LETTERS FROM MAINE

Bein' L.L.-Like (or Bein' Like L.L. Bean)

What do you call the children and parents that you spend most of your days and some of your nights with? I usually refer to them as patients and their families. This shouldn't surprise you since I am old enough that no one seems embarrassed to ask me if I would like a senior citizen discount. But you may refer to the people you serve as clients, particularly if you consider yourself a provider.

WILLIAM G. WILKOFF, M.D.

Whether you call them patients or clients, the bottom line is that they are our customers and as such deserve good customer service. Unfortunately, I fear that as a group we physicians don't have a great reputation for providing customer-friendly service. I know of – and have endured myself – waiting room experiences on a par with the tarmac imprisonments for which airlines now must pay hefty fines. Some of us work with receptionists and billing office personnel, who as preschoolers must have bonded with Oscar the Grouch instead of Grover or Bert and Ernie.

The ingredients of bad customer service are obvious to anyone who is on the receiving end. However, while you know when you have gotten good customer service, it might be difficult to dissect out exactly what it was that created that impression. Often, it's simply because the person you were dealing is blessed with a pleasant demeanor inherited from a parent. But good customer service can be learned by those of us who are genetically less fortunate.

For example, L.L. Bean perennially receives several awards for good customer service. This past year they were ranked No. 1 by Bloomberg Businessweek. Good customer service has been built into the culture of their business since it was founded by Leon Bean. The company's willingness to accept and/or replace returned items with little question has spawned amusing and amazing suburban legends (hiking boots with bloody gunshot holes, etc.). The people on the phones are knowledgeable, courteous, and eager to help.

Many of my patients' parents work for the company (as does our son) and so, from time to time, I get a glimpse inside the culture that has created this customer-friendly aura. It isn't rocket science. It is a commitment from the top down that they are not only going to offer a quality product, but they will treat you as they'd like to be treated themselves. Now, no person or system is perfect, but I'll bet you have been the beneficiary of good customer service from L.L. Bean.

Can you say that about the patients who come to your office? Do you really know? Do you ever go into your waiting room? Do you hear what your receptionists and billing people tell your patients? As groups get larger and new offices are built, we are often insulated from the ugliness or just plain callousness that goes on over the phone or when the sliding glass window gets rolled back (I hate those).

Let's assume for the moment that none of us physicians is the cause of bad customer service. But are we enabling or permitting it to persist? Parents and patients might not feel comfortable sharing their bad experiences and complaints with us. They may be intimidated by us as authority figures or they may assume that we don't care and/or can't do anything about a rude receptionist.

As more physicians become employees, it is rare that a practice can claim that "the owner is in the store." However, abandoning ownership doesn't mean that our patients are no longer our customers. They deserve to be treated as we would like to be treated ourselves, and we must take the lead role in making customer service a top priority. ■

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LETTERS

Vaccine Issues

Twenty years ago I might have appreciated a fellow physician extolling the virtues of certain vaccines, as Dr. Harry Pellman did in his commentary about industry-sponsored continuing medical education ("Industry-Sponsored CME's Value," August 2010, p. 38).

No doubt vaccines are important in preventing disease, some of which I have seen in 20+ years of pediatric practice. I didn't mind spending an extra 2-4 minutes explaining why we need vaccines to parents who were questioning their benefit, much of which I learned at vaccine industry–sponsored CME or casual lunches at our five-pediatrician/four–nurse practitioner practice.

About 5 years ago, though, when Gardasil (Merck & Co., one of Dr. Pellman's disclosures) was licensed and its introductory cost to the clinic turned out to be greater than the original reimbursement, our practice slowly quit appreciating those lunches and dinners. Now Gardasil is reimbursed through Blue Cross/Blue Shield at less than $1 above our cost (the cost of the vaccine itself is more than $130). We buy the maximum amount of vaccine so that we achieve the greatest discount, even buying through vaccine clearinghouses. For us to make Dr. Pellman's money for a luncheon (I assume $1,000), we would have to give over 1,000 Gardasil shots and hope our nurses never draw one inappropriately so that it would have to be discarded.

That is why some vaccine sales people are not very welcome in our clinic, nor are physicians hired as salespeople. Two years ago our Merck salesperson wanted to bring lunch to our clinic, promising us a 2% discount on the cost of their vaccines. She did not tell us that Merck had already decided to go up 3%, again above the cost of Blue Cross/Blue Shield reimbursement. When it comes to vaccines, especially certain manufacturers, the only physician making any discernible money is the hired salesperson/physician.

Have you noticed that most family practice physicians don't give vaccines? To be honest with you, it makes no business sense to give most vaccines. We give vaccines because they save lives and, yes, we still explain to parents the benefits, but please don't cry on my shoulder when we don't appreciate hired physicians coming into our clinic wearing three-piece silk suits and pushing their vaccine du jour. Publish your findings in Pediatrics or PEDIATRIC NEWS or discuss them in an open forum of accredited CME (such as American Academy of Pediatrics meetings), and I'll take it from there.

M. Andy Connaughton, M.D.
Conway, Ark.

Dr. Pellman responds:

I understand Dr. Connaughton's frustration and anger with vaccine issues in private practice, but I think it is important to put everything into proper perspective. Vaccines have been described as the most important public health achievement of the 20th century, eliminating smallpox and greatly reducing death and disability from a whole host of infectious diseases.

Our office has done vaccine research trials for more than 20 years. In my frequent dealings with vaccine researchers and developers over the years, I have been impressed with their dedication, honesty, and intelligence.

Vaccine development comes at a very high cost. For example, the length of time from the start of development until Food and Drug Administration licensure for the pentavalent rotavirus vaccine was over 20 years. The live attenuated influenza vaccine took more than 30 years. Spending time and money to develop a vaccine does not ensure success. Remember the Wyeth rotavirus vaccine, RotaShield, which was withdrawn after a little more than a year on the market?

Dr. Connaughton should be frustrated with the poor reimbursement we receive from the insurers, not the vaccine developers. As he mentions, we spend a great deal of time educating families on the importance of vaccines that are expensive to purchase, require proper storage, and need expertise to correctly deliver to children.

By the way, I only own one suit that I purchased 10 years ago. I do not remember when I last wore it, and it is definitely not silk.

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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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Correction

In the article "Trials Give Nod to Antibiotics With Certain AOM" (February 2011, p. 16), there was discussion of 2004 recommendations by the American Academy of Pediatrics and the American Academy of Family Physicians regarding initial observations as an option in children aged 6-23 months with mild otalgia and with a temperature of less than 39° C in the last 24 hours, and in whom the diagnosis of acute otitis media is uncertain. It stated the recommendations were based on previous trials that contained "substantial limitations."

The following sentence should have read, "These include 'the lack of stringent diagnostic criteria, the inclusion of very *few* young children, and the use of an antimicrobial drug that had limited efficacy or that was administered in suboptimal doses.' "

The following sentence should have read, "To meet eligibility for the trial, the children were required to have received at least two doses of pneumococcal conjugate vaccine and to have AOM that was diagnosed based on *all* three criteria: onset of symptoms within 48 hours that parents rated with a score of at least 3 on the Acute Otitis Media Severity of Symptoms (AOM-SOS) scale; the presence of middle-ear effusion; and moderate or marked bulging of the tympanic membrane or slight bulging accompanied by either otalgia or marked erythema of the membrane.