

# Maximizing the 15-minute Office Visit

The classic 15-minute office visit is largely a myth. You may see one patient for three minutes and the next for twenty minutes and deliver quality care to both.

## Chapter in Brief:

- ▲ *Simple steps can help you see more patients in less time, deliver the highest level of care, and enjoy even your busiest days in the office.*
- ▲ *Arrange and organize your office space so that you can move efficiently from task to task.*
- ▲ *Prepare for your day by reviewing charts ahead of time.*
- ▲ *Stay present and focused during the visit—no multitasking in the presence of patients.*
- ▲ *Learn to manage those situations that can throw off your expected schedule.*
- ▲ *Integrate dictating or note taking into the visit so that by the time the patient leaves, the chart is complete.*

**T**he reason most physicians work on improving their efficiency is this: *so that they can spend the appropriate amount of time with each patient and deliver quality care.* Note the phrase, the “appropriate” amount of time—as opposed to spending a lot of time with each patient. That’s because every patient you see is unique, and a single appointment length does not fit all.

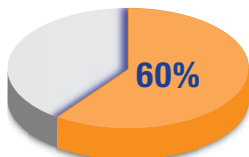
Making the most of each office visit begins before the doctor or the patient is even on the scene. Having an efficient work space is the first step toward good patient flow and delivering

# Tussionex®: The only FDA-approved 12-hour Rx syrup antitussive

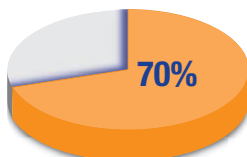


## Syrup formulation preferred by patients and physicians

- 7 out of 10 consumers preferred syrup for the treatment of cough<sup>1\*</sup>



agreed that syrup gives them  
a feeling of instant relief



agreed that syrup coats the  
throat with soothing medication

- 9 out of 10 physicians preferred to prescribe a syrup  
for the treatment of cough<sup>†</sup>

## INDICATION AND IMPORTANT SAFETY INFORMATION

TUSSIONEX® is indicated for the relief of cough and upper respiratory symptoms associated with allergy or a cold in adults and children 6 years of age and older. Each 5 mL of TUSSIONEX® contains hydrocodone polistirex equivalent to 10 mg hydrocodone bitartrate and chlorpheniramine polistirex equivalent to 8 mg chlorpheniramine maleate.

TUSSIONEX® is contraindicated in children less than 6 years of age due to the risk of fatal respiratory depression, and in the presence of known allergy or sensitivity to hydrocodone or chlorpheniramine. The most common adverse reactions associated with TUSSIONEX® are sedation, drowsiness, and mental clouding, which may impair the mental and/or physical abilities required for potentially hazardous tasks such as driving or operating machinery. TUSSIONEX® should not be taken with alcohol or other CNS depressants. TUSSIONEX® is dosed at 5 mL every 12 hours in patients 12 years of age and older, and at 2.5 mL every 12 hours in patients 6-11 years of age. Overdose with TUSSIONEX® has been associated with fatal respiratory depression. Patients should be advised to measure TUSSIONEX® with an accurate measuring device. A household teaspoon is not an accurate measuring device. As with any other drugs in this class, the possibility of tolerance and/or dependence, particularly in patients with a history of drug dependence, should be considered.

Please see full Prescribing Information on reverse.

\*Data from a consumer survey (N=510) conducted January 31-February 6, 2007. Questions asked during survey: If cough medicine was available in 1 form only, which would you prefer: Syrup? Tablets or capsules? Please indicate your level of agreement with each of the following statements about why you would prefer cough medicine in syrup form instead of tablets or capsules: Cough syrup gives me a feeling of instant relief. Cough syrup makes the tickle in my throat go away. Cough syrup coats my throat with soothing medication. Use a 7-point scale where "1" means "do not agree at all" and "7" means "strongly agree."

†Data from a physician survey (N=102) conducted in September 2005. Question asked during survey: For treatment of cough, do you prefer to prescribe a: Syrup? Tablet? Capsule?

Reference: 1. Data on file. UCB, Inc.

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Tussionex®  
Penkinetic®  
(hydrocodone polistirex/  
chlorpheniramine polistirex)  
Extended-Release Suspension

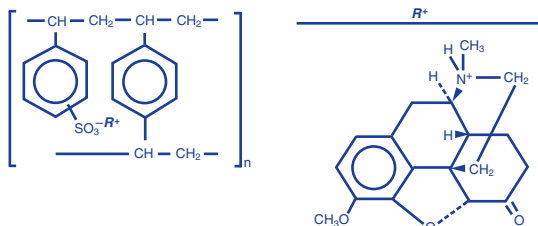
**(hydrocodone polistirex and chlorpheniramine polistirex)  
 Extended-Release Suspension**

**DESCRIPTION**

Each teaspoonful (5 mL) of TUSSIONEX Pennkinetic Extended-Release Suspension contains hydrocodone polistirex equivalent to 10 mg of hydrocodone bitartrate and chlorpheniramine polistirex equivalent to 8 mg of chlorpheniramine maleate. TUSSIONEX Pennkinetic Extended-Release Suspension provides up to 12-hour relief per dose. Hydrocodone is a centrally-acting narcotic antitussive. Chlorpheniramine is an antihistamine. TUSSIONEX Pennkinetic Extended-Release Suspension is for oral use only.

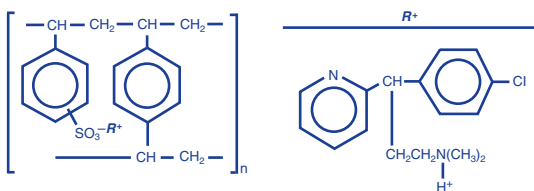
**Hydrocodone Polistirex**

Sulfonated styrene-divinylbenzene copolymer complex with 4,5 $\alpha$ -epoxy-3-methoxy-17-methylmorphinan-6-one.



**Chlorpheniramine Polistirex**

Sulfonated styrene-divinylbenzene copolymer complex with 2-[p-chloro- $\alpha$ -[2-(dimethylamino)ethyl]-benzyl]pyridine.



**Inactive Ingredients**

Ascorbic acid, D&C Yellow No. 10, ethylcellulose, FD&C Yellow No. 6, flavor, high fructose corn syrup, methylparaben, polyethylene glycol 3350, polysorbate 80, pregelatinized starch, propylene glycol, propylparaben, purified water, sucrose, vegetable oil, xanthan gum.

**CLINICAL PHARMACOLOGY**

Hydrocodone is a semisynthetic narcotic antitussive and analgesic with multiple actions qualitatively similar to those of codeine. The precise mechanism of action of hydrocodone and other opiates is not known; however, hydrocodone is believed to act directly on the cough center. In excessive doses, hydrocodone, like other opium derivatives, will depress respiration. The effects of hydrocodone in therapeutic doses on the cardiovascular system are insignificant. Hydrocodone can produce miosis, euphoria, and physical and psychological dependence.

Chlorpheniramine is an antihistamine drug (H<sub>1</sub> receptor antagonist) that also possesses anticholinergic and sedative activity. It prevents released histamine from dilating capillaries and causing edema of the respiratory mucosa.

Hydrocodone release from TUSSIONEX Pennkinetic Extended-Release Suspension is controlled by the Pennkinetic System, an extended-release drug delivery system, which combines an ion-exchange polymer matrix with a diffusion rate-limiting permeable coating. Chlorpheniramine release is prolonged by use of an ion-exchange polymer system.

Following multiple dosing with TUSSIONEX Pennkinetic Extended-Release Suspension, hydrocodone mean (S.D.) peak plasma concentrations of 22.8 (5.9) ng/mL occurred at 3.4 hours. Chlorpheniramine mean (S.D.) peak plasma concentrations of 58.4 (14.7) ng/mL occurred at 6.3 hours following multiple dosing. Peak plasma levels obtained with an immediate-release syrup occurred at approximately 1.5 hours for hydrocodone and 2.8 hours for chlorpheniramine. The plasma half-lives of hydrocodone and chlorpheniramine have been reported to be approximately 4 and 16 hours, respectively.

**INDICATIONS AND USAGE**

TUSSIONEX Pennkinetic Extended-Release Suspension is indicated for relief of cough and upper respiratory symptoms associated with allergy or a cold in adults and children 6 years of age and older.

**CONTRAINDICATIONS**

TUSSIONEX Pennkinetic Extended-Release Suspension is contraindicated in patients with a known allergy or sensitivity to hydrocodone or chlorpheniramine.

The use of TUSSIONEX Pennkinetic Extended-Release Suspension is contraindicated in children less than 6 years of age due to the risk of fatal respiratory depression.

**WARNINGS**

**Respiratory Depression**

As with all narcotics, TUSSIONEX Pennkinetic Extended-Release Suspension produces dose-related respiratory depression by directly acting on brain stem respiratory centers. Hydrocodone affects the center that controls respiratory rhythm and may produce irregular and periodic breathing. Caution should be exercised when TUSSIONEX Pennkinetic Extended-Release Suspension is used postoperatively and in patients with pulmonary disease, or whenever ventilatory function is depressed. If respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride and other supportive measures when indicated (see OVERDOSAGE).

**Head Injury and Increased Intracranial Pressure**

The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions, which may obscure the clinical course of patients with head injuries.

