R E S O L U T I O N

The **Pennsylvania State Legislative Committee** of the **American Association of Retired Persons**, representing 1,700,000 members in Pennsylvania and 40% of the voters in Pennsylvania, reaffirms its position opposing the passage of House Bill 1105.

We cannot allow the rights of the citizens of Pennsylvania, especially the elderly, to be jeopardized so that the irresponsible and negligent actions of health care providers go unnoticed.

We cannot allow our access to the Courts and the right to fair and just compensation to be curtailed in any way.

PENNSYLVANIA STATE LEGISLATIVE COMMITTEE

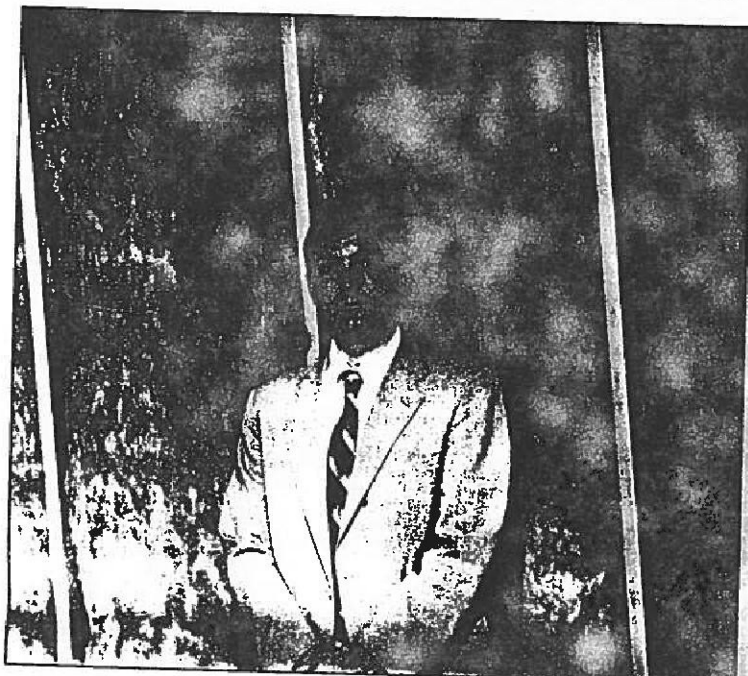
Paul D. Schroeder

THE REVEREND PAUL D. SCHROEDER, CHAIRMAN

July 18, 1989

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700

Louise D. Crooks *President* Horace B. Deets *Executive Director*



Banking on the future

PAUL TARINI/AMN

Before applying for a loan, Timothy D. Heitman, MD, did his homework. 'I was really prepared. I gave them all this data and explanations as to why I would be good at this.'

Business sense helps young MDs go solo

Banks scrutinize physicians seeking loans

By Paul Tarini
AMN STAFF

Many new MDs are discovering that realizing the dream of solo practice means developing some market sense and business savvy.

Intensifying competition has made medicine subject to market forces more than ever before. Banks that once easily made loans to physicians just starting out are these days subjecting them to serious scrutiny.

"We are looking at them more closely than we did five years ago," says Lori Craig, a medical banking specialist with BankOne in Milwaukee. "You used to be able to just walk in with the potential income that doctors [were] almost guaranteed and say, 'I'm graduating, I need money.'"

The changes have caused some brows to furrow. "We are concerned about problems with young physicians who often have difficulty getting financial backing, especially in small rural areas and urban areas where competition is tight," says George E. McGee, MD, chairman of the AMA's Young Physicians Section (YPS). "All this is encouraging younger physicians to join existing groups because you don't have all those start-up expenses."

YOUR CHANGING PRACTICE

A weekly practice-trends feature

The expenses mount quickly. The tally starts when an MD picks a practice location and rents space. Chances are that remodeling will be needed. Outfitting the office requires purchasing basic medical supplies, examining tables, and other equipment particular to the subspecialty. Add in desks, chairs, and office equipment, and don't forget the first liability insurance premium, as well as the expense of hiring and paying the office staff.

It can all vary from "a couple thousand for a couch for a psychiatrist to a couple hundred thousand for a surgeon with a laser," says Mike Arnow, a certified public accountant in Milwaukee and a practice management teacher.

Cash also is needed to cover rents, salaries, and the physician's own living expenses until the practice starts generating accounts receivables. "It costs a minimum of $6,000 to $10,000 a month to run a small medical office," says George Conomikes, president of Conomikes Associates Inc., a Los Angeles-based health care consulting firm.

The costs have had the YPS concerned for a while. The YPS delegate to the 1987 AMA Annual Meeting introduced a resolution calling in part on the AMA to "deposit its resources in financial institutions which will, in response to those deposits, make specific efforts to assist young physicians financially."

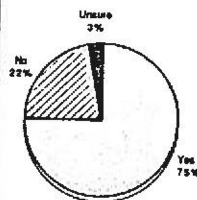
The measure never made it to the House of Delegates. "We were told by various sources that it was patently illegal," Dr. McGee says.

Increasingly, physicians interested in going solo will have to learn something about business.

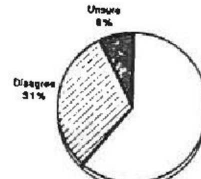
PERHAPS the easiest thing to learn is that some people make a business out of knowing business. "The key to success is delegating responsibility to people who have expertise," says Timothy D. Heitman, MD. "You're going to pay in the beginning, but I

See SOLO, page 17

Physicians say they order more tests due to threat of malpractice suits; majority of public agrees



Physician opinion: 1989



Public opinion: 1989

Source: AMA Office on Issue and Communications Research

Fear of suits affecting practice of medicine

Fully three-quarters of physicians surveyed said the threat of malpractice lawsuits has caused them to order clinical tests that they "might otherwise believe are not needed," according to a new Gallup Organization poll commissioned by the AMA.

The poll, which gauged MD and public opinion on issues relating to professional liability, indicated only a very slight change from when the question was last asked, in 1986. That year, 78% of MDs polled indicated they had ordered additional tests, 18% said no, and 4% were unsure or didn't answer. In this year's poll, 22% said no and 3% were unsure or non-responsive.

In the companion poll of public opinion, 61% of the public surveyed said yes, "doctors do too many tests because of the fear of malpractice suits." Only 31% disagreed, with 8% unsure. When this question was last asked in 1986, 59% of the public said yes, 33% said no, and 8% were undecided.

While some MDs are reacting to liability fears by ordering tests, other MDs — a minority — are declining to take on high-risk patients due to liability concerns.

Seventy-six percent of physicians continue to provide services to high-risk patients despite the fear of malpractice lawsuits. The question specifically targeted the 12 months prior to the survey.

But 14% said they had declined service, for fear of lawsuits, 10 times or less, and 4% said they had declined service more than 10 times. Five percent said the question didn't apply to them because they had not encountered high-risk patients in the past 12 months, and 1% were unsure.

When it came to saying who was most likely to bring a suit, 39% of the MDs believed indi-

See SUITS, page 19

Ban on pay to assistants in cataract surgery upheld

By Karen Torry
AMN STAFF

The U.S. Supreme Court has upheld a federal law barring Medicare patients from paying for assistant surgeons in cataract operations, a decision that may force ophthalmologists to pay assistants' fees themselves.

The high court let stand without comment a 1986 law that not only prohibits Medicare payments for assistant cataract surgeons, but also forbids patients from paying for the assistants' services out of their own pockets — unless a local Medicare peer review organization (PRO) rules that a "complicating medical condition" exists to justify a second surgeon's presence.

"I think this is a sign of deterioration in patient care," said Sherwin Sloan, MD, past president of the California Assn. of Ophthalmology, and a plaintiff in the suit challenging the law. "The ophthalmologist will not be able to use the most qualified person to assist him at the cataract surgery, and the patients won't have a say-so in who assists in their operation."

Dr. Sloan predicted that ophthalmologists either will perform cataract operations alone, with a nurse or other "less qualified" assistant or — when they want an assistant but can't get PRO approval — take a lower fee themselves to

See CATARACT, next page

Reception

Continued from facing page

florists have a delivery service and will provide a good-looking arrangement every Monday, which will usually last until the end of the week. Special floral settings that have colors and flowers associated with holiday times are also available.

Many offices have unpleasant odors that give the office the characteristic medicinal smell. This can be alleviated simply with an attractive bowl containing potpourri. The potpourri aroma can be enhanced with special scented drops when the fragrance diminishes. These bowls of potpourri can also be used in the restroom and the exam rooms for the same purpose.

Pleasant background music for the reception area is available from Muzak or by tuning in one of the "easy listening" stations that are popular in most metropolitan areas. If this is not available in your area, the same effect can be accomplished by purchasing a compact disc player that accepts five or six discs and will play them in a random or predetermined fashion.

MOST MEDICAL offices provide patients with reading material such as *Reader's Digest*, *People*, and *National Geographic*. However, today's patients are very interested in their health and are more well-read on health and wellness than ever before. It makes sense to augment the usual reception area reading fare with health-related magazines and periodicals. It has been my observation that since I have started providing such medically related reading material in the reception room, most patients prefer to read health magazines than other general publications frequently found in most offices.

I suggest *American Health*, *Prevention*, and *Hippocrates*, as well as *Men's Health* if you have you a large number of male patients. I also suggest subscribing to one or two medical newsletters such as *The Harvard Medical Letter* or *The Mayo Clinic Medical Letter*.

You can also provide your patients with a copy of the daily local newspaper.

Neil Baum, MD, is a urologist in solo practice in New Orleans, and a speaker on physician marketing issues.

If you have a particular area of interest in your practice or within your specialty, you may want to inform your patients by providing reading material on this subject in the reception room.

For example, I am interested in infertility, impotence, and incontinence and I have obtained articles from the newspapers and non-medical magazines that I have placed in a notebook with the subject matter clearly written on the cover. These articles are placed in plastic protective covers and we offer to make copies of any articles for the patients.

It is also good to provide another notebook with general medical information even if it is outside your area of interest or specialty. Subjects such as wellness, nutrition, sports medicine, sexually transmitted diseases, cancer prevention, and smoking cessation are of interest to nearly all patients.

A bulletin board can be an effective way to market your practice. On this board you can inform the patients of any talks or programs or support groups that you will participate in or have recently completed. This is also a means to inform your patients of community or non-medical involvement. The bulletin board can also tell about your staff's accomplishments, hobbies, or interests.

I also provide a joke for the day or a quote on health, wellness, success, or motivation. (These are available in calendar form as "joke-a-day" or "quote-a-day" from most bookstores.) Another suggestion is to place healthy and nutritious recipes on the bulletin board and offer to provide copies of the recipes for the patients. These can be obtained in most women's magazines or from the dietitian in your hospital.

Our patients are impressed by any articles that were written by their physician or that have appeared in the local magazines or newspapers about their physicians. Although patients may not fully understand the technical content of articles that appeared in medical journals, they still enjoy seeing their physician's name in print.

If you have a particular area of interest in your practice or within your specialty, you may want to provide reading material on this subject in the reception room.

It is nice to have your diplomas on the wall for your patients to know your medical background. However, most offices do not provide a single area where you can place your credentials for all of your patients to see. That's why I suggest you provide them with a current curriculum vitae in the reception room.

In the book containing the CV I also recommend you list your continuing medical education courses. The patients not only want to know where you were yesterday but what are you doing today to stay current. It is also important that your staff be familiar with your CV and your CME courses.

If you are delayed, have your office staff inform those patients of the delay and give them an estimate of when you will be returning to the office.

Patients can be given an opportunity to reschedule their appointment or leave and return when you are expected back in the office. If the patient elects to stay, it is a thoughtful gesture to offer him and his family coffee, tea, or soft drinks. If you have a VCR and there are children in the reception room, ask them to come into the room with the VCR and play an appropriate video for them until you return to the office.

Many reception rooms contain a television, which can be used to promote you and your practice. If you have been on television or have had a seminar videotaped, you can play it periodically in the reception room. Also, there are a number of television programs that deal with health care subjects. These can be recorded and shown in the reception room.

Consider also providing your patients with a courtesy phone in the reception area. Ideally, this should be a separate line from your business phones.

MANY BUSINESS and medical offices have expressed their goals and their purpose in a mission statement or a pledge. Our office pledge was created by the staff and states, "This office is committed to: 1) Excellence, 2) Providing the best health care, and 3) Persistent and consistent attention to little details because they make a BIG difference."

This pledge is displayed in the reception room as well as in the office and the employe lounge. I think this commitment is important for the patients to see as soon as they enter the office. It informs the patients what they can expect from the physician and staff.

Remember, one of the first impressions that a patient will have of you and your practice is the moment he opens the door to your reception area. This is an opportunity for you to create a positive image. The examples given here are just a few of things that you can effectively and inexpensively do to enhance your reception area.

The editors would appreciate your comments, ideas, and suggestions. Please write to the Business Editor, American Medical News, *535 N. Dearborn St., Chicago, Ill. 60610; or call at (312) 645-4437.*

Suits

Continued from page 15

gent patients are more likely to sue for malpractice. Thirty-one percent said it made no difference whether the patient was indigent. Twenty-two percent said indigent patients were less likely to sue, 4% said they did not see indigent patients and 5% were unsure.

"I believe it is a critical comment on the state of our legal system that even one patient would not receive care because physicians feared being sued," said James H. Sammons, MD, AMA executive vice president. "All of these factors — declining high-risk patients, limiting their type of practice, and believing indigent patients are more likely to sue — impact on the public's ability to receive medical care.

"An even more damning indictment of our legal system is that almost half of the public surveyed believe that people are just looking for an easy way to make money when they sue," said Dr. Sammons, referring to poll results that 48% of the public believe "people who sue physicians for malpractice are just looking for an easy way to make money."

Only 27% believe that malpractice suits are usually justified. Twenty-five percent are unsure. Since 1982, when the question was first asked, the number who believed the lawsuits were justifiable has declined from 47%. Those who stated the suits are an "easy way to make money" increased from 43% in 1982. Those who were unsure climbed from 10% in 1982.

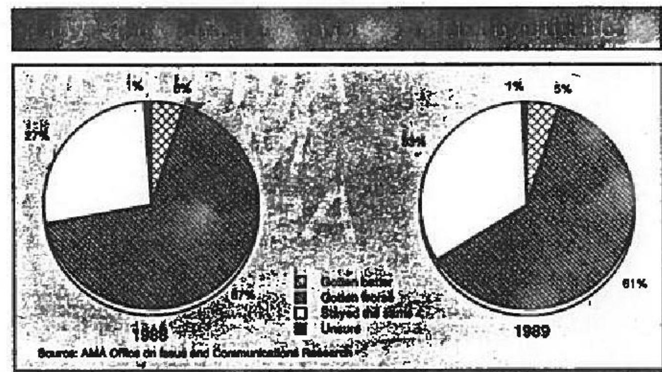
More than half (54%) of the public think the money awarded by juries in malpractice cases is too much. This compares to 47% in 1982. This year 6% said the amounts were not enough, as compared to 7% in 1982. Those who thought the amounts were "about right" fell from 38% in 1982 to 24% in 1989. The number who were unsure rose from 8% to 17%.

Sixty-two percent of the public favor a ceiling for "pain and suffering" awards, down from the 66% who favored the ceiling in 1986. Twenty-six percent oppose the ceiling this year as compared to 23% in 1986. The unsure percentage was virtually unchanged (11% in 1986 and 12% in 1989.)

"When you combine excessive awards, no limits on 'pain and suffering' awards, and legally necessary, but medically unnecessary tests, you see three major contributors to the rising costs of medical care in the U.S.," said Dr. Sammons.

Sixty-one percent of the MDs surveyed believe the professional liability situation has become worse in the past year, 33% said the situation is the same as last year, and only 5% said the situation had improved. In the 1988 survey, 67% said 1988 was worse than 1987, 27% said it was the same, and again only 5% said the situation was better than the previous year. In both years, 1% of the MDs were unsure.

Thirty-five percent of the physicians surveyed said there are areas of medicine they do not practice, despite being qualified to practice, because of rising liability insurance costs. Among general and family practice physicians, the rate of practice-limiting MDs was 62%.



But 60% of MDs said that rising rates have not caused them to alter their practices, and 5% were either unsure or did not respond.

For the physician opinions, the Gallup Organization surveyed 1,004 physicians who work in the United States. They were randomly selected from the AMA's Masterfile, a computerized listing of all physicians in the nation. The sample was stratified by age and AMA membership to ensure that the sample contained the appropriate proportions of both younger and older physicians and members and non-members. The interviews were performed by Gallup's Lincoln, Neb., office Jan. 19 through Feb. 8, via telephone. The sampling error may be plus or minus 3.5% at the 95% confidence level.

For the public opinions, the Gallup Organization surveyed 1,500 randomly selected U.S. residents age 18 and above during the last week of January and the first week of February. The interviews were performed by Gallup's Houston office via telephone. The sample was drawn from Gallup's database of 2 million households, which was developed and is updated annually by R.R. Donnelly. The sampling error may be plus or minus 2.5% at the 95% confidence level.

JUST HOW HEAVY IS THE BURDEN OF MALPRACTICE PREMIUMS?

They're taking the biggest-ever bite out of gross incomes, our survey shows. But there are signs that the worst may be over.

By Harry T. Paxton

Is the cost of malpractice insurance leveling off? The most recent MEDICAL ECONOMICS Continuing Survey shows that premiums have risen more steeply over the past two years than in the early '80s. However, 1988's rate of increase was down 6 percentage points—to 13.7 percent—from the year before. And a study published last year by Medical Liability Monitor suggests that the moderating trend is continuing for 1989. In some states, premiums have even been held level or reduced.

All told, however, malpractice premiums not only remain the third biggest expense of office-based physicians, but take a median 4.5 percent of gross practice receipts—the largest proportion we've ever found.

For quite a few doctors, liability insurance takes even a larger bite. The overall median premium expense for surgical specialists amounts to 7.4 percent of gross. In some fields, the percentages run well above that—10.1 for thoracic surgeons, 10.0 for OBG specialists, 9.3 for neurosurgeons.

Even at the other end of the spectrum, where malpractice insurance costs come to around 3 percent of gross, premiums in such low-paying—but low-earning—specialties as pediatrics and family medicine are edging up at the same pace as in some high-risk fields.

For M.D.s as a whole, the median dollar outlay for malpractice coverage last year came to nearly $11,000, up from about $4,200 in 1983 (see page 170). That's a 163 percent leap. By comparison, median practice expenses went up only 43.7 percent from 1983 to 1987—the latest year for which we have data. Part of the explanation is that physicians are buying more malpractice protection. Whereas only two out of five had at least $1 million coverage in 1983, almost two out of three do today.

How much you're paying continues to depend on your specialty, location, and type of practice. The overall median ranges from $9,940 in the East to $12,000 in the South. Urban physicians are shelling out 44 percent more than, and rural doctors almost as much as, their suburban colleagues. Florida practitioners pay more than twice as much as those in Texas and North Carolina.

As for type of practice, the contrast between incorporated and unincorporated is especially striking: a median of $14,060 vs. $7,810. Doctors in higher-risk—and higher-income—specialties tend to practice in incorporated groups. The groups themselves often incur an extra premium charge.

Are many doctors taking the risk of going bare? While some

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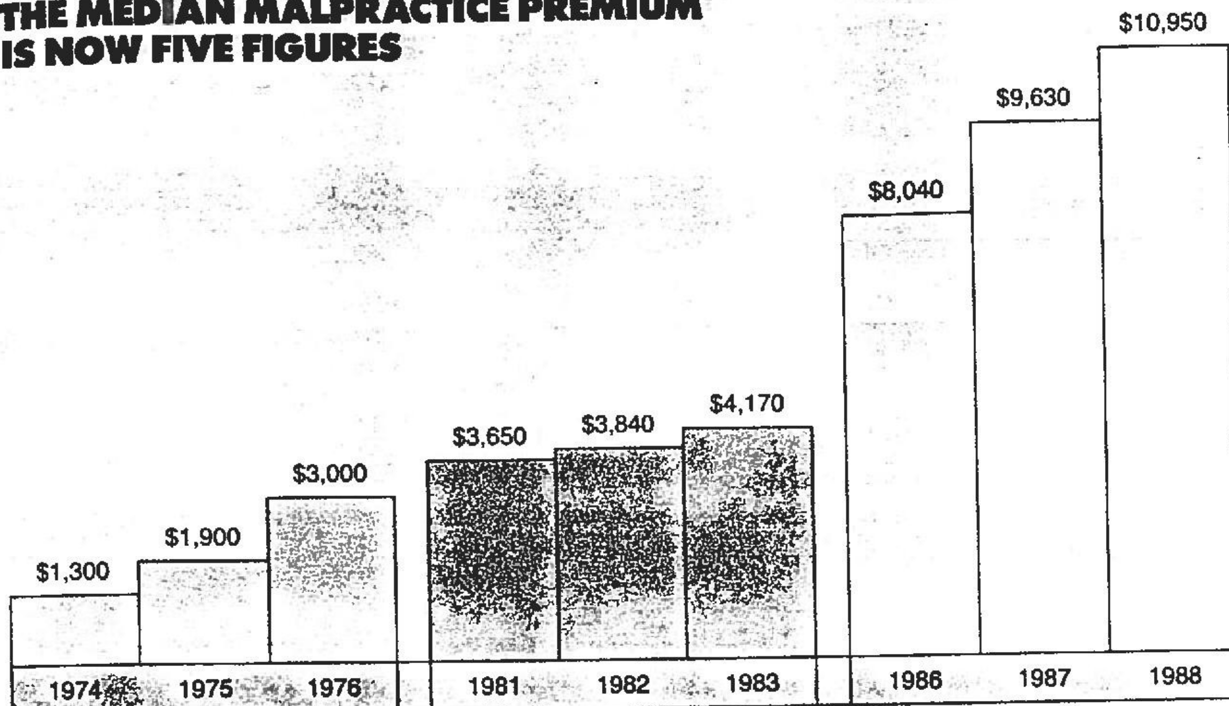
THE AUTHOR, formerly Professional Editor of MEDICAL ECONOMICS, is a free-lance writer.



Dollar figures are medians for physicians in office-based practice. Unless otherwise indicated, figures in this and other charts and tables exclude physicians with no malpractice coverage. All figures have been drawn from the MEDICAL ECONOMICS Continuing Survey.

percent of respondents said they paid no malpractice insurance premiums last year, only 1 percent said they had no malpractice coverage. The other 7 percent practice in entities that pay for their insurance. For doctors who start out in high-risk specialties and don't have a lot of cash, joining such practices is the only way to get coverage, because carriers demand full payment up front. And some physicians have privileges at hospitals that pay their premiums.

What's ahead? Insurance industry experts say the slowdown in premium increases is due to a smaller number and faster resolution of claims, although dollar amounts haven't decreased. They also cite a cyclical trend in liability premiums general, a "wait and see" attitude on the part of carriers, increased competition among insurers, and growing pressure from state insurance departments to hold premiums down.

"At this point, it's difficult to say how much of the downturn in malpractice claims is due to a low point in the cycle and how much is attributable to the strides in loss prevention and claims management made by physicians and their insurance companies," says Peter Sweetland, president of the Medical Inter-Insurance Exchange of New Jersey, a doctor-owned carrier. "If the picture stays positive, you may not see substantial rate reductions, but more of the successful companies may pay dividends to policyholders—an approach that can maintain a stable premium base if the cycle turns upward in a few years."

However, the picture for the next few years isn't entirely rosy. "Even though premiums will stay level or increase only moderately, there are still some trouble spots out there," says Carol Brierly Golin, publisher of Medical Liability Monitor. "Arizona got a 34.5 percent increase for next year. Increases in the 20 to 30 percent range will probably be imposed in at least five states next year. And all malpractice carriers face very big tax bills under the 1988 'technical corrections' law, which may undercut their financial position and trigger a new round of premium increases."

And no matter which direction premiums take, the growing number of physicians who have claims-made insurance will face the increasingly expensive problem of buying tail coverage when they want to move, change carriers, or retire.

Meanwhile, the accompanying charts and tables, which include breakdowns for 13 fields of practice, will give you a good grounding in where things stand now—and where you fit in.

Continued on page 172

THE WIDE VARIATIONS BY SPECIALTY

	Cardiovascular surgeons	FPs	GPs	Ge su
1974	N.A.	$1,000	$1,000	$ 2
1975	N.A.	1,200	1,300	4
1976	N.A.	1,700	1,750	6
1981	N.A.	2,110	2,210	7
1982	N.A.	2,290	2,450	8
1983	N.A.	2,510	2,630	8
1986	$25,690	4,650	4,780	1
1987	30,250	5,580	5,960	2
1988	32,120	6,580	6,860	2

	Otolaryn-gologists	Pediatricians	Plastic surgeons	Th su
1974	N.A.	$ 600	N.A.	
1975	N.A.	800	N.A.	
1976	N.A.	1,300	N.A.	
1981	N.A.	1,670	$10,790	$1
1982	N.A.	1,840	11,220	1
1983	N.A.	2,030	12,570	1
1986	$16,670	4,500	21,170	2
1987	17,250	5,110	25,000	2
1988	19,830	5,680	26,500	3

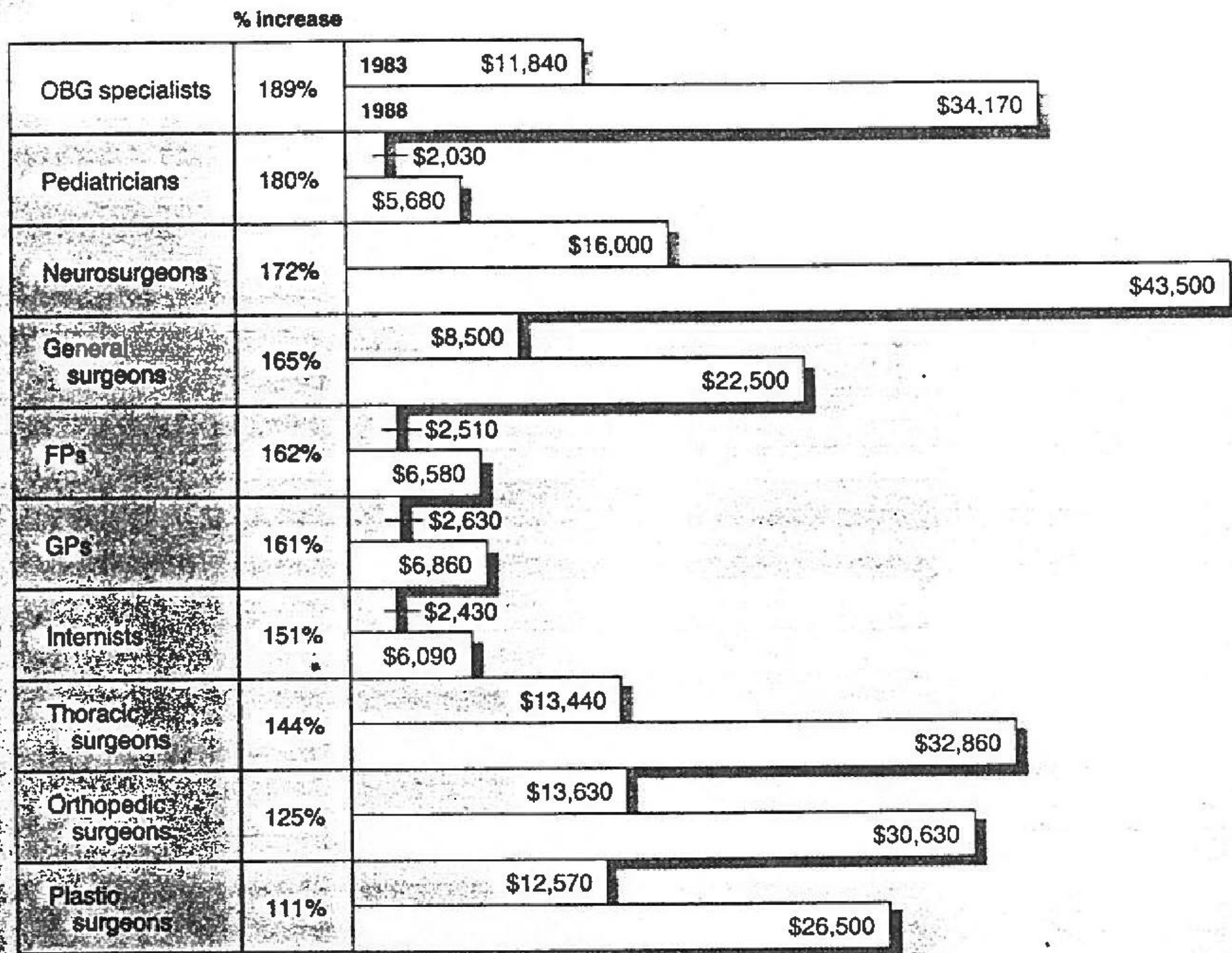
General surgeons	Internists	Neuro-surgeons	OBG specialists	Orthopedic surgeons
$ 2,600	$ 700	N.A.	$ 3,300	N.A.
4,000	900	N.A.	4,900	N.A.
6,000	1,500	N.A.	7,500	N.A.
7,770	1,950	$13,970	10,500	$12,170
8,000	2,200	14,880	11,250	12,890
8,500	2,430	16,000	11,840	13,630
18,570	4,780	30,940	26,200	21,600
20,170	5,670	37,500	31,560	27,600
22,500	6,090	43,500	34,170	30,630

Thoracic surgeons	Urologists	All surgical specialists	All non-surgical specialists*
N.A.	N.A.	N.A.	N.A.
N.A.	N.A.	N.A.	N.A.
N.A.	N.A.	N.A.	N.A.
$12,410	N.A.	$ 8,300	$1,960
12,550	N.A.	8,600	2,140
13,440	N.A.	9,260	2,350
24,440	$12,430	19,210	4,820
28,500	13,860	23,640	5,520
32,860	14,680	25,000	6,420

*Excludes FPs and GPs. N.A. means data not available from the earlier surveys. Figures are medians.

PREMIUMS HAVE BEEN SOARING ACROSS THE BOARD

The dollar increases for surgical specialists dwarf those for non-surgeons, but when you look at it from the standpoint of percentage increases over the last five years, there's little if any difference.



Dollar figures are medians.

Continued on page 176

MEDIANS DON'T GIVE THE FULL PICTURE ON PREMIUMS

Just as there are wide variations among specialties, so there are big divergences within them. For instance, although one neurosurgeon in 15 laid out $100,000 or more for his malpractice insurance last

	Cardiovascular surgeons	FPs	GPs
$50,000 or more	25%	—[2]	1%
40,000-49,999	9	2%	2
30,000-39,999	25	—[2]	1
20,000-29,999	26	4	3
15,000-19,999	9	1	6
10,000-14,999	3	21	15
8,000-9,999	—[2]	10	13
6,000-7,999	1	18	16
4,000-5,999	—[2]	23	21
2,000-3,999	1	17	17
1,000-1,999	1	4	4
Less than $1,000	—[2]	—[2]	1

	Otolaryngologists	Pediatricians	Plastic surgeons
$50,000 or more	6%	1%	17%
40,000-49,999	7	—[2]	11
30,000-39,999	13	1	13
20,000-29,999	23	2	44
15,000-19,999	28	4	9
10,000-14,999	15	11	5
8,000-9,999	4	13	—[2]
6,000-7,999	4	13	—[2]
4,000-5,999	—[2]	29	—[2]
2,000-3,999	—[2]	20	—[2]
1,000-1,999	—[2]	5	1
Less than $1,000	—[2]	1	—[2]

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year, one in 13 paid less than $16,000. One out of 10 OBG specialists shelled out $70,000 or more, but an equal number spent less than $16,000.

General surgeons	Internists	Neuro-surgeons	OBG specialists	Orthopedic surgeons
6%	1%	34%	20%	21%
4	—[2]	25	16	15
18	—[2]	20	25	15
31	1	9	19	31
24	4	4	13	11
9	12	5	2	2
4	12	—[2]	3	2
1	20	2	—[2]	1
—[2]	25	1	2	1
—[2]	20	—[2]	—[2]	—[2]
1	4	—[2]	—[2]	—[2]
2	1	—[2]	—[2]	1

Thoracic surgeons	Urologists	All surgical specialists	All non-surgical specialists[1]
15%	—[2]	14%	4%
19	2%	7	—[2]
26	5	18	—[2]
28	16	24	2
7	25	17	6
2	31	10	12
—[2]	6	6	12
1	8	2	17
1	3	2	20
—[2]	—[2]	—[2]	22
—[2]	2	—[2]	4
1	2	—[2]	1

[1]Excludes FPs and GPs.
[2]Less than 1 percent.

Continued on page 181

INCORPORATED PHYSICIANS SPEND MUCH MORE FOR COVERAGE

	Incorporated		
Premium range	Solo	Multi-physician	All incorporated
$50,000 or more	8%	10%	9%
40,000-49,999	5	2	3
30,000-39,999	7	12	10
20,000-29,999	13	14	14
15,000-19,999	11	11	11
10,000-14,999	16	11	13
8,000-9,999	10	8	9
6,000-7,999	9	13	11
4,000-5,999	12	8	10
2,000-3,999	8	8	8
1,000-1,999	1	2	2
Less than $1,000	—*	1	—*
Medians	**$13,500**	**$14,630**	**$14,060**

	Unincorporated		
Premium range	Solo	Partnership or group	All unincorporated
$50,000 or more	5%	6%	6%
40,000-49,999	3	6	4
30,000-39,999	4	4	4
20,000-29,999	8	11	8
15,000-19,999	6	10	7
10,000-14,999	11	6	11
8,000-9,999	11	8	9
6,000-7,999	11	15	13
4,000-5,999	21	17	19
2,000-3,999	14	15	15
1,000-1,999	6	—*	4
Less than $1,000	—*	2	—*
Medians	**$7,690**	**$8,500**	**$7,810**

*Less than 1 percent.

LOCALE MAKES A BIG DIFFERENCE

HOW PREMIUM RANGES VARY BY REGION . . .

	West	Midwest	South	East
$50,000 or more	6%	8%	7%	10%
40,000-49,999	4	2	3	4
30,000-39,999	4	10	7	9
20,000-29,999	13	8	15	9
15,000-19,999	8	12	11	8
10,000-14,999	16	14	13	10
8,000-9,999	7	6	10	11
6,000-7,999	12	10	9	16
4,000-5,999	14	14	10	13
2,000-3,999	14	11	12	8
1,000-1,999	1	4	3	1
Less than $1,000	1	1	—*	1
Medians	**$10,100**	**$11,330**	**$12,000**	**$9,940**

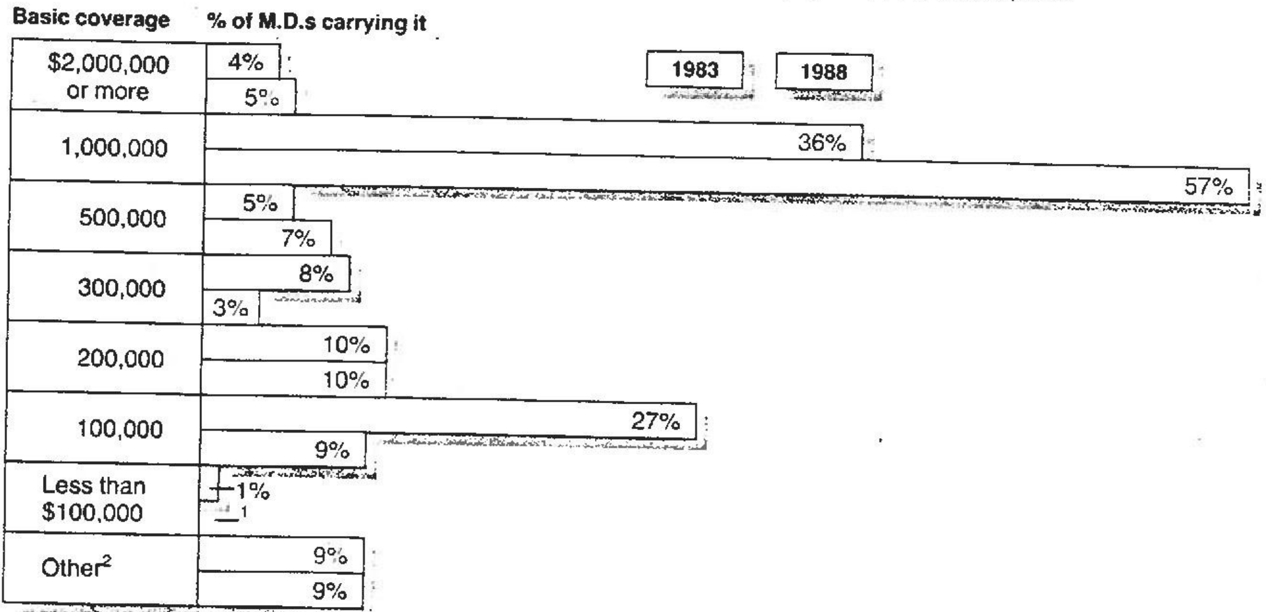
. . . AND BY TYPE OF COMMUNITY

	Urban	Suburban	Rural
$50,000 or more	10%	7%	2%
40,000-49,999	3	3	3
30,000-39,999	9	6	8
20,000-29,999	13	9	11
15,000-19,999	10	8	14
10,000-14,999	13	12	17
8,000-9,999	10	8	7
6,000-7,999	8	14	18
4,000-5,999	12	15	8
2,000-3,999	9	14	10
1,000-1,999	2	4	1
Less than $1,000	1	—*	1
Medians	**$12,620**	**$8,780**	**$11,800**

*Less than 1 percent.

DOCTORS ARE BUYING MORE COVERAGE

These dollar figures are for basic malpractice coverage per claim. In some policies, this also is the maximum the insurer will pay for all claims within a year. More often, the doctor's total protection is two or three times that amount. The most common policy limits—purchased by 46 percent of the surveyed doctors—are $1,000,000/3,000,000.

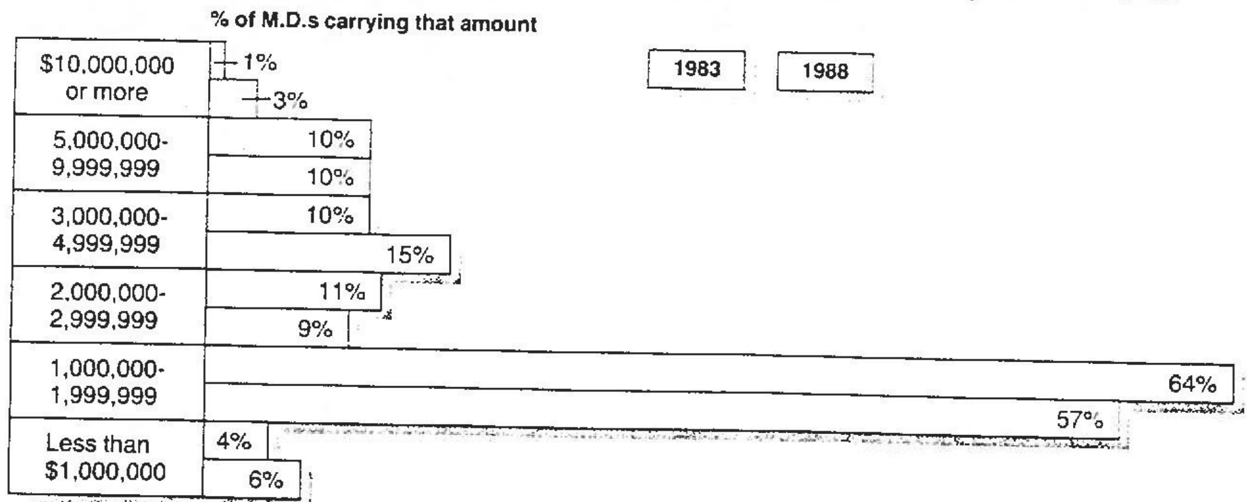


Basic coverage	% of M.D.s carrying it: 1983	% of M.D.s carrying it: 1988
$2,000,000 or more	4%	5%
1,000,000	36%	57%
500,000	5%	7%
300,000	8%	3%
200,000	10%	10%
100,000	27%	9%
Less than $100,000	1%	1
Other[2]	9%	9%

[1]Less than 1 percent. [2]"Other" applies to survey respondents who specified policy limits not listed above, and may include physicians who have coverage intermediate between those amounts. The $200,000 and $100,000 figures include limits of $250,000 and $150,000, respectively.

EXCESS COVERAGE: A FIVE-YEAR COMPARISON

Although doctors have increased their amounts of excess coverage, fewer of them appear to be buying it. Among those who answered questions concerning excess coverage, only 51 percent said they carried it in 1988, compared with 61 percent in 1983.



	% of M.D.s carrying that amount: 1983	% of M.D.s carrying that amount: 1988
$10,000,000 or more	1%	3%
5,000,000-9,999,999	10%	10%
3,000,000-4,999,999	10%	15%
2,000,000-2,999,999	11%	9%
1,000,000-1,999,999	64%	57%
Less than $1,000,000	4%	6%

Figures are medians

BASIC COVERAGE RANGES BY SPECIALTY

	Cardiovascular surgeons	FPs	GPs
$2,000,000 or more	14%	4%	2%
1,000,000	47	52	43
500,000	7	5	12
300,000	2	4	6
200,000	12	13	13
100,000	7	13	16
Less than $100,000	—[2]	1	—[2]
Other[3]	11	8	8

	Otolaryngologists	Pediatricians	Plastic surgeons
$2,000,000 or more	4%	8%	3%
1,000,000	55	57	58
500,000	6	8	9
300,000	5	2	3
200,000	7	7	10
100,000	8	8	6
Less than $100,000	—[2]	—[2]	—[2]
Other[3]	15	10	11

[1]Excludes FPs and GPs. [2]Less than 1 percent. [3]"Other" applies to survey respondents who specified policy limits not listed above, and may include physicians who have coverage intermediate between those amounts. The $200,000 and $100,000 figures include limits of $250,000 and $150,000, respectively.

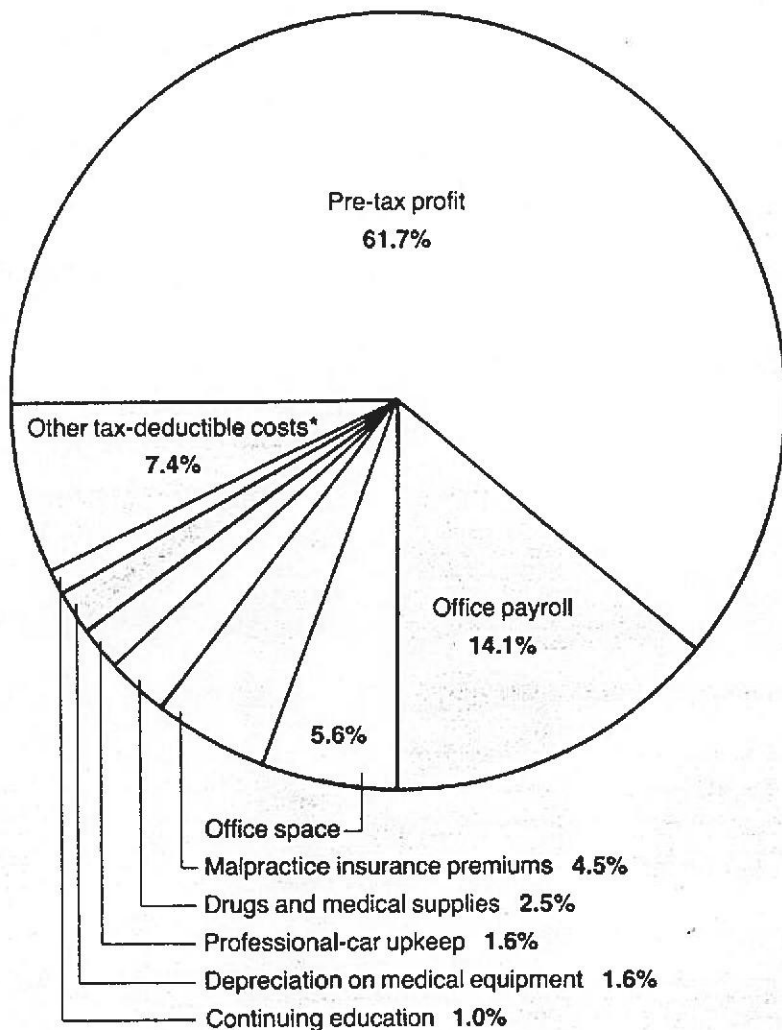
General surgeons	Internists	Neuro-surgeons	OBG specialists	Orthopedic surgeons
3%	4%	8%	6%	6%
55	59	56	55	59
10	8	7	5	8
2	2	2	2	2
8	9	6	13	10
9	9	9	12	6
1	—[2]	—[2]	—[2]	—[2]
12	9	12	7	9

Thoracic surgeons	Urologists	All surgical specialists	All non-surgical specialists[1]
4%	5%	5%	5%
59	59	55	63
6	6	7	5
5	1	3	3
10	11	10	8
9	8	9	8
1	—[2]	—[2]	—[2]
6	10	11	8

■

WHERE PRACTICE RECEIPTS GO

Payroll, office space, and malpractice premiums have all been absorbing larger shares of gross income; they got 12.8, 5.0, and 3.5 percent, respectively, in 1982. So has the category of "other tax-deductible costs," which took only 2.5 percent of gross five years earlier. Expenditures in each of the other categories have decreased by 1 to 2 percentage points of gross.



*Includes office supplies, utilities, dues, subscriptions, travel, and legal, accounting, and management fees.

SPENDING RANGES FOR

The proportion of doctors whose non-physician office help cost $50,000 or more annually almost doubled in the five years following 1982. And the proportion paying at least $15,000 for malpractice insurance quadrupled. But a noteworthy change also occurred at the bottom of our expense scales: Compared with 1982, twice as many physicians in 1987 paid nothing for malpractice coverage and professional-car upkeep. The number getting a free ride on the other items (courtesy of hospitals, group practices, HMOs, etc.)—or perhaps doing without—has expanded by 21 to 38 percent.

Drugs and medical supplies

	% of M.D.s
$30,000 or more	5%
20,000-29,999	4
15,000-19,999	5
10,000-14,999	11
8,000-9,999	5
6,000-7,999	6
5,000-5,999	8
4,000-4,999	5
3,000-3,999	6
2,000-2,999	8
1,000-1,999	8
1-999	7
None	22

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FOR MAJOR ITEMS IN 1987

Office payroll

	% of M.D.s
$100,000 or more	6%
80,000-99,999	4
70,000-79,999	3
60,000-69,999	4
50,000-59,999	7
40,000-49,999	9
30,000-39,999	13
20,000-29,999	14
15,000-19,999	6
10,000-14,999	5
5,000-9,999	3
1-4,999	4
None	22

Office space

	% of M.D.s
$50,000 or more	3%
40,000-49,999	2
30,000-39,999	6
25,000-29,999	3
20,000-24,999	9
15,000-19,999	12
10,000-14,999	18
5,000-9,999	19
3,000-4,999	4
2,000-2,999	2
1,000-1,999	3
1-999	2
None	17

Malpractice insurance premiums

	% of M.D.s
$50,000 or more	4%
40,000-49,999	3
30,000-39,999	5
25,000-29,999	6
20,000-24,999	6
15,000-19,999	8
10,000-14,999	13
8,000-9,999	7
5,000-7,999	17
3,000-4,999	13
1,000-2,999	10
1-999	—*
None	8

Professional-car upkeep

	% of M.D.s
$15,000 or more	2%
10,000-14,999	5
9,000-9,999	1
8,000-8,999	3
7,000-7,999	3
6,000-6,999	6
5,000-5,999	9
4,000-4,999	9
3,000-3,999	11
2,000-2,999	11
1,000-1,999	12
1-999	5
None	23

Depreciation on medical equipment

	% of M.D.s
$15,000 or more	7%
10,000-14,999	7
9,000-9,999	1
8,000-8,999	3
7,000-7,999	2
6,000-6,999	3
5,000-5,999	7
4,000-4,999	3
3,000-3,999	6
2,000-2,999	8
1,000-1,999	9
1-999	10
None	34

Continuing education

	% of M.D.s
$15,000 or more	2%
10,000-14,999	2
9,000-9,999	—*
8,000-8,999	1
7,000-7,999	1
6,000-6,999	3
5,000-5,999	8
3,000-4,999	19
2,000-2,999	21
1,000-1,999	21
500-999	8
1-499	6
None	8

*Less than 1 percent.

HOW EXPENSES COMPARE IN 17 SPECIALTIES

Of every dollar taken in, the typical FP spends about 20 cents on office personnel. But psychiatrists, cardiovascular surgeons, anesthesiologists, and thoracic surgeons spend less than 10 cents. With the biggest five-year spending increase (60 percent) of any field for which we have comparative data, plastic surgeons main-

	Office payroll		Office space		Malpractice insurance premiums	
	In $	As % of gross	In $	As % of gross	In $	As % of gross
Anesthesiologists	$23,500	9.0%	$3,000	1.0%	$19,670	7.8%
Cardiovascular surgeons	52,190	8.8	16,250	3.7	31,550	5.7
FPs	41,890	20.4	12,760	6.4	7,030	3.4
GPs	33,710	18.4	10,320	6.0	6,740	4.3
General surgeons	29,350	11.0	12,650	4.7	22,200	7.9
Internists	32,740	16.3	12,500	6.3	5,640	2.8
Neurosurgeons	46,550	11.3	15,860	3.9	40,600	9.3
OBG specialists	41,000	13.2	15,730	5.5	32,350	10.0
Ophthalmologists	51,670	14.0	18,750	5.8	10,670	3.2
Orthopedic surgeons	55,400	13.6	21,880	5.4	32,930	8.2
Otolaryngologists	53,130	15.1	20,290	6.8	19,790	5.8
Pediatricians	34,320	17.2	12,560	6.4	5,750	3.1
Plastic surgeons	50,650	12.3	24,020	6.6	26,510	6.8
Psychiatrists	16,750	7.9	9,000	6.0	3,230	2.4
Radiologists	35,000	12.9	8,000	1.9	8,710	3.4
Thoracic surgeons	29,670	9.7	12,950	4.0	31,300	10.1
Urologists	32,580	12.2	15,190	5.4	15,800	5.6
All surgical specialists	38,700	12.7	15,600	5.3	23,740	7.4
All non-surgical specialists*	31,510	13.7	11,440	5.7	5,620	2.7
All M.D.s	34,280	14.1	12,650	5.6	9,850	4.5

*Excludes FPs and GPs.

tained their lead in the office-space category. Malpractice coverage, as a percentage of gross income, is just as much of a burden to thoracic surgeons as it is to OBGs. However, premiums went up the most for pediatricians (213 percent) and FPs (207 percent) since 1982. Also, pediatricians were the top spenders on drugs and medical supplies, with a five-year increase of 126 percent—more than triple the increase for M.D.s overall. A probable consequence of the outpatient-surgery trend: Claims for depreciation on medical equipment shot up 88 percent among all surgeons combined. The jump was only 35 percent among non-surgeons.

Drugs and medical supplies		Professional-car upkeep		Depreciation on medical equipment		Continuing education	
In $	As % of gross	In $	As % of gross	In $	As % of gross	In $	As % of gross
$1,750	0.7%	$3,500	1.4%	$2,200	0.5%	$3,000	1.2%
3,280	0.7	5,420	1.1	5,030	0.8	4,860	0.9
8,460	4.3	3,110	1.5	3,940	2.0	1,500	0.9
6,610	3.8	3,280	2.0	2,700	1.5	1,430	0.8
4,160	1.5	4,480	1.8	3,000	1.1	3,000	1.1
4,830	2.4	4,050	1.9	3,300	1.5	1,500	0.8
2,140	0.4	4,480	1.0	4,060	0.9	3,800	1.0
7,330	2.2	4,540	1.6	5,330	1.7	3,000	1.0
5,100	1.6	4,110	1.0	8,500	2.7	3,000	0.9
10,100	2.6	4,580	1.1	6,130	1.4	3,840	1.0
6,330	2.2	4,100	1.3	6,300	1.8	3,000	0.9
12,000	6.1	3,280	1.9	2,950	1.4	1,500	0.9
11,600	3.2	5,250	1.2	6,170	1.7	5,030	1.2
1,380	0.6	4,130	2.1	2,060	1.0	1,500	1.3
4,000	0.8	4,190	1.6	5,000	2.8	3,000	1.2
2,520	0.8	5,320	1.8	3,940	1.0	3,000	1.1
6,830	2.6	4,250	1.6	4,120	1.3	3,000	1.1
5,830	2.0	4,290	1.5	5,420	1.6	3,000	1.0
5,030	2.4	3,750	1.8	3,120	1.4	2,000	1.0
5,750	2.5	3,850	1.6	3,980	1.6	2,000	1.0

EXPENSE BREAKDOWNS BY REGION

	Office payroll		Office space		Malpractice insurance premiums	
	In $	As % of gross	In $	As % of gross	In $	As % of gross
WEST	**$36,070**	**14.7%**	**$15,000**	**6.2%**	**$10,410**	**4.4%**
Rocky Mountain states	34,170	13.0	14,500	5.9	12,710	5.1
Far Western states	37,000	15.5	15,130	6.3	9,520	4.1
MIDWEST	**33,870**	**14.2**	**12,040**	**5.0**	**10,040**	**4.9**
Great Lakes states	33,260	14.3	11,600	5.1	9,620	4.9
Plains states	36,000	13.9	12,250	4.7	11,130	4.9
SOUTH	**36,960**	**13.9**	**12,750**	**5.5**	**9,130**	**3.9**
South Atlantic states	39,620	13.9	12,630	5.3	10,440	4.2
Mid-Southern states	34,640	14.3	12,280	5.6	8,140	3.8
Southwestern states	34,770	13.8	14,200	6.1	7,670	3.5
EAST	**30,860**	**13.5**	**12,170**	**5.8**	**10,610**	**5.4**
New England states	34,690	15.8	12,560	6.3	8,000	4.5
Mid-Eastern states	29,610	12.9	12,000	5.6	11,000	5.6

Some of the more striking developments between 1982 and 1987: Median costs for depreciation on medical equipment rose 173 percent among New England practices, 111 percent in the Rockies; Mid-Southern and Southwestern physicians held median payroll expenses below the inflation rate; doctors in the Plains states kept a similar lid on the costs of office space, depreciation on medical equipment, and drugs and medical supplies.

Drugs and medical supplies		Professional-car upkeep		Depreciation on medical equipment		Continuing education	
In $	As % of gross	In $	As % of gross	In $	As % of gross	In $	As % of gross
$5,810	**2.5%**	**$4,230**	**1.7%**	**$4,320**	**1.5%**	**$2,000**	**1.0%**
5,600	2.3	4,100	1.8	5,110	1.6	2,000	1.0
5,870	2.5	4,260	1.7	3,910	1.5	2,000	1.0
5,900	**2.6**	**3,430**	**1.5**	**3,710**	**1.5**	**2,000**	**1.0**
5,780	2.5	3,400	1.6	3,630	1.5	2,000	1.0
6,430	2.8	3,560	1.4	3,830	1.9	2,000	0.9
6,300	**2.6**	**3,590**	**1.6**	**4,570**	**1.6**	**2,000**	**0.9**
6,000	2.4	3,680	1.6	4,500	1.6	2,000	0.9
6,200	2.9	3,250	1.5	3,750	1.4	2,000	0.9
6,900	2.8	3,800	1.7	5,270	1.7	2,000	0.9
5,260	**2.3**	**4,050**	**1.8**	**3,550**	**1.5**	**2,000**	**1.0**
4,560	1.8	3,330	1.5	5,000	1.6	1,500	0.8
5,410	2.5	4,150	1.9	3,390	1.4	2,030	1.0

THE TYPE OF PRACTICE MAKES A DIFFERENCE

	Office payroll		Office space	
	In $	As % of gross	In $	As % of gross
ALL INCORPORATED	$41,180	13.5%	$14,440	5.3%
Solo	38,460	13.2	14,930	5.5
Multiphysician	45,130	14.0	13,500	4.9
ALL UNINCORPORATED	28,280	15.1	10,900	6.3
Solo	26,800	14.8	10,740	6.6
Expense-sharing	29,580	15.0	10,560	5.7
Partnership or group	36,000	17.1	12,230	5.2

	Malpractice insurance premiums		Drugs and medical supplies		Professional-car upkeep	
	In $	As % of gross	In $	As % of gross	In $	As % of gross
ALL INCORPORATED	$12,790	4.6%	$6,410	2.4%	$4,200	1.5%
Solo	12,520	4.5	5,850	2.3	4,290	1.6
Multiphysician	13,040	4.6	7,800	2.6	4,100	1.4
ALL UNINCORPORATED	7,480	4.3	5,220	2.7	3,290	1.9
Solo	7,330	4.4	4,920	2.6	3,340	2.0
Expense-sharing	6,400	3.7	5,600	3.2	2,900	1.5
Partnership or group	9,500	4.8	7,000	3.6	3,320	1.8

	Depreciation on medical equipment		Continuing education	
	In $	As % of gross	In $	As % of gross
ALL INCORPORATED	$4,880	1.5%	$2,580	0.9%
Solo	4,630	1.5	2,870	1.0
Multiphysician	5,130	1.6	2,290	0.9
ALL UNINCORPORATED	3,310	1.6	2,000	1.0
Solo	3,540	1.7	2,000	0.9
Expense-sharing	2,720	1.5	2,000	1.0
Partnership or group	3,500	1.5	2,000	1.0

HOW OUTLAYS VARY BY TYPE OF COMMUNITY

	Office payroll		Office space	
	In $	As % of gross	In $	As % of gross
Urban	$32,390	13.2%	$12,720	5.7%
Suburban	37,300	14.7	14,250	5.9
Rural	35,130	15.5	10,260	4.9

	Malpractice insurance premiums		Drugs and medical supplies		Professional-car upkeep	
	In $	As % of gross	In $	As % of gross	In $	As % of gross
Urban	$10,680	4.7%	$5,080	2.1%	$4,070	1.6%
Suburban	9,570	4.3	6,120	2.7	3,860	1.7
Rural	8,770	4.3	6,820	3.0	3,400	1.7

	Depreciation on medical equipment		Continuing education	
	In $	As % of gross	In $	As % of gross
Urban	$3,710	1.5%	$2,020	1.1%
Suburban	3,890	1.4	2,000	0.9
Rural	5,090	1.8	2,000	0.9

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TOO MANY OF US ARE JUST PLAIN GREEDY

An angry surgeon says so many physicians routinely overcharge that the medical profession may deserve its mercenary reputation.

By George B. Markle IV, M.D. GENERAL SURGEON CARLSBAD, N.M.

We all know the popular stereotype: Doctors are interested mainly in money; we charge what the traffic will bear; we bend or stretch the rules to enrich ourselves; we've got a "public-be-damned" attitude.

Yes, our years of training, long hours, the strain of responsibility, the constant need to keep abreast of new developments entitle us to a good life. And the considerable price of malpractice insurance and of defensive medicine drives up charges.

But in my 34 years of practice I have seen such out-and-out greed that it makes me wonder if we don't deserve our reputation for being mercenary. While most doctors would no sooner steal money from the government or an insurance company than from a blind man's cup, a few don't have such scruples. They poison the well for the rest of us.

I was furious when I learned of this case: A 26-year-old man called his primary physician on a weekend, describing what sounded like typical appendicitis. The doctor met him in the emergency room, and confirmed the diagnosis. Then he called in a bright, aggressive young surgeon, who agreed with the diagnosis and took out the bad appendix the same day.

The primary doctor whistled a little when he heard that the bill for the surgery was $865. But he gagged when he learned that the surgeon charged another $125 to see the patient in the ER and then had the monumental gall to bill $95 on top of that—for admitting the patient. The primary doctor knew full well that the ER consult and the admitting process hadn't taken more than 15 minutes together, and he also knew that he himself had charged only $45 for meeting his patient in the ER and making the diagnosis in the first place.

Here's another example: A well-trained surgeon, just starting out, was sent a patient with acute abdominal pain believed to be due to an obstruction of some sort. The surgeon treated the "obstruction" conservatively for several hours with no improvement. Then he operated, and discovered that he'd failed to detect a perforated ulcer.

Of course, the peritoneal cavity had to be cleaned out and irrigated. As the surgeon did so, it seemed to him that a loop of small intestine looked inflamed and dark, so he resected a few inches of it and stitched the ends together. And, naturally, the ulcer perforation had to be sewn closed.

Was this eager beaver satisfied to charge for treating a perforated ulcer? Don't bet on it.

For that little bowel resection, probably unnecessary in the first place, he charged the same price as for a radical colon resection for cancer. Not content with this, he went looking for more. Of course, there was the charge for the abdominal exploration, then there was the fee for washing out the peritoneum. And you wouldn't want

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the patient to walk around with a hole in his stomach, would you? That's right, another separate charge for sewing that up.

The patient died, but for some reason beyond my ability to comprehend, the surgeon is still the favorite of the referring physician he served so poorly.

Or how about another surgeon, who operated on a young woman for appendicitis? He found a normal appendix, so the operation suddenly was labeled an exploration, for which he could charge a bit more. Naturally, he removed the healthy appendix as a routine precaution—but billed for both the exploration and the appendectomy, getting roughly double what he should have.

I know an orthopedist who charges for an ER visit even when the patient goes directly to surgery. His surgical fee doesn't include any workups, and he bills extra for visiting his patients in the hospital after surgery. If you add in all the charges he shouldn't be billing, his OR time comes to $1,200 an hour. Is it really worth that much? Sometimes Medicare knocks him down on these extras, but he always bills the patient for the balance if he thinks he can get away with it.

I once saw an orthopod set a bimalleolar ankle fracture. It needed some aligning and a couple of screws. When he found a

chip of bone knocked out of place, he did what any surgeon would do—pinned it with a little piece of wire. Noting a small tear in a ligament, he put in a couple of stitches. Look at what he itemized: open reduction of the fracture, which commands a goodly fee; repair of the torn ligament, also well-paid; and a "bone graft"—which pays more than the rest put together.

A gynecologist greatly upset one of my patients with a bill of $1,413.13 for removing a tube and an ovary. True, he charged only $475 for that, but he added $750 for the laparotomy. I'm still waiting for someone to tell me how anyone could do the first without the second. Let's not forget that he snipped a few adhesions, which allowed him to add $188.13 to the bill. I wonder what the 13 cents was for.

Surgeons aren't alone in gouging patients a la carte. I sent a self-paying patient to an internist because of moderate hypertension. In one 20-minute office visit, he managed to itemize enough services—including an ECG—to run the bill up to $134. That may not sound like a lot of money by big-city standards, but try telling that to a woman of ordinary means who has no insurance.

I know a GP who manages to get twice as large a percentage of his patients into the hospital as any of his colleagues with similar practices. I wonder whether his patients are really that much sicker than anybody else's—or is it that each patient he keeps in bed is just pumping out dollars like a successful oil well?

In case you're wondering, this doctor occasionally gets taken to task by his hospital's utilization review committee and the PRO reviewers, but most of the time he manages to get by them.

As might be imagined, the physicians I've described here have net incomes more than three times that of the typical American doctor.

Physicians aren't entirely to blame for this sad state of affairs. We're required by Medicare and private insurance companies to itemize our services according to standard codes and modifiers. But what started out as an attempt to control expenses and keep us honest has become a license to steal for unscrupulous physicians.

These "creative billers" can vastly increase their incomes by misusing the perfectly legitimate books and computer programs that tell doctors exactly which codes to use, in what order, to get correctly reimbursed.

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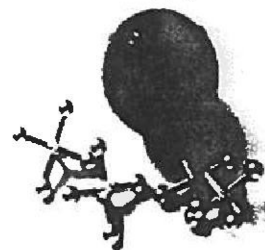

Surveys indicate that many parents overestimate the physical fitness of their children because they appear so active. The fact is, to be physically fit, children need one to two *hours* of vigorous exercise each day.

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INDICATIONS AND USAGE
Anxiety disorders, short-term relief of the symptoms of anxiety, and anxiety associated with depression. Anxiety or tension associated with the stress of everyday life usually does not require an anxiolytic. Effectiveness for more than four months has not been established; periodically reassess the usefulness of the drug for the individual patient.

CONTRAINDICATIONS
Sensitivity to XANAX or other benzodiazepines, and in acute narrow angle glaucoma.

WARNINGS
Benzodiazepines can cause fetal harm in pregnant women, hence women who may become pregnant should be warned. Avoid during the first trimester. Withdrawal seizures have been reported upon rapid dose reduction or abrupt discontinuation, thus reduce dose gradually. (See Drug Abuse and Dependence and Dosage and Administration.)

PRECAUTIONS
General: If XANAX is combined with other psychotropics or anticonvulsants, consider drug potentiation. (See Drug Interactions). Use the usual precautions in patients with renal or hepatic impairment and regarding prescription size in depressed and suicidal patients. In elderly and debilitated patients, use the lowest possible dose. (See Dosage and Administration.) Hypomania and mania has been reported in depressed patients.

Information for Patients: Alert patients about: (a) consumption of alcohol and drugs, (b) possible fetal abnormalities, (c) operating machinery or driving, (d) not increasing dose of the drug due to risk of dependence, (e) not stopping the drug abruptly. ***Laboratory Tests:*** Not ordinarily required in otherwise healthy patients. ***Drug Interactions:*** Additive CNS depressant effects with other psychotropics, anticonvulsants, antihistamines, ethanol and other CNS depressants. Plasma levels of imipramine and desipramine are increased. Pharmacokinetic interactions with other drugs have been reported. Cimetidine can delay clearance of benzodiazepines. ***Drug/Laboratory Test Interactions:*** No consistent pattern for a drug or test. ***Carcinogenesis, Mutagenesis, Impairment of Fertility:*** No carcinogenic potential or impairment of fertility in rats. ***Pregnancy:*** See Warnings. ***Nonteratogenic Effects:*** The child born of a mother on benzodiazepines may be at some risk for withdrawal symptoms, neonatal flaccidity and respiratory problems. ***Labor and Delivery:*** No established use. ***Nursing Mothers:*** Benzodiazepines are excreted in human milk. Women on XANAX should not nurse. ***Pediatric Use:*** Safety and effectiveness in children below the age of 18 have not been established.

ADVERSE REACTIONS
Side effects are generally observed at the beginning of therapy and usually disappear with continued medication. In the usual patient, the most frequent side effects are likely to be an extension of the pharmacologic activity of XANAX, e.g., drowsiness or lightheadedness.

Central nervous system: Drowsiness, lightheadedness, depression, headache, confusion, insomnia, nervousness, syncope, dizziness, akathisia, and tiredness/sleepiness. ***Gastrointestinal:*** Dry mouth, constipation, diarrhea, nausea/vomiting, and increased salivation. ***Cardiovascular:*** Tachycardia/palpitations, and hypotension. ***Sensory:*** Blurred vision. ***Musculoskeletal:*** Rigidity and tremor. ***Cutaneous:*** Dermatitis/allergy. ***Other side effects:*** Nasal congestion, weight gain, and weight loss.

Withdrawal seizures with rapid decrease or abrupt discontinuation. (See Warnings.)

The following adverse events have been reported with benzodiazepines: dystonia, irritability, concentration difficulties, anorexia, transient amnesia or memory impairment, loss of coordination, fatigue, seizures, sedation, slurred speech, jaundice, musculoskeletal weakness, pruritus, diplopia, dysarthria, changes in libido, menstrual irregularities, incontinence, and urinary retention.

Paradoxical reactions such as stimulation, agitation, rage, increased muscle spasticity, sleep disturbances, and hallucinations may occur. Should these occur, discontinue the drug.

During prolonged treatment, periodic blood counts, urinalysis, and blood chemistry analysis are advisable. Minor EEG changes, of unknown significance, have been observed.

Liver enzyme elevations, gynecomastia and galactorrhea have been reported but no causal relationship was established.

DRUG ABUSE AND DEPENDENCE
Physical and Psychological Dependence: Withdrawal symptoms including seizures have occurred following abrupt discontinuance or rapid dose reduction of benzodiazepines. (See Warnings). Dosage should be gradually tapered under close supervision. Patients with a history of seizures or epilepsy should not be abruptly withdrawn from XANAX. Addiction-prone individuals should be under careful surveillance. ***Controlled Substance Class:*** XANAX is a controlled substance and has been assigned to schedule IV.

OVERDOSAGE
Manifestations include somnolence, confusion, impaired coordination, diminished reflexes and coma. No delayed reactions have been reported.

DOSAGE AND ADMINISTRATION
Dosage should be individualized.

The usual starting dose is 0.25 to 0.5 mg, t.i.d. Maximum total daily dose is 4 mg. In the elderly or debilitated, the usual starting dose is 0.25 mg, two or three times daily. Reduce dosage gradually when terminating therapy, by no more than 0.5 mg every three days.

HOW SUPPLIED
XANAX Tablets are available as 0.25 mg, 0.5 mg, and 1 mg tablets.

CAUTION:
FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION. B-7-S

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J-9135
April 1988

tices, because some large institution such as the government or an insurance company pays the bills. But it's only a matter of time before the doctor who's willing to cheat an insurance company starts to chisel his own patients. As far as I'm concerned, we need to be as honest with the government and insurance companies as we are with an individual sitting across the desk from us.

Consumerists, industrialists, labor leaders, politicians, and retirees have been pointing their artillery at our profession for a long time now, and abuses like the ones I've described paint a target on all of us.

The majority of doctors, who work hard, care, and are doing their best completely aboveboard, are being hurt by those who are out to make their millions as fast and as long as society will permit. Abuse of the system by a greedy minority is eating away at our marvelous profession, and we will have only ourselves to blame if we continue to put up with it.

Medical schools should take a role by talking about the ethics of money as much as the ethics of medicine. But we can start solving the problem by not referring any more patients to these crooks. And then we can stop playing golf with them on Wednesdays. ■