



DOCTOR'S DIGEST[®]

Your Guide to
Practice
Management

Jan / Feb 2005

Error Proofing Your Practice

Are We Making Progress in Cutting Medical Errors?

Stopping Errors at Their Source

Creating a Culture of Safety in Your Practice

Technology to the Rescue

Should Errors Be Disclosed Fully?

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DOCTOR'S DIGEST

Error Proofing Your Practice

By Lynn Wagner

ABOUT THE AUTHOR

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Introduction



Dear Doctor:

Welcome to Doctor's Digest, YOUR guide to practice management. This series of pocket-sized reference manuals tackles complex practice management problems that distract many physicians from patient care and thwart professional satisfaction. The manuals result from in-depth research among practicing physicians, who described their ideal resource as one that offers comprehensive, easy-to-access solutions to everyday practice management problems, enabling them to get back to what is most important: providing high-quality care to their patients.

Topics for these manuals were also determined by our research. This year's lineup includes Error Proofing Your Practice, Maximizing Practice Profits, Resolving Practice Dilemmas, Retirement Planning, Physicians' Legal Handbook and Finding Work-Life Balance. All of these manuals will draw on the expertise of professionals in various fields.

This inaugural issue focuses on one of health-care's most pressing problems: medical errors. In November 1999, the Institute of Medicine made the shattering announcement that medical errors accounted for as many as 98,000 deaths annually. The good news is that the profession is making progress in dealing with this problem. For one thing, research is exploring how and why errors occur. