revenue derived from capitated sources



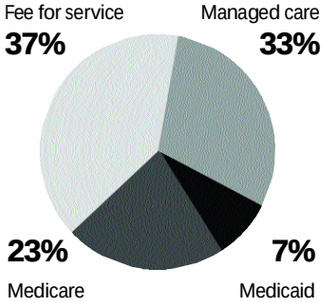
Notes: The chart shows the average of revenue that is derived from capitated and non-capitated sources for the 204 responding medical groups. The percentage of capitated revenue has decreased by 10% since 1999. Capitation is where the doctor or medical group is paid a set monthly fee per patient, whether the patient requires treatment or not.

Capitated revenue components



Notes: The chart represents the 98 medical groups that indicated from which source they received their capitated revenue. The percentages reported did not differ significantly from previous years.

Non-capitated revenue components



Notes: The chart indicates from which source the 164 medical groups responding received their non-capitated revenue. Since 1999, there has been a 5% decrease in the fee-for-service component and a 6% increase in managed care.

Source: Amercian Medical Group Association's 2002 Medical Group Compensation and Productivity Survey; The AMGA is located in Alexandria, Va.

THE SHINGLE ...

JACK BERDY, M.D. CEO, Berdy Medical Systems, Saddlebrook, N.J.; Dr. Berdy also is a practicing physician

RICHARD DERMAN, M.D., MPH. Associate dean, Women's Health The Victor and Caroline Schutte Chair in Women's Health, and interim associate dean for research, Obstetrics and Gynecology, University of Missouri-Kansas City School of Medicine, Kansas City, Mo.; Dr. Derman specializes in peventive health aspects of women's health

JEFF DOBRO, M.D. Assistant professor at New York University Medical School, New York; Dr. Dobro is a rheumatologist

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CAROL LIVINGSTON, M.D., Trissa Baden, M.D. and Carol Livingston M.D., PC, Lawrenceville, N.J.; Dr. Livingston specializes in obstetrics and gynecology

DAVID A. LUBARSKY, M.D., MBA. Professor and chairman, Department of Anesthesiology, Perioperative Medicine, and Pain Management, University of Miami School of Medicine, Miami; chair of Vertibrae Inc.'s AnesthesiaWeb.com, an independent educational resource by and for anesthesia providers, which is supported by an unrestricted educational grant from Abbott Laboratories in partnership with Duke University

DANIEL T. RUBINO, M.D. Devon Health Services Inc., Devon, Pa.; Dr. Rubino's specialty is physiatry

MATTHEW B. STERN, M.D. Director of the Parkinson's Disease and Movement Disorders Center, University of Pennsylvania Health System, Philadelphia; chief, Movement Disorders Division, Department of Neurology, Pennsylvania Hospital, Philadelphia; and professor; Dr. Stern is a certified neurologist

MICHAEL R. UDWIN, M.D. Assistant professor, Obstetrics and Gynecology, Georgetown University Medical Center, Washington, D.C.; Dr. Udwin is a practicing obstetrician/gynecologist

Michael R. Ud win, M.D. Knowledgeable and informed are two different issues related to patients. Patients have a recognition of new products, but often they may not necessarily know all the subtleties and nuances of the medication. DTC is good in that it brings patients into the office who might not otherwise come. However, it's important for a patient to discuss any new product with the provider.

ticularly for chronic illnesses. In other words if a patient has Parkinson's disease, he or she is going to go to a Parkinson's disease center. If someone has cancer, they are going to go to a cancer center. As a specialty center, we are gatekeepers. We have social workers, physical therapists, nurses, research projects, clinical trials, access to the latest and the best data that most primary-care physicians don't have access to. It's very costly to maintain this type of program, and insurance doesn't really help us. For example when I see a patient with Parkinson's disease, the center is reimbursed a certain amount from Medicare. That reimbursement doesn't come close to covering what the costs are to operate a center like ours, which provides comprehensive care for a patient with a chronic illness. Therefore, as director of the program, I spend a lot of my time making sure that we have the money to run the center. That means that I have to go to foundations, I need to write grants, I need to spend a lot of time to make sure my younger colleagues are protected, and have the financial resources to continue doing what they do best.

RUBINO. The biggest challenge right now is dealing with insurance companies, in terms of reimbursement. It's time consuming, and I had to get an outside billing service to handle this, rather than pay somebody here. I try to get fees up front and stay away from the insurance companies when I can. I would say the insurance end of the practice is probably the most trying.

LIVINGSTON. We thought we were doing something unusual, but we are hearing from our obstetric patients that they are having difficulty finding Ob-Gyns who will take different types of insurance. If the insurance companies don't reimburse well and match the costs of the physician, more doctors, as a participating provider, are not going to associate with those insurance companies. This is something that will even out over time in accordance with market forces, but people get caught in the crunch. We got caught in the crunch because we had an additional $100,000 in insurance expenses, which is a lot of money from our total budget, and it comes directly out of our salaries.

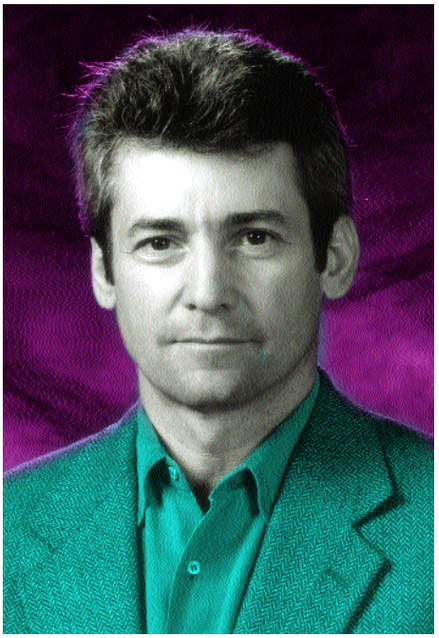
LUBARSKY. Another vexing problem is dealing with the myriad rules and regulations of the government to submit a legal bill. Documentation takes an inordinate amount of effort and attention, it detracts rather than improves patient care, and it causes a great deal of physician dissatisfaction.

STERN. On the patient end, probably the No. 1 concern is the cost of medications. Patients, such as those with Parkinson's disease, are best managed with small doses of different medications. Many of these patients are spending $10,000 to $20,000 a year on drugs and there aren't too many people who can afford that. There are a number of potential solutions. There's better coverage, government intervention, better prescription plans for seniors, and of course, there are cost efficiencies that the industry could consider. Should the industry be spending less on marketing and less on research and development? I don't have the answers to those questions. However, those marketing dollars play a very important role in educating physicians.

LUBARSKY. One of my biggest challenges is the recruitment of qualified attending anesthesiologists. There is a critical shortage of anesthesiologists. Well-trained, English-speaking recent graduates who are good teachers/communicators are in particularly short supply. There are thousands of open jobs, and hundreds of open academic positions.

BERDY. The biggest, and probably most frustrating, challenge to me today is the lack of information exchange. For example, if a patient has been under the care of another doctor, I would estimate that about 90% of the time I either don't get the records or get the records three to six months after the fact. The same problem exists with hospital information. It's weeks to months until that hospital record reaches our office. If a patient was seen in the emergency room over the weekend or during the night, we spend hours calling the emergency room to get information as to what happened.

UDWIN. Perhaps the greatest office challenge centers around communication. Communication between providers and patients, providers and pharmacies, providers and insurance companies, and providers and laboratories. Combine these complex encounters with even higher patient volumes and the end result is



Matthew B. Stern, M.D. The whole sales representative system should be changed. Field reps should be more like consultants and should do a better job of educating physicians and not focus so much on direct sales.

heightened frustration. The end result may be a delay in returning a phone call, reporting a laboratory result, phoning a prescription to the pharmacy, or processing an insurance claim.

HIER. There are a couple of problems that loom large. Medical errors and medical malpractice are two very big issues. We worry about making mistakes. Also the cost of insuring ourselves against medical malpractice is becoming prohibitive. The errors that occur among physicians tend to be not prescribing the right drug, or not getting to the right diagnosis. To give you an example, as a neurologist, I look at a lot of cases in which tPA, tissue plasminogen activator, which is approved for acute stroke, either wasn't prescribed, or the stroke wasn't recognized. We are faced with: are we knowledgeable of what the current therapy is, do we get to the right diagnosis, and do we prescribe the right medication in a timely way?

BERDY. Red tape is bogging down the physician's office and consuming all the time that should be available for patients. There is a tremendous amount of red tape involved in accomplishing anything, from getting authorization to see the patient, to writing a prescription for the patient, or referring the patient for treatment or evaluation.

HIER. If you ask most physicians, the biggest challenge they have is time management. Most physicians are busy, they're being forced to see more patients in less time, and there are two things at work here. One is, what is the most efficient way to see a patient? And two, it's well-recognized that for every minute a physician spends with a patient, there is time that has to be spent sorting out non-reimbursed functions related to patient care. Whether it's looking at medical records, or calling people, or communicating with other physicians, or documenting care, or reviewing x-rays, or filling out insurance forms, or doing billing — these are all of the "non-patient care" tasks that physicians face. For every hour of direct patient-care time, there's another hour of back-room time. We've got to make ourselves more efficient in terms of time spent seeing the patient, as well as making the back room more efficient. I think physician productivity is one of the biggest challenges we face.

DOBRO. There are at least three issues that I believe need to be addressed. One is work flow. This entails a host of things, but in general it is the office work load, including patient management, coding, billing, and collections — information management issues that have to be dealt with in the office. With HIPAA becoming more real, there are more and more documentation requirements. The second is patient education. Do we have the right materials, and are we giving out the right information to patients so we can maximize their compliance of, and understanding with, the program they are supposed to be on, whether it's diagnostics, medications, exercise, or diet? Then there's the issue of assimilating information for my own use. There is the need to access medical records, and keep up to date on medication lists and drug interactions. Do I have enough access to information about the patient's disease? About new indications? About newly reported data?

STERN. I run a large Parkinson's disease clinical and research program at the University of Pennsylvania. Predominantly we see patients with chronic neurological disorders. These are patients who often are on multiple medications and who have a number of healthcare concerns. These also are patients whose illness not only affects them, but their entire family. One of our biggest challenges is access to healthcare — we have trouble meeting the demand.

DERMAN. Patients, as well as our colleagues in medicine, are looking for answers on patient-management issues and counseling issues. There needs to be a real focus on the concept of primary and secondary prevention, if we are to avoid bankrupting the U.S. healthcare system.

Tapping into technology

DOBRO. From my perspective, most of what medicine is about is collecting and processing information, and that is what computers do. This should be a natural transition for physicians. But I don't think an IT transition is going to happen very fast. Docs are slow to trust information to any computer database that's out of their own practice. And, technology is expensive. I think there's a 'show me' attitude now, and rightly so after the last five years of all the hype. I used to manage a national practice management company, with a thousand docs coast

Carol Livingst on,M.D. The bottom line is as a participating provider, the reimbursements from the insurance companies were not enought to cover our expenses. The option was to perform lots and lots of births and not spend as much time with patients. Or become a nonparticipating provider.

to coast. We were constantly looking for different types of technology solutions to help improve the efficiency in the practice and to reduce errors. The last time I looked, about two years ago, the solutions were not cost effective, user friendly, or easily integrated into the whole database. These are major hurdles to overcome but I look forward to that happening.

HIER. I am a believer in information technology, but the goal of information technology should be two-fold. One, to make medicine safer, which will help us on the malpractice end. And two, to make medicine more efficient, which will make us more productive. The challenge over the next five years will be to use technology to make medicine safer and more efficient; that's where we have to go. A lot of the technology right now is demonstration projects; there are a lot of toys and systems that are experimental.

LUBARSKY. Our department is committed to being a leader in the field of high technology in education. We have the largest anesthesia residency program in the country, maybe the world. We recently purchased Palm Pilots for every one of our 125 residents and fellows, and contracted with a software development firm to work with us. We have begun using PDAs for case logs and board review questions and answers. We are translating the most recent American Heart Association preoperative workup algorithm into an interactive Palm-based application. We also tap ePocrates since access to drug information is crucial in our business. Furthermore, we are planning a full server-based electronic library, with books on Palm Pilot cards for point-of-care access. We are distributing computers to all of the major care areas, and connecting the computers with our anesthesia information system to the server-based library. We expect our residents to be fully acquainted with the use of the Internet.

BERDY. The technologies to provide information interchange and exchange all exist. But most hospitals are still archaic, yet believe they are current. Many hospitals resist using simple technologies, such as e-mail, which are available to everybody today. There is concern regarding privacy and transferring records electronically. The fact is, it's more important to save the patient's life than to worry about exacting compliance to all the rules.

DERMAN. Most of us use our Palm Pilots to download information when traveling. We might use it for collection of data or as a guide for communicating with a patient or doing a call-back. But there are any other uses for technology. Because my practice is totally academic based, we use such technology for literature searches, obtaining information so that we can apply competitively for grants, and preparing for grand rounds as an educational vehicle for our colleagues, residents, and medical students.

STERN. I always feel face-to-face interactions are more effective, whether it is a big conference, a small roundtable, or a preceptorship where community physicians from the major educational centers are brought together. This is where I would spend my energy. I would rather forego the CD ROMs, audio cassettes, and give-aways, and spend my time at face-to-face events.

DOBRO. With new guidelines and articles coming out all the time, it's hard to keep up. There are different technological aides that can help us keep up with what's going on, but they certainly are not sufficient solutions. I have a combination Palm Pilot/telephone that I use to access information. Print is a waste of time during the day, because I have to leave the exam room, and it takes forever to look something up.

UDWIN. For a while, we thought e-mail might be the answer. However, security and privacy concerns have dampened initial enthusiasm. We briefly experimented with such an approach and were suprised by the sheer volume of patient enquires made via the Internet. There certainly is patient interest in this form of communication. Perhaps as privacy and security concerns are addressed and such systems are integrated into an electronic medical record we will return to electronic communication as a standard.

RUBINO. I stick to the old-fashioned methods with record keeping. I like to have written documents. I am from the old school. When I grew up we still had slide rules in college. I still have a bit of distrust in terms of putting any records on electronic media.

DOBRO. It's too expensive to put a computer in every office or put in the very extensive types of technology tools that have been promoted in the past. I teach at NYU, where we

have electronic medical records that are so cumbersome that it takes twice as long to see a patient, because it takes twice as long to fill out the electronic record than it did the paper record. The docs sit down at a keyboard and type out a whole medical record, which is difficult for most. The advantage is that we can retrieve patient records more easily, but there's no sorting function or analysis program. It's just cumbersome.

HIER. Technology has a role for the prescribing function. It's clear for a lot of patients that a typed prescription is better than a handwritten prescription. Programs that contain information on different medications are an advantage. These might be whether a drug comes as a tablet or as a capsule, or on dosages whether the drug is 180 milligrams or 60 milligrams, and what typical dosages would be. I actually write my prescription as a note in an electronic medical record. This provides several advantages. One, the note is legible. Two, the prescription is automatically documented as part of an electronic medical record. Three, when I see the patient again I can bring the old prescription forward and I don't have to rewrite it. There are disadvantages as well, in the sense that the information is not live. Suppose I order Dilantin 75 milligrams. I happen to know there's no 75-milligram Dilantin, but I can type whatever I want. There's no checking going on, I'm just writing a note. And, there's no way to check for drug allergies or drug interactions. The goal would be to take the prescribing process and not just make it electronic, but make it smart prescribing. Just having a handheld doesn't solve all the problems. I don't want to write a note stating Dilantin 100 milligrams, three times a day, and then have to go to the Palm Pilot to write that prescription. Ideally, the prescription should become part of the note. There are a lot of technology opportunities to make prescribing smarter and more efficient. There are a lot of good companies working on it, but they haven't quite solved it yet. I also use a PDA now to check the price of a drug when I prescribe it. Drug companies are going to have to face pricing at some point. With so many physicians having PDAs, it's very easy to look up the dose of drug as well as the price. I think there will be some surprising responses to certain drugs being priced higher than others. For example, if a patient comes to me with high-blood pressure, I can prescribe any one of several products that basically have the same profile. I would be more inclined to prescribe Drug X for $75 a month than Drug Y for $115 a month. I think more physicians are going to catch on to this.

UDWIN. I use palm-based portable computer devices in my capacity as an assistant professor working with residents and students and in private practice. Obstetrics and gynecology residents and medical students use PDAs to track patient encounters, read medical text, and review pharmacology data. In practice, our provider group "beam" an up-to-date patient database to one another at staff meetings ensuring each of us has the most current information on our patient population. The PDA also is used to prescribe electronically via a wireless environment and to review pharmacology information. And of course, the PDA is used extensively for time management, coordinating the busy schedules of the providers in our group.

DOBRO. The biggest problem with all the systems that I know about, is integrating different databases for hand-held applications. I am not going to pay somebody to enter the patient's name, insurance information, and other information twice. Although I understand there are some programs that are in development to solve this problem.

BERDY. I do not use e-detailing. I generally do not use CD ROMs. I do occasionally look up drug references on Netscape or WebMD.

HIER. I've done a little e-detailing over the Internet, but I have to say I've lost interest in it, even though I like the Internet. To me e-detailing is pretty dull. It's obviously a growth industry. I just wonder, long term, whether it's going to make it or not. There's something to be said about a sales rep coming and talking to me. The challenge is doing it in a way that they get their message across, and in a way that doesn't waste too much of our time.

Daniel T. Rubino, M.D. I like to make extra time for my patients and explain to them, in layman's terms, just what we're doing, what the findings are, and how they are going to be treated. I try to make my patients feel like they're participating in their care and I find I get a lot better compliance doing it that way, and the patient is much happier.

Rep admissions

STERN. I really feel that the whole sales representative system should be changed. The field representatives should be more like consultants and should do a better job of educat-

David A. L ubarsk y, M.D., MBA. A vexing problem is dealing the myriad rules and regulations of the government to submit a legal bill. Documentation takes an inordinate amount of effort and attention,it detracts rather than improves patient care, and it causes a great deal of physician dissatisfaction.

ing physicians and not focusing so much on direct sales. I know their job is to sell, but they would be much more effective if they were more like liaisons to medical information. It is so obvious that many of these sales representatives are uni-dimensional and purely come to the office to do their best to sell their drug. I believe they would be a lot more effective if their primary role was in serving an educational purpose and they were better trained in the particular disease they were dealing with. We do a lot of two- and three-day program preceptorships and invite sales representatives to come to the center. They spend time seeing patients with us, and listening to lectures. When they leave here they have a much better understanding of the disease they're dealing with and, most importantly, they have an understanding of where their drug is not indicated, as opposed to where it is indicated. The best thing sales representatives can tell a physician is that their drug is not indicated for a condition, or it's not useful in certain situations, or that it has side effects. This would enhance their credibility. Some companies have had the foresight to realize that their salesforce should not be quota based, but rather act as an educational force.

HIER. I'm at a large university, where we have a large practice of neurologists and 10,000 patients — this is a very difficult environment for pharmaceutical sales representatives. The difficulty is there are 10, 12, or 15 companies with products competing for my time. You can imagine how I feel when there are 10 or 12 different representatives pursuing me in the clinic, where I'm supposed to be seeing patients. I just don't have time to talk to them. If I've got 12 patients to see, do I really have time to spend 20 minutes in the middle of my clinic hours talking to a representative?

DERMAN. There's no doubt companies are investing money in what is commonly referred to as health-sciences advisors. Hiring more former Pharm.D.s who can talk to physicians about labeling and in some cases even off-labeling when questions are asked is a major goal.

HIER. If there were some kind of contract between the sales representative and the doctor that limited the visits, physicians would be more likely to make time for them. For example, if the sales representative were to say, 'I want to talk to you for 10 minutes and I want to talk to you about Product Y. This is my agenda and this is what I specifically want to talk to you about. After I do that, doctor, you're not going to see me again for 6 months or 12 months.' A lot of us experience the sales-representative hordes that descend on the office. They want to spend as much time as they can, they have a hard time focusing on what message they want to get across, and then no sooner are they gone than they are banging on the door to come back. All of those things, in my opinion, work to the sales reps' disfavor.

DOBRO. I used to see maybe three or four sales reps in a day and spend 5 or 10 minutes with them. But that took the place of seeing a couple more patients in a day.

RUBINO. Reps come in on a regular basis and they're always cheerful and polite. There are a couple of pharmaceutical companies I'd like to hear from more. Even though I've made phone calls to their headquarters I find it hard to get certain sales representatives in here sometimes. I like to hear the new innovations and the new uses that are being found for drugs, such as off-label information.

LUBARSKY. Pharmaceutical reps can best serve an academic department by providing experts to educate our diverse and large group of 300 anesthesiologists, interns, residents, fellows, and CRNAs. They also disseminate important information about advances associated with their products.

BERDY. I happen to like the detail representatives, they serve me well. Not in terms of a free lunch, but the information they can provide in a five-minute window. I find them to be a tremendous source of educational information.

STERN. In my opinion, the best thing that the pharmaceutical industry could do is educate physicians in an unbiased format. CME courses, educational programs, that's where I'd like to see the marketing dollars focused, with less on the give aways.

The DTC dilemma

UDWIN. Knowledgeable and informed are

two different issues related to patients. Patients have a recognition of new products, but often they may not necessarily know all the subtleties and nuances of the medication. DTC is good in that it brings patients into the office who might not otherwise come. And it brings up issues they might not otherwise have thought about. However, it's important for the patient to discuss any new product with the provider to ensure a more 'balanced' perspective before initiating treatment.

BERDY. I believe DTC confuses the issue. I don't find patients very educated, I find them informed, which often means misinformed. I find also that DTC creates a lot of conflict in the office between the patient and the doctor. Not in the sense that the medication is inappropriate, but in the sense that it might not be covered by the insurance company. The patient tends to assign the blame for that to the physician rather than the insurance company.

DOBRO. I don't mind the idea of patients being really educated and asking me questions about everything they've heard. I'm a little resentful that some of the direct-to-consumer ads that I've seen are a bit manipulative. I think they try to oversell the benefits of a drug. It may just be a perception because I know what the risks and benefits of most of the drugs are.

HIER. I think DTC is a positive in the sense that when we do suggest a new drug, the medication is accepted faster by the patients because they have some familiarity with it. And we spend less time educating the patient, which is another plus. That goes back to saving us time, less salesmanship on the part of the doctor.

Patient care

RUBINO. I like to make extra time for my patients and explain to them, in layman's terms, just what we're doing, what the findings are, and how they are going to be treated. I try to make my patients feel like they're participating in their care and I find I get a lot better compliance doing it that way, and the patient is much happier.

UDWIN. The availability of online resources has significantly improved the care I provide. Patients may be given a 'homework' assignment before the visit. Then, in the office we may discuss the finer points of a diagnosis or treatment rather than simply basic information. Patients leave the office with a higher level of satisfaction and a deeper understanding of their situation. Of course it is important to know where your patient is coming from before instituting this approach.

LUBARSKY. At Jackson Memorial Hospital, with 1,450 beds, the second-largest indigent county hospital in the nation, we see a broad-spectrum of individuals. We must tailor our conversations in terms of both complexity and language to the individual.

STERN. Either you're born with a certain empathy and ability to address cross gender and cultural lines, or you're not. It's always a challenge. What I say to one patient may be completely different from what I say to the next patient, depending upon their educational background or ability to understand. Of course, that is a significant challenge to us and one that some physicians deal with better than others.

UDWIN. Today, patients have a keen understanding of the realities of managed care. They realize that we can't spend an hour addressing 14 items when there's a waiting room filled with patients. Patients readily accept that we can address the two or three most pressing items on the list and return to the office to review the remainder.

DOBRO. In my experience of doing disease management and case management, most people do not have a good understanding of their disease. I am finding that patients are at least starting to ask better questions. Patients have access to the Internet, and magazines and newspapers are writing slightly more accurate articles about different diseases. I find that I have more patients coming in with a file of questions and articles that they'd like me to read. I don't mind. I can't take up a long time in an exam doing that, but I can answer their questions or get back to them. I often use e-mail to get back to them with an answer. ❖

PharmaVoice welcomes comments about this article. E-mail us at feedback@pharmalinx.com.

Jack B erdy, M.D. Red tape is bogging down the physician's office today and consuming all the time that should be available for patients. There is a tremendous amount of red tape involved in accomplishing anything, from getting authorization to see the patient, to writing a prescription for the patient, or referring the patient for treatment or evaluation.