**Acute Abdominal Conditions**

The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

**Obstructive Bowel Disease**

Chronic use of narcotics may result in obstructive bowel disease especially in patients with underlying intestinal motility disorder.

**(hydrocodone polistirex and chlorpheniramine polistirex)  
Extended-Release Suspension**

**Pediatric Use**

The use of TUSSIONEX Pennkinetic Extended-Release Suspension is contraindicated in children less than 6 years of age (see CONTRAINDICATIONS). In pediatric patients, as well as adults, the respiratory center is sensitive to the depressant action of narcotic cough suppressants in a dose-dependent manner. Caution should be exercised when administering TUSSIONEX Pennkinetic Extended-Release Suspension to pediatric patients 6 years of age and older. Overdose or concomitant administration of TUSSIONEX Pennkinetic Extended-Release Suspension with other respiratory depressants may increase the risk of respiratory depression in pediatric patients. Benefit to risk ratio should be carefully considered, especially in pediatric patients with respiratory embarrassment (e.g., croup) (see PRECAUTIONS).

**PRECAUTIONS**

**General**

Caution is advised when prescribing this drug to patients with narrow-angle glaucoma, asthma, or prostatic hypertrophy.

**Special Risk Patients**

As with any narcotic agent, TUSSIONEX Pennkinetic Extended-Release Suspension should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy, or urethral stricture. The usual precautions should be observed and the possibility of respiratory depression should be kept in mind.

**Information for Patients**

As with all narcotics, TUSSIONEX Pennkinetic Extended-Release Suspension may produce marked drowsiness and impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly. TUSSIONEX Pennkinetic Extended-Release Suspension must not be diluted with fluids or mixed with other drugs as this may alter the resin-binding and change the absorption rate, possibly increasing the toxicity.

Patients should be advised to measure TUSSIONEX Pennkinetic Extended-Release Suspension with an accurate measuring device. A household teaspoon is not an accurate measuring device and could lead to overdose, especially when a half a teaspoon is measured. A pharmacist can recommend an appropriate measuring device and can provide instructions for measuring the correct dose.

Shake well before using.

Keep out of the reach of children.

**Cough Reflex**

Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when TUSSIONEX Pennkinetic Extended-Release Suspension is used postoperatively, and in patients with pulmonary disease.

**Drug Interactions**

Patients receiving narcotics, antihistaminics, antipsychotics, anti-anxiety agents, or other CNS depressants (including alcohol) concomitantly with TUSSIONEX Pennkinetic Extended-Release Suspension may exhibit an additive CNS depression. When combined therapy is contemplated, the dose of one or both agents should be reduced.

The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of other anticholinergics with hydrocodone may produce paralytic ileus.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**

Carcinogenicity, mutagenicity, and reproductive studies have not been conducted with TUSSIONEX Pennkinetic Extended-Release Suspension.

**Pregnancy**

**Teratogenic Effects – Pregnancy Category C**

Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. TUSSIONEX Pennkinetic Extended-Release Suspension should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nonteratogenic Effects**

Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.

**Labor and Delivery**

As with all narcotics, administration of TUSSIONEX Pennkinetic Extended-Release Suspension to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

**Nursing Mothers**

It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from TUSSIONEX Pennkinetic Extended-Release Suspension, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**

The use of TUSSIONEX Pennkinetic Extended-Release Suspension is contraindicated in children less than 6 years of age (see CONTRAINDICATIONS and ADVERSE REACTIONS, Respiratory, Thoracic and Mediastinal Disorders).

TUSSIONEX Pennkinetic Extended-Release Suspension should be used with caution in pediatric patients 6 years of age and older (see WARNINGS, Pediatric Use).

**Geriatric Use**

Clinical studies of TUSSIONEX did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

This drug is known to be substantially excreted by the kidney, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function.

**ADVERSE REACTIONS**

**Gastrointestinal Disorders**

Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of TUSSIONEX Pennkinetic Extended-Release Suspension may produce constipation.

**General Disorders and Administration Site Conditions**

Droth

**(hydrocodone polistirex and chlorpheniramine polistirex)  
Extended-Release Suspension****Nervous System Disorders**

Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, euphoria, dizziness, psychic dependence, mood changes.

**Renal and Urinary Disorders**

Ureteral spasm, spasm of vesical sphincters, and urinary retention have been reported with opiates.

**Respiratory, Thoracic and Mediastinal Disorders**

Dryness of the pharynx, occasional tightness of the chest, and respiratory depression (see CONTRAINDICATIONS).

TUSSIONEX Pennkinetic Extended-Release Suspension may produce dose-related respiratory depression by acting directly on brain stem respiratory centers (see OVERDOSAGE). Use of TUSSIONEX Pennkinetic Extended-Release Suspension in children less than 6 years of age has been associated with fatal respiratory depression. Overdose with TUSSIONEX Pennkinetic Extended-Release Suspension in children 6 years of age and older, in adolescents, and in adults has been associated with fatal respiratory depression.

**Skin and Subcutaneous Tissue Disorders**

Rash, pruritus.

**DRUG ABUSE AND DEPENDENCE**

TUSSIONEX Pennkinetic Extended-Release Suspension is a Schedule III narcotic. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, TUSSIONEX Pennkinetic Extended-Release Suspension should be prescribed and administered with caution. However, psychic dependence is unlikely to develop when TUSSIONEX Pennkinetic Extended-Release Suspension is used for a short time for the treatment of cough. Physical dependence, the condition in which continued administration of the drug is required to prevent the appearance of a withdrawal syndrome, assumes clinically significant proportions only after several weeks of continued oral narcotic use, although some mild degree of physical dependence may develop after a few days of narcotic therapy.

**OVERDOSAGE****Signs and Symptoms**

Serious overdosage with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. Although miosis is characteristic of narcotic overdose, mydriasis may occur in terminal narcosis or severe hypoxia. In severe overdosage apnea, circulatory collapse, cardiac arrest and death may occur. The manifestations of chlorpheniramine overdosage may vary from central nervous system depression to stimulation.

**Treatment**

Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and the institution of assisted or controlled ventilation. The narcotic antagonist naloxone hydrochloride is a specific antidote for respiratory depression which may result from overdosage or unusual sensitivity to narcotics including hydrocodone. Therefore, an appropriate dose of naloxone hydrochloride should be administered, preferably by the intravenous route, simultaneously with efforts at respiratory resuscitation. Since the duration of action of hydrocodone in this formulation may exceed that of the antagonist, the patient should be kept under continued surveillance and repeated doses of the antagonist should be administered as needed to maintain adequate respiration. For further information, see full prescribing information for naloxone hydrochloride. An antagonist should not be administered in the absence of clinically significant respiratory depression. Oxygen, intravenous fluids, vasopressors and other supportive measures should be employed as indicated. Gastric emptying may be useful in removing unabsorbed drug.

**DOSAGE AND ADMINISTRATION**

*It is important that TUSSIONEX is measured with an accurate measuring device (see PRECAUTIONS, Information for Patients).* A household teaspoon is not an accurate measuring device and could lead to overdosage, especially when half a teaspoon is to be measured. It is strongly recommended that an accurate measuring device be used. A pharmacist can provide an appropriate measuring device and can provide instructions for measuring the correct dose.

Shake well before using.

**Adults and Children 12 Years and Older**

5 mL (1 teaspoonful) every 12 hours; do not exceed 10 mL (2 teaspoonfuls) in 24 hours.

**Children 6-11 Years of Age**

2.5 mL (1/2 teaspoonful) every 12 hours; do not exceed 5 mL (1 teaspoonful) in 24 hours.

This medicine is contraindicated in children under 6 years of age (see CONTRAINDICATIONS).

**HOW SUPPLIED**

TUSSIONEX Pennkinetic (hydrocodone polistirex and chlorpheniramine polistirex) Extended-Release Suspension is a gold-colored suspension.

NDC 53014-548-67 473 mL bottle

**For Medical Information**

Contact: Medical Affairs Department

Phone: (866) 822-0068

Fax: (770) 970-8859

**Storage:**

Shake well. Dispense in a well-closed container.

Store at 20-25°C (68-77°F); excursions permitted to 15-30°C (59-86°F) [see USP Controlled Room Temperature].

TUSSIONEX Pennkinetic Extended-Release Suspension

Manufactured for:

UCB, Inc.

Smyrna, GA 30080



good care. Rob Scroggins, a consultant with Cincinnati-based Clayton L. Scroggins Associates, Inc., says there are a few key factors related to the physical space and organization of an office that can increase your productivity.

### **Planning and Preparation Pay Off**

An exam room flag or light system in the hallway can significantly improve patient flow, says Mr. Scroggins. “Staff should never be standing around waiting for doctors to come out of exam rooms to be told what needs to be done next,” he says. Nor should doctors spend time looking for staff members to give simple instructions. Flagging rooms—to indicate that a patient is ready to be prepped for a procedure or that a room is ready to clean—is an example of how visual indicators are commonly used. Installing a light system in an existing building can be costly, but easy-to-install, color-coded flag systems can be purchased for about \$50 per room.

Richard Honaker, MD, is CEO and the busiest physician in his 12-doctor group, Family Medicine Associates of Texas, just north of Dallas. He averages 40 office visits per day, working 8 am to 4 pm, and says the light/buzzer system in his office is one of the main reasons he is able to see so many patients. “When I leave the room, I put the chart in the chart box and push a button that lights and sounds at the nursing station,” he says. Dr. Honaker contends that—at least in his practice—a light alone or a flag system would not work. It’s the “beep, beep, beep” at the nursing station that keeps everyone moving.

Mr. Scroggins is a proponent of having all exam rooms furnished and stocked as close to identically as possible. Doctors and medical assistants should not waste valuable time opening multiple drawers or cabinets to find the tools and supplies they need. Eliminating unnecessary clutter in exam rooms and nursing stations saves time as well.

Having an adequate number of exam rooms speeds up patient flow. “Exam room space is not the most expensive space in the office,” says Mr. Scroggins. “It certainly makes sense to lease an extra 100 or 150 square feet for an additional exam room,” he adds. This is something to keep in mind if you have plans to relocate or expand your office. Also, if your practice has a sig-

nificant number of patients who come in for “nurse-only” visits, consider adding a small consultation room for those encounters rather than using exam room space.

Review the layout of your office. Are you or your staff members taking unnecessary steps throughout the day? If so, consider what would need to be done to make the layout more efficient. Something as simple as moving the nurses’ work station, setting up your own small workspace in a central location

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**“The art of practicing medicine is helping people prioritize their symptoms,”** says Dr. Kollus. **“You’ll see a patient and he’ll say that his most urgent problem is dry skin, but he has diabetes that is out of control or has stopped taking his heart medication,”** she says.

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to avoid returning to your private office between patients, or adding a storage area closer to the exam rooms could save time.

Mr. Scroggins advocates having all patient charts reviewed a day in advance and says that this task can be accomplished by a nurse, medical assistant, or even well-trained front office staff. “This is done so the patients can be handled appropriately when they arrive,” says Mr. Scroggins. “If something needs to happen prior to the doctor’s seeing the patient, the staff needs to know what the plan is,” he says. For example, the person reviewing the charts can make sure that the results of recent diagnostic studies are in the record in advance. This prevents physicians from needing to wander in and out of an exam room unnecessarily once the patient encounter is underway.

Helen Kollus, MD, an internist in Cleveland, Ohio, spends about a half-hour each morning reviewing the records of every patient she has scheduled for that day. “I make a summary on one sheet of what each patient will need,” says Dr. Kollus. “When I walk through the door, I’m completely focused on the patient,” she says. Using her electronic medical records system, Dr. Kollus typically enters orders ahead of time for diagnostic studies she knows she’ll need for certain patients. If, for example, a patient is due for a mammogram, she puts that order in while doing her morning chart review. “I can always delete if a

patient doesn't want the study," says Dr. Kollus.

With a patient load of about 24 visits per day, plus hospital and teaching responsibilities, Dr. Kollus makes efficiency a top priority, but not at the expense of providing good patient care. "The art of practicing medicine is helping people prioritize their symptoms," she says. "You'll see a patient and he'll say that his most urgent problem is dry skin, but he has diabetes that is out of control or has stopped taking his heart medication," says Dr. Kollus. Her approach is to focus on what is genuinely most important to the patient's well-being in the moment and address less pressing concerns at a future appointment. Dr. Kollus feels that an extremely thorough initial visit with each patient is a time-saver in the long run.

### **What Matters More Than Minutes**

Making the most of a 15-minute office visit is about more than the minutes, according to Pam Vaccaro, nationally recognized speaker and owner of Designs On Time in St. Louis, Mo. She says doctors should continually ask themselves, "What's the most important thing that needs to happen with this patient?" as a technique to stay focused and achieve the best clinical outcome. "A patient may want to talk again about his or her family history of diabetes, but that may not be the most important issue that day," says Ms. Vaccaro. "Or there may be six things a patient wants to talk about. A physician with good clinical skills and good doctor-patient relationship skills will know how to guide the conversation," she says.

Ms. Vaccaro teaches the 80/20 principle (i.e., that 20 percent of your efforts produces 80 percent of your results) and says that doctors can apply this simple formula to make sure patients feel they have your attention during office visits. "Focus on the 20 percent that is most important, and the patient will leave feeling he or she has received your attention," she says.

Picking out what's most important during each patient encounter is a skill that can be learned and honed over time. Careful listening is a significant part of the process. By letting a patient tell his or her full story (within reason), you may avoid having to circle back with extra questions and clarifications in order to fully grasp the situation. Being willing to listen for one

extra minute may lead you to a more accurate diagnosis or give you a better sense of which treatment options to offer. The bottom line is, don't rush the process because haste can indeed make waste.

Multitasking during a patient encounter, according to Ms. Vaccaro, should never happen. "The human brain cannot focus on two things at the same time," she says, citing research from the Massachusetts Institute for Technology. "We can *do* two things at the same time, but we can't *think* about two things," she explains. Naturally, physicians multitask off and on all day; and most have patients waiting in multiple exam rooms at any given time. But once you open the exam room door, make every effort to become single-minded and 100-percent focused on the patient

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in front of you. "Take a deep breath upon entering an exam room, and be with that patient. When we give our full attention, it saves time in the end," says Ms. Vaccaro.

Dr. Honaker moves quickly from room to room; but once he's with a patient, he or she has his undivided attention, he says. "I just shut the door and nothing can touch me," he says. Body language is important, he adds. "I always sit down, cross my legs, lean forward or way back, and put my arms in my lap," he says. He also starts each visit with an apology, even when it's not necessary. "I say, 'I'm sorry I kept you waiting' even if it's been only a minute." This demonstrates that he values the patient's time. Eye contact is also important, says Dr. Honaker. "Touch the patient's arm to show that you care," he advises, and adds, "Don't try to fake it—you have to actually care. Don't be in a hurry. Focus on the patient."

Every physician has certain patients (or types of patients) who take up more time than they are allotted in the appointment book. It goes with the territory. But if you're not careful, a suc-

cession of such patients can put even the most efficient doctor way behind in short order. Dr. Honaker has developed some techniques for dealing with four common situations that can cause doctors to get off schedule:

**The rambling patient.** This individual has a genuine medical problem but hasn't thought it through well enough to convey the most critical facts, such as a time line of symptoms. "They haven't yet distilled it down. They'll say, 'It was five years ago . . . or four . . . no, it was three years ago.' I've got to get them focused," says Dr. Honaker. He tells the patient that he has a sick patient next door (which is always true since, after all, this is a doctor's office) and asks the unfocused patient to write down key points and the time line of his or her symptoms. "I tell the patient to give me the three most important times." By the time he returns to the patient's room, the patient has zeroed in on the most pertinent points, and he is able to make an accurate diagnosis and map out a treatment plan more quickly. "They've done all the work I would have done while I've seen another patient," says Dr. Honaker.

**The "long list" patient.** After taking a full inventory of the patient's symptoms, Dr. Honaker asks him or her to pick out the top three most critical issues to address during the visit. "I say to the patient, 'I don't want to short-change you,'" he explains, and advises the patient to set up another appointment to discuss the less important issues.

**The depressed patient.** When he suspects a patient is depressed, rather than spending a half-hour going over every possible symptom and trying to convince him or her that medication might be appropriate, Dr. Honaker leaves the patient alone with a handout on depression and a Beck depression scale to complete. By the time he comes back, the patient is more ready to hear about how to treat the depression. He then reviews the Beck scale and makes sure it confirms the diagnosis before prescribing. This technique can turn a 40-minute discussion into a 10-minute one, leaving him more time to talk to the patient about his or her specific situation.

**The multi-organ-system symptomatic patient.** These patients are similar to "long-list" patients except that their lists are even longer because of the wide range of conditions they

have. Dr. Honaker gives the patient the practice's review-of-symptoms form to complete. "Put a checkmark next to every symptom you have, then rank the top five," he tells the patient. "This forces them into filtering mode. They get to check it off, but it's distilled to five things, and they've had their say on paper," says Dr. Honaker.

Dr. Honaker's ability to move from room to room means that he can see more patients in less time. Not only are patients not put off by Dr. Honaker's practice style, they are highly satisfied.

### E-mail Management Made Easy

David Allen, productivity expert and author of *Making It All Work: Winning at the Game of Work and Business of Life* (Viking Adult, 2008), says that when it comes to e-mail, doctors have two choices: accept that it's part of their life and deal with it effectively or get rid of it altogether. Complaining about having too much e-mail, avoiding it even as the in-box fills to capacity, or frittering away hour after hour in front of the computer screen is simply not productive. If e-mail is going to remain a part of your life—and most likely it is—become as proficient as possible in dealing with it.

"Process incoming e-mail for 30 to 60 minutes a day," suggests Mr. Allen. If you're receiving more than you can handle in that amount of time, look for ways to reduce the flow by unsubscribing to anything you don't routinely read, asking friends to resist "forwards" no matter how clever they may seem, installing a foolproof spam filter, or training your assistant to screen and handle e-mail that does not need your personal attention.

"Clean up e-mail at the end of the day," says Mr. Allen. "Keep the backlog as close to zero as possible. If you're not dealing with it, then you'll have an increasing backlog." Use the two-minute rule, which states if an e-mail can be handled within two minutes, deal with it immediately. "Don't open and reopen and reread for days . . . don't keep on not deciding," advises Mr. Allen. "Typing fast helps," says Mr. Allen. "The keyboard is the most important tool for the rest of your life," he adds.

The debate about whether to use e-mail with patients continues. Some physicians consider it an efficient mode of communication to handle straightforward questions and requests. Others see e-mail as a time-consuming task that isn't reimbursed and may leave them open

He has been named one of the “Best Doctors in Dallas” by *D* magazine and a “Texas Super Doc” by *Texas Monthly* magazine. The trick, he says, is to always make it about the patient and what’s in it for them. “Give people more time when they need it,” says Dr. Honaker.

The manner in which you end an appointment is critical if high productivity is your goal. “You have to get closure with a patient, which is hard especially if you’ve known them for a while,” he says. The system that works for Dr. Honaker is to end

to liability. Privacy concerns are also a factor. However, for some physicians with certain patients, e-mail makes sense; and the benefits outweigh any potential risk. Here is how e-mail works in the practices of three expert sources interviewed for this issue of *Doctor’s Digest*.

■ Using e-mail for simple questions and prescription refills has turned out to be a time-saver for Catherine Kimball, DO, of Waterville, Me. “I have a small cadre of patients who use e-mail to give or request information,” says Dr. Kimball. “They’re all counseled that if they don’t hear back from me within a certain time frame, they should call,” she adds. Dr. Kimball likes e-mail as a mode of communication but notes that it’s not for all patients. “These are people I know fairly well . . . they communicate effectively,” she says, adding that e-mail probably would not work for overly anxious or overly stoic patients.

■ Internist Helen Kollus, MD, of Cleveland, Ohio, uses e-mail regularly to receive diagnostic results and communicate with colleagues. Because she is part of a large, hospital-based medical group, occasionally a patient will decipher her e-mail address and make contact that way; but she does not encourage e-mail use with patients.

■ At Dermatology and Skin Surgery in Shreveport, La., the doctors don’t have time for e-mail, says administrator Rhonda Holloway. The group debated the pros and cons of communicating with patients via e-mail; but after consulting with their risk management advisor, Ms. Holloway says they elected not to go that route. “It consumes doctors, and you don’t want anyone else answering those e-mails,” she says.

Even if you’re not using e-mail to communicate with patients about clinical issues, consider using it for administrative functions like sending out your practice brochure, newsletter, and registration forms to new patients. If you have a Website, post these documents as downloadable PDFs to save even more time.

each visit by asking, “Did we cover everything?” and then leaving a note for the nurse about what samples or information the patient needs. As he’s wrapping up his visit, he tells the patient what to expect. “I’ll say, ‘Let me get my nurse to give you a reflux handout,’” says Dr. Honaker. Then he’s on to the next exam room while the nurse attends to the patient’s needs.

Managing time between patients also helps Dr. Honaker stay on schedule and maintain his heavy patient load without spending every waking hour at work. “Between patients I’ll go out and take care of quick phone calls or refills,” he says. “I can spend two minutes taking care of three little things and keep the nurses busy while I’m seeing patients.”

Dr. Honaker won’t take phone calls during patient hours unless he knows they’ll be short. Even with other doctors, he’s likely to keep conversations to the point. When you make it clear that you

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**Practice management expert Elizabeth Woodcock says that “on-the-spot” dictation is a time-saver for doctors and requires no new investment. It’s also good quality care in that it allows patients to hear their diagnosis, treatment plan, and follow-up instructions a second time.**

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have only two minutes, he says, often business can be taken care of just that quickly. Taking calls and keeping them succinct saves everyone from playing phone tag later. If you’re friendly and professional, your colleagues—who are probably just as pressed for time as you—will most likely appreciate the brevity.

Occasionally a patient calls who insists on speaking only with the doctor. In such cases he instructs his nurse to offer the patient his private voice mail. “[The patient then] gets all his stuff out rambling on for three or four minutes [on the voice mail],” says Dr. Honaker. Often the only follow-up required at that point is making a quick return call or having the nurse call the patient back with a referral.

## Chart as You Go

As more practices invest in electronic medical record systems, fewer physicians are faced with a huge stacks of charts to be

completed or dictated at the end of the day. This not only makes it more likely that staff will be out of the office at a reasonable hour, but it's also good for patient care. Integrating dictation or note taking into the office appointment can mean more complete and accurate notes.

If you have a computer terminal in each exam room, you'll have to decide if it's your style to enter data as you interview patients or if you're more comfortable taking a few minutes at the end of each appointment to record your findings, treatment, diagnostics ordered, prescriptions given, etc. Either way, the benefits of completely finishing one patient encounter before moving on to the next are significant. If you see three patients with back pain over the course of a day, charting as you go means that you won't inadvertently confuse Mr. Garcia's symptoms with those of Mr. Weaver and Mr. Peterson—who all happen to be about the same age and who are relatively new patients. Charting as you go also makes it more likely that you will code properly for billing purposes and keep charges for your service from slipping through the cracks.

Even if you dictate your charts, many consultants now advocate doing so in the presence of patients. Practice management expert Elizabeth Woodcock says that “on-the-spot” dictation is a time-saver for doctors and requires no new investment. It's also good quality care in that it allows patients to hear their diagnosis, treatment plan, and follow-up instructions a second time. Ms. Woodcock says that dictating in front of patients also gives them an opportunity to clear up anything you may have misunderstood, which improves patient care and reduces your liability risk. She recommends ending notes with “Dictated in the presence of the patient.”

Dr. Kollus makes it her goal to complete everything required for an office encounter by the time the patient leaves. “Over the years I've developed a system where I can do everything during



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the visit,” she says. Dr. Kollus uses templates for common problems like urinary tract infections, upper respiratory infections, skin rash, and back pain; and she inputs notes into the electronic medical records system before moving on to the next patient. “This saves me from spending hours at home typing notes from the day,” says Dr. Kollus. She also prints out all orders and prescriptions before saying goodbye and turning a patient over to one of the group’s medical assistants.

Dr. Kollus makes good use of time between patients. “Between patients I’m sending out results, doing refills, returning phone calls,” she says. At the end of the day, her work is truly done. “Every chart is closed, every call has been returned, every result has been given,” says Dr. Kollus. “In medicine,

### Should You Use a Scribe?

Medical assistants can often do much more than physicians realize or allow. In addition to rooming patients, taking vital signs, recording the chief complaint and history, and preparing patients for exams, a well-trained assistant can save you a tremendous amount of time by documenting your findings and treatments in real time.

Dermatologist Susan Sanders, MD, of Durango, Colo., uses paper records in her practice; but only on rare occasions does she herself write in them. Instead, her medical assistant functions as a scribe, which allows Dr. Sanders to stay focused on her patients. “I can maintain eye contact,” she says. “If I have to break [to write in the chart], it really affects the relationship and the flow of the whole visit.” Having used a scribe from the day she first began practice in 1980, Dr. Sanders says it’s a huge time-saver. “If I’m shorthanded—if someone is home sick—it takes me one-quarter more time to see patients,” she says. “Plus, I’m just not as calm.”

In addition to efficiency, another benefit of this documentation method is that patients get to hear exactly what the doctor is seeing, thinking, planning, and doing. “I’ll say to the patient ‘I’m going to describe this rash to Liz and then I’m going to tell you about it,’” explains Dr. Sanders. This kind of communication flow allows her to spend more time in conversation with patients while her assistant is making notes, writing out prescriptions, preparing a biopsy tray, or getting samples ready for a patient.

you've got to have a system. If you get behind today, you'll just be more behind tomorrow," she notes. "They don't teach you this in medical school, but I try to teach it to my residents."

Her efficiency pays off. In Dr. Kollus's group, physicians receive monetary incentives based on quality indicators. "They look at the numbers and determine how many patients meet the criteria for good diabetes or blood pressure control . . . compared nationally and with your peers," explains Dr. Kollus. "I get high incentive [payments] because of my organization, and I'm confident and proud that my patients get their PAPs, mammos, and DEXAs . . . [and that] things don't fall through the cracks," she says. Good for the patients and good for the doctor—the classic win-win.

Training a medical assistant to function as a scribe takes time. Dr. Sanders requires new medical assistants to observe an experienced scribe for at least a week before the two change places and the new person takes notes while being closely supervised. Good communication between doctor and scribe is critical and sometimes subtle. "If I see that they're not writing, I'll look over at them or alter my voice as their signal to write," says Dr. Sanders. Once on his or her own, the new scribe's notes are reviewed by a more seasoned staff member until Dr. Sanders feels he or she is working up to standards. New scribes are given a small spiral notebook to carry around in which they record new terminology and spelling. Even after scribes are completely trained and working independently, Dr. Sanders personally reviews every clinical note. "They put charts in a little container on the wall, and between seeing patients I go through them," she says, adding that she never lets records stack up until the end of the day.

"It takes about a year to get someone fully trained," she says. Because of this investment, Dr. Sanders works hard to keep staff turnover low. She currently has two employees who have been with her for more than a decade, and a third who has been with the practice for three years. Generous annual raises, says Dr. Sanders, helps keep employees loyal to the practice. "I can't imagine a dermatologist's not having a scribe," says Dr. Sanders, adding that she can imagine this process's working well in other specialties as well, such as family practice and pediatrics.