What Makes A "Top" Doctor

Quick Tips

- If in doubt about a doctor's training, ask the doctor if the residency completed was in the specialty of his/her practice. If not, ask why not.
- Board certification and recertification are the best ways to measure competence and training.
- The easiest way you can assess the quality of a doctor's residency program is to see if it took place in a large medical center with a name you recognize.
- If a doctor does not have admitting privileges or is not on the attending staff of a hospital, you may wish to consider choosing another doctor.
- There are many excellent, well-trained doctors at community hospitals and they should be as carefully evaluated and considered in your search as a doctor at a teaching hospital.
- Doctors who are full-time academicians may be in the forefront of new techniques and research, but they are not necessarily better doctors.
- The best care is provided by a combination of primary care doctors and other specialists and subspecialists.
- Do not hesitate to ask how frequently your doctor has performed a procedure and with what degree of success. Practice may not lead to perfection, but it improves skills and enhances the probability of success.
- Check the date of graduation from medical school or completion of residency if you want to know precisely how long a doctor has been in practice.

Quick Take

... If a doctor does not have admitting privileges or is not on the attending staff of a hospital, you may wish to consider choosing another doctor.

Key Terms

- **Academic Medical Center** A large medical complex that centers around a teaching hospital in which residency and fellowship programs are offered, where the medical school faculty practices full time, and where major clinical research activities occur.
- **Board Certified -** Term signifying that a doctor is qualified for specialization by one of the American Board of Medical Specialties (ABMS) boards. Qualification includes completing an approved residency and passing a rigid exam.
- **Board Eligible -** Term signifying that a doctor has completed an approved residency but has not yet taken the exam given by one of the ABMS recognized boards. The term conveys no official status in the eyes of the ABMS.
- **Clinical** -Medical care that involves direct contact with patients.
- **Credentialing -** A process of screening conducted by hospitals by means of which they review the training and licenses of doctors applying to practice on their medical staffs.
- Indemnity A form of health insurance coverage that pays for healthcare but permits the patients to select their provider. Until 1990, indemnity insurance covered most insured people in the United States.
- **Licensure** Official credentials by individual states that permit a doctor to practice medicine in that state. In some states doctors may be licensed with no more than one year of post-graduate training.
- **Residency** A training period spent in a hospital by a graduate of a medical school before going into practice. Residents have earned a medical degree and, therefore, are doctors but must complete an approved residency and pass an exam to become board certified.
- **Tertiary Care** Medical services provided by a hospital or medical center that include complex treatments and procedures such as open heart surgery, organ transplants, and burn care.

What Makes A "Top" Doctor

While the overwhelming majority of doctors are competent practitioners, some are less well trained or, for various other reasons, lack a desired level of professional skill or personal characteristics. They have met certain minimum standards, passed the necessary exams and are licensed, but you would still be better off to avoid them. At the same time, among the many good doctors you could choose from, there will be some who are better for you and your family for a variety of reasons.

Identifying the "top" doctors in a particular specialty is a challenge. There may be some who are generally acknowledged as leaders in a particular field, but that level of national reputation is typically built on appointments to important academic positions, innovative research, or the development of cutting-edge clinical techniques and treatments. Unless you are in need of those techniques and treatments, those doctors may not be the best for you. Since most people will obtain all, or certainly most, of their medical care near where they live, it is important for you to identify which doctors are among the best in your own community.

There are four basic criteria for selecting your own best doctor: professional preparation, professional reputation, office and practice arrangements and personal or bedside manner. The first three of these assessments can be made prior to your first visit, which is when you can make your fourth evaluation.

Professional Preparation

Education

Your review of your prospective doctor's education and training should begin with medical school. While you may feel that the institution where someone earned a bachelor's degree could be an indication of the quality of the doctor, most people in the medical field do not believe it plays a major role. A degree from a highly selective undergraduate college or university will help an aspiring doctor gain admission to a medical school, but once there, all students are peers. However, the information on undergraduate colleges, if important to you, is available in the American Board of Medical Specialties (ABMS) Compendium of Certified Medical Specialists and other medical directories.

American medical schools are highly standardized, at least in terms of minimum quality. All U.S. medical schools that grant medical degrees (MDs) and osteopathic degrees (DOs) are accredited by a group known as the LCME (Liaison Committee for Medical Education). Most are also accredited by the appropriate state agency, if one exists, and by regional accrediting agencies that accredit colleges and universities of all kinds.

Furthermore, U.S. medical schools have universally high standards for admission, including success on the undergraduate level and on the Medical College Admissions Tests (MCATs). Although frequently criticized for being slow to change and for training too many specialists, the system of medical education in the United States has insured high quality in medical practice. One recent positive change is a strong effort in most medical schools to diversify the composition of the student body. While these schools have been less successful in enrolling racial minorities, the number of women in U.S. medical schools has increased to the point where they now make up about 50 percent of most classes. In certain specialties preferred by women medical graduates (pediatrics, for example), it is possible that, in coming years, the majority of specialists will be female.

Most doctors practicing in the United States are graduates of U.S. medical schools. There are two other groups of doctors in practice who make up a relatively small proportion of the total doctor population. They are: (1) foreign nationals who graduated from foreign schools; and (2) U.S. nationals who graduated from foreign schools (Canadian medical schools are not considered foreign).

Foreign Medical Graduates

Foreign medical schools vary greatly in quality. Even some of the oldest and finest European schools have become virtually "open door," with huge numbers of unscreened students making teaching and learning difficult. Others are excellent and provided the model for our own system of medical education.

The fact that someone graduated from a foreign school does not mean that he or she is a poor doctor. Foreign schools, like U.S. schools, produce good doctors and poor doctors. Foreign medical graduates must pass the same exam taken by U.S. graduates for licensure, but the failure rate for foreign graduates is significantly higher. In the first year of using the new United States Medical Licensing Exam (USMLE), 93 percent of U.S. medical school graduates passed Step II, the clinical exam, as compared with 39 percent of foreign graduates. It is clear that the quality of foreign schools, if not individual doctors, is not the same as U.S. medical schools, at least as measured by our standards. Nonetheless, many communities and patients have been well served by foreign medical graduates practicing in this country—often in areas where it has been difficult to attract graduates of American schools.

Residency

Most doctors practicing today have at least three years of postgraduate training (following the MD or DO) in an approved residency program. This is not only an important step in the process of becoming a competent doctor, but it is also a requirement for board (specialty) certification. Most people assume that a prospective doctor needs to complete a three-year residency program to obtain a medical license. This is not true in some states. New York State, for example, requires only one postgraduate year. However, since all approved residencies last at least three years and some, such as those in neurosurgery, general surgery, orthopaedic surgery and urology may extend for five or more years, it is important to know the details of a doctor's training. Licensure alone is not enough of a basis on which to make a good choice.

Without undertaking extensive and detailed research on every residency program, the best assessment you can make of a doctor's residency program is to see if it took place in a large medical center whose name you recognize. The more prestigious institutions tend to attract the best medical students, sometimes regardless of the quality of the individual residency program. If in doubt about a doctor's training, ask the doctor if the residency completed was in the specialty of his/her practice. If not, ask why.

It is also important to be certain that a doctor completed a residency that has been approved by the appropriate governing board of the specialty such as the American Board of Surgery, the American Board of Radiology or the American Osteopathic Board of Pediatrics. These board groups are listed in Appendix A. If you are really concerned about a doctor's training, you should first call the hospital that offered the residency and ask if the residency was approved by the appropriate specialty group. If still in doubt, review the publication Directory of Graduate Medical Education Programs, often called the "green book," found in medical school or hospital libraries, which lists all approved residencies.

Board Certification

With an MD or DO degree and a license, an individual may practice any kind of medicine—with or without additional special training. For example, doctors with a license but no special training may call themselves cardiologists or pediatricians. This is why board certification is such an important factor. Twenty-five specialties are recognized by the American Board of Medical Specialties (ABMS). (Visit www.abms.org or call 866-275-2267 for more information.) Eighteen boards certify in 106 specialties under the aegis of the American Osteopathic Association (AOA). (Visit www.osteopathic.org or call 800-621-1773 for more information.) Doctors who have qualified for such specialization are called board certified; they have completed an approved residency and passed the board's exam. (See Appendix A for an approved ABMS and AOA list; see pages 78-83 for a description of each specialty and subspecialty.) While many doctors who are not board certified do call themselves specialists, board certification is the best standard by which to measure competence and training.

You can be confident that doctors who are board certified have at a minimum the proper training in their specialty and have demonstrated their proficiency through supervision and testing. While there are many non-board certified doctors who are highly competent, it is more difficult to assess the level of their training. Board certification alone does not guarantee competence, but it is a standard that reflects successful completion of an appropriate training program.

Recertification

A relatively new focus of the specialty boards is the area of recertification. Until recently, board certification lasted for an unlimited time period. Now, almost all the boards have put time limits on the certification period. For example, in internal medicine, it is ten years; in family practice seven years. In osteopathic medicine, some of the boards need to set a recertification period within 10 years. Many have done so already. These more stringent standards reflect an increasing emphasis, by both the medical boards and state agencies responsible for licensing doctors, on recertification.

Since the policies of the boards vary widely, it is good procedure to ask a doctor if certification was awarded and when. If the date was seven to ten years ago, ask if he/she has been recertified. Note: The most recent date of board certification or recertification is indicated in each physician's listing in this guide.

Unfortunately, many boards permit "grandfathering," whereby already certified doctors do not have to be recertified, and recertification demands apply only to newly certified doctors. Appendix A contains a list of the names and addresses of the boards and the certification period for each board specialty. Even if recertification is not required, it is good professional practice for doctors to undertake the process. It assures you, the patient, that they are attempting to stay current.

Many states have a continuing medical education (CME) requirement for doctors. These states typically require a minimum number of CME credits for a doctor to maintain a medical license. Seven states require 150 CME credits over a three-year period. Osteopathic doctors are required to take 120 hours of CME credits within three years to maintain

certification.

Board Eligibility

Many doctors who have been recently trained are waiting to take the boards. They are sometimes described as "board eligible," a common term that the ABMS advocates abandoning because of its ambiguity. Board eligible means that the doctor has completed an approved residency and is qualified to sit for the related board's exam.

Each member board of the ABMS has its own policy regarding the use and recognition of the board eligible term. Therefore, the description "board eligible" should not be viewed as a genuine qualification, especially if a doctor has been out of medical school long enough to have taken the certification exam. To the boards, a doctor is either board certified or not. Furthermore, most of the specialty boards permit unlimited attempts to pass the exam and, in some cases, doctors who have failed the exam twice or even ten times continue to call themselves board eligible. In osteopathic medicine, the board eligible status is recognized only for the first six years after completion of a residency.

Self-Designated Medical Specialties

In addition to the ABMS and AOA-approved list of specialties and subspecialties, there is a wide variety of other doctors, and groups of doctors, who may call themselves "specialists". There are, at present, at least 100 such groups called self-designated medical specialties. They range from doctors who are working to create a recognized body of knowledge and subspecialty training to less formal groups interested in a particular approach to the practice of medicine. These groups may or may not have standards for membership. There is no way of determining the true extent of their members' training, and they are not recognized by the ABMS* or the AOA. While you should be cautious of doctors who claim they are specialists in these areas, many do have advanced training and the groups at least offer a listing of people interested in a particular approach to medical care. Rely on board certification to assure yourself of basic competence and use membership in one of these groups to indicate strong interest and possible additional training in a particular aspect of medicine. A list of these self-designated medical specialties may be found in Appendix B.

Fellowships

The purpose of a fellowship is to provide advanced training in the clinical techniques and research of a particular subspecialty. In the U.S. there are a variety of fellowship programs available to doctors, and they fall into two broad categories: approved and unapproved. Approved fellowships are those approved by the appropriate medical specialty board (e.g., the American Board of Radiology) and that lead to a subspecialty certificate. Fellowship programs that are not approved are often in the same areas of training as those that are, but they do not lead to a subspecialty certificate. Unfortunately, all too often, unapproved fellowships exist only to provide relatively inexpensive labor for the research and/or patient care activities of a clinical department in a medical school or hospital. In such cases, the learning that takes place is secondary and may be a good deal less than in an approved fellowship. On the other hand, any fellowship is better than none at all and some unapproved fellowships have that status for a valid reason, which should not reflect negatively on the program. For example, the fellowship may have been recently created with approval being sought. To check that a fellowship is an approved one, call the hospital where the training took place or the medical board for that specialty.

Professional Reputation

There are doctors who meet every professional standard on paper, but who are simply not good doctors. In all probability the medical community has ascertained that and, while the individual may still practice medicine, his or her reputation will reflect that collective assessment. There are also doctors who are outstanding leaders in their fields because of research or professional activities, but who are not particularly strong or perhaps even active in patient care. It is important to distinguish that kind of professional reputation from a reputation as a competent, caring doctor in delivering patient care. In a consumer survey conducted by Towers Perrin, the management consulting firm, the chief criterion by which the respondents selected doctors was reputation. This was the most important factor for those enrolled in either managed care or indemnity plans.

Hospital Appointment

Most doctors are on the medical staff of one or more hospitals and are known as attendings. If a doctor does not have admitting privileges or is not on the attending staff of a hospital, you may wish to consider choosing another doctor. It can be very difficult to ascertain whether the lack of hospital appointment is for a good reason or not. For example, it is understandable that some doctors who are raising families or heading toward retirement choose not to meet the demands (meetings, committees, etc.) of being an attending. However, if you need care in a hospital, the lack of such an appointment means that another doctor will have to oversee that care. In some specialties such as dermatology and psychiatry, doctors may conduct their entire practices in the office, and a hospital appointment is not as essential, or as good a criterion for assessment, as in other specialties.

While mistakes are made, most hospitals are quite careful about admissions to their medical staffs. The best hospitals are highly selective, so a degree of screening (or "credentialing") has been done for you. In other words, the best doctors practice at the best hospitals. Since caring for a patient in the hospital also is often a team effort involving a number of specialists, the reputation of the hospital where the doctor admits patients carries special weight. Hospital medical staffs also review their colleagues credentials before authorizing them to perform specific procedures. In addition, they typically reappoint their medical staffs—and review them—every two or three years. In effect, this is an additional screening to protect patients. It is especially true of hospitals that have what are known as closed staffs, where it is impossible to obtain admitting privileges unless there is a vacancy that the administration and medical staff deem necessary to fill. If you are having some type of surgical procedure and are concerned about the doctor's skill or experience with it, it may be worthwhile to call the Medical Affairs office at the doctor's hospital to see if he or she is authorized to perform that procedure in the hospital.

The reasons for a hospital's selectivity are easy to understand: every hospital wants to have the best reputation possible in order to attract patients, and no hospital, excellent or not, wishes to expose itself to liability. Obviously, the quality of the medical staff is immensely important in creating that reputation. Unfortunately, some hospitals are less diligent when a major group practice of doctors, all of whom have previously been affiliated with the institution, adds new members. In such cases, the hospital may almost automatically grant privileges without conducting the same intensive review given to individual doctors who are not members of a group practice. Also, some hospitals are less selective in granting privileges when beds are empty than when beds are full, since additional attendings provide additional patients.

A last and very important reason why a hospital appointment is an essential requirement in your choice of a doctor is that many states permit doctors to practice without malpractice insurance. If you are injured as a result of the doctor's poor care, you could be without recourse. However, few hospitals permit doctors to practice in them unless they carry malpractice insurance. This not only protects the hospital, but the patient as well.

Many people believe that they should choose a doctor with an appointment at a major medical center as opposed to a community hospital. This assumption is incorrect on two counts. For one thing, there are many excellent, well-trained doctors at community hospitals and they should be as carefully evaluated and considered in your search as a doctor at a large institution. What's more, the term "medical center" has less significance today than it did years ago when the term was used to describe only the major university hospitals of medical schools. A true medical center is a teaching hospital that offers multiple residency programs and at which the medical school faculty practices full-time, with fellowship programs and major clinical research activities an integral part of the teaching of medical students. These large centers also are involved in tertiary care, offering services such as organ transplants, burn care and cardiovascular surgery.

Today many community hospitals have added the term medical center to their name. They do this for two purposes: to indicate that they, too, offer advanced and sophisticated medical programs, and to compete for patients with the academic medical centers. With academic medical centers turning out many well-trained specialists and subspecialists who establish practices in nearby communities and then want to continue the highly specialized techniques they have learned, many community hospitals have initiated tertiary care programs of their own, further blurring the distinction between medical centers and hospitals.

In any case, most of our healthcare today is delivered outside of the hospital in ambulatory outpatient settings. Those who are hospitalized for acute illness (e.g., surgery, serious infection) will find that community hospitals and their staffs are well-suited to the task.

When extremely difficult and complex problems develop, or when tertiary care is needed, many communities have excellent academic medical centers. Of course, they offer primary care as well, especially to those who live nearby. This illustrates the point, once again, that medical care is a local issue.

Medical School Faculty Appointment

Many doctors have appointments on the faculties of medical schools. There is a range of categories from "straight" appointments—meaning full-time appointment as professor, associate professor, assistant professor or instructor—to clinical ranks that may reflect lesser degrees of involvement in teaching or research. If someone carries what is known as a straight academic rank (i.e., professor of surgery, without "clinical" in the title), this usually means that the individual is engaged full-time in medical school research and/or teaching activities. The title "professor of clinical surgery" usually describes a doctor who has a full-time appointment in a medical school, but who puts a greater emphasis on clinical practice (patient care) than on research or teaching. The title "clinical professor of surgery" usually specifies a part-time or adjunct appointment and less direct involvement in medical school activities.

Doctors who are full-time academicians may be in the forefront of new techniques and research, but they are not necessarily better doctors. Nonetheless, you can be assured that they have the support of other faculty, residents and medical students.

When you are seeking a subspecialist, a doctor's relationship to a medical school becomes more meaningful since medical school faculties tend to be made up of subspecialists. You are less likely to find large numbers of general or primary care practitioners engaged full-time on a medical school faculty. The newest approaches and techniques in medicine, for the most part, are explored and developed by medical school faculties in their laboratories and clinical practice settings. This is where they practice their subspecialities, as well as teach and perform research. Such leading specialists are not necessarily better doctors than community doctors—they are trained to provide a different kind of medical care. The best care is provided by a combination of primary care doctors and other specialists and subspecialists.

Medical Society Membership

Most medical society memberships sound very prestigious and some are; however, there are many societies that are not selective and which virtually any doctor can join. In addition, membership in many of the more prestigious societies is based on research and publication, or on leadership in the field, and may have little to do with direct patient care. While it is clearly an honor to be invited to join these groups, membership may be less than helpful in discerning whether a doctor can meet your needs.

Board certified doctors are referred to as Diplomates of the Board. Some of the colleges of medical specialties (e.g., the American College of Radiology and the American College of Surgeons) have multiple levels of recognition. The first is basic membership and the second, more prestigious and difficult to obtain, is status as a Fellow. Fellowship status in the colleges is meaningful and is based on experience, professional achievement and recognition by one's peers, including extensive experience in patient care. It should be viewed as a significant professional qualification.

Experience

Experience is difficult to assess. Obviously, in most cases, an older doctor has more experience; on the other hand, a younger doctor has been more recently immersed in residency, the challenge of medical school, or even a fellowship, and may be the most up-to-date. If a doctor is board certified, you may assume that assures at least a minimal amount of experience, but it could be as little as a year. In this guide the board certification date may reflect a doctor's most recent recertification, so check the date of graduation from medical school or completion of residency if you want to know precisely how long a doctor has been in practice.

There is a good deal of evidence that there is a positive relationship between quantity of experience and quality of care. That is, the more often a doctor performs a procedure, the better he/she becomes at it. That is why it is important to ask a doctor about his or her experience with the procedure that you need. Does the doctor see and treat similar cases every day, every week or only rarely? Of course, with some rare conditions, rarely is the only possible answer, but it is relative frequency that is critical. Major metropolitan areas, especially New York and San Francisco, became leaders in the treatment of AIDS because of the large number of patients seen in those metropolitan areas. Doctors in the suburbs of New York City (especially in New York's Westchester, Nassau and Suffolk counties) and in Fairfield County, Connecticut became leaders in the research and treatment of Lyme disease because that region is the epicenter of the disease.

In some states, data is available on volume or numbers of certain procedures performed at hospitals. For this information in New York you can call the Center for Medical Consumers, a non-profit advocacy organization, or visit its website at www.medicalconsumers.org. For volume and outcome information in other states, visit the Website of Health Care Choices at www.healthcarechoices.org. There is a good deal of controversy, however, on the validity and usefulness of such data. Opponents cite the fact that some of the data is produced from Medicare patient records only and, thus, is based solely on an elderly population that does not represent the total activity of a hospital or doctor. Proponents of the use of such volume data agree that it is not perfect, but suggest that it can be one useful criterion in selecting the best places to receive care for these specific problems. Recognizing the limitations of such data, the healthcare consumer may, nonetheless, find it of interest and use.

Office and Practice Arrangements

Although clearly not as important as training or reputation, office and practice arrangements are usually of great significance to patients. Practice arrangements include office hours, office location, billing procedures and office testing among the many factors that result in how well the office is run.

Many years ago most doctors practiced independently in private offices. They were called solo practitioners and usually had agreements with other doctors to respond to their patients' calls when they were unavailable. In recent decades, most doctors have entered group practices; indeed, this is becoming the most common way for young doctors to begin to practice. Two or more doctors in the same specialty, or in different specialties (a multi-specialty group), share offices and staff to lower their costs of operations. They also cover for each other on rotation for weekends, evenings and vacations. As a patient you may prefer one of the following: a solo practitioner who is covered occasionally; a group where you usually, but not always, see the same doctor; or a multi-specialty group where, if a consultation or referral is necessary, the specialist is at the same location. The choice is really one of personal preference.

There are other factors relating to practice arrangements that may or may not be important to an individual when choosing a doctor. One is the location of the office. A consumer poll conducted for the Robert Wood Johnson Foundation identified office location as one of the two most important factors in the selection of a doctor (the other was a recommendation by a relative or friend). Actually, the site of the office can be very important in choosing a doctor you may visit on a regular basis. If the location is inconvenient, you may be discouraged from making needed visits.

Another important factor concerns the use of nurse practitioners and physician's assistants in the office. Licensed nurse practitioners are advanced practice nurses in primary care. They have additional training beyond the basic requirements for nursing licensure, usually a master's degree or special certificate. They perform a broad range of nursing functions as well as functions that, historically, have been performed by doctors, including assessing and diagnosing, conducting physical examinations, ordering diagnostic tests, implementing treatment plans and monitoring patient status. Physician's assistants are licensed to provide medical care in many states. However, unlike nurses, they may practice only under a doctor's direction and supervision. According to an article in the professional journal Family Practice Management, these "midlevel providers," as they are called, "can handle 80 to 90 percent of the problems that occasion office visits." These providers have become more of a presence in healthcare in recent years, especially in medical groups and HMOs. If you don't think you will be satisfied having your office visit and examination conducted by anyone but the doctor, you should determine up front how many midlevel providers are on staff and how extensive their responsibilities are.

Narrowing the Choice

Here are 10 additional questions that will guide you in assessing if the practice patterns or arrangements of a doctor meet your needs. If there are other items not listed that are important to you, add them to the list before you make your initial appointment. You should try to obtain as much of the information as possible from the staff.

- Are you currently accepting new patients and, if so, is a referral required?
- On average, how long does a patient have to wait for an appointment?
- Are you open on weekends? In the evening?
- If lab work and X-rays are performed in the office what are the qualifications of the people doing the tests?
- Are full payment, deductibles or co-payments required at the time of the appointment?
- Do you accept my insurance plan? Medicare? Medicaid? Workers' compensation? No-fault insurance?
- Do you accept credit cards and, if so, which do you accept?
- Do you accept patient phone calls?
- Will you care for patients in their homes?
- Is your office handicapped-accessible?

If you have a chronic illness or disease, there may be certain additional aspects of a doctor's practice that could be particularly important to you. You should discuss any chronic problems when first establishing a relationship with a doctor. In fact, you may want to find a doctor with special interest or training in that problem.

House calls also continue to be important to some people. Yes, some doctors still do make house calls! In fact, a recent American Medical News article suggested that 43 percent of internal medicine specialists and 65 percent of family practice specialists made one or more house calls a year. However, it is important to point out that the number of doctors making house calls has declined because of technology, liability risks and time pressures. Important diagnostic equipment often cannot be carried around in a doctor's little black bag and is only available in the office or hospital. Also, the time required to visit one patient at home markedly reduces the time available to see other patients.

Personal or Bedside Manner

To many patients, once they have determined that a doctor is competent, the doctor's professional manner—also

known as bedside manner—is the most important part of their choice. The Towers Perrin report cited earlier indicated that after reputation, skill in communicating was the most important factor sought in doctors. Patients prefer sensitive and caring doctors who listen carefully and demonstrate their concern. Studies show that such doctors are sued less often than others!

What characteristics make up a doctor's personal manner? The four described below may, when considered together, give you a clear idea of whether a particular doctor will be your personal "top" doctor.

- **Listening**. Professional manner includes the doctor's willingness to listen to patients, be supportive and understanding, explain procedures and exhibit concern and respect. These skills are expressed at the bedside, in the office, or in any setting where there is doctor/patient contact. Listening is also a valuable diagnostic tool. Unfortunately, these skills often have not been taught well in medical schools and the lack of them forms the primary basis for complaints from patients. However, there is growing emphasis on these vital interpersonal and communications skills in medical schools today and with good reason. They are critically important to most patients.
- **Cultural Sensitivity.** Some patients may prefer doctors who speak their language or are familiar with their cultural background. The term "culturally competent physician" is a relatively new one describing doctors who have the needed skills and attitudes to effectively treat patients from minority cultures.
- Ethical, Religious and Philosophical Views. Religion, or at least views on issues such as abortion, utilization of life-sustaining measures, natural childbirth, breast-feeding and other such matters can also be important. It is perfectly appropriate to ask doctors their views on sensitive issues.
- **Decision-making Procedures.** Years ago patients took the words of the doctor as law, not to be questioned or perhaps even discussed. That is not the case today. Consumers are better informed about health issues and may want to be actively involved in the decision-making affecting their health. Some patients do not feel this way and are comfortable accepting a doctor's diagnosis or course of treatment without question. Some doctors—in diminishing numbers, thankfully—feel uncomfortable with patients who want everything explained to them or want to be involved in decision-making. Consider how you feel about this issue and discuss it with your doctor to be certain you are on compatible wavelengths.

Of course, what ultimately makes a "top" doctor are the results, the "outcomes," of care. Unfortunately, there is relatively little information available to consumers on the outcomes of physicians and hospitals. Some states, New York for example, have produced studies on outcomes for cardiac surgery. Also, some HMOs are talking about producing report cards for doctors. Generally, however, consumers will have difficulty finding outcome studies for individual doctors.

On the other hand, there is a growing movement to track and publish outcomes data on hospitals. The federal government has taken the lead by releasing outcomes data by hospitals for selected procedures. Visit www.hospitalcompare.hhs.gov.

ne woman—a long-time City resident who moved to the suburbs to be near her children—found out the hard way about advice when she selected a doctor on the basis of her neighbor's glowing praise. During the initial visit, the patient's numerous questions about her chronic arthritis condition went unanswered while the doctor merely patted her on the shoulder and assured her that he would "take care of everything." While the paternalistic attitude might have suited the neighbor's needs, it fell far short for this senior patient, who was used to a good give-and-take with her former internist. She resumed her search for a doctor—this time with the assistance of the Castle Connolly guide, a more reliable source than a friend's recommendation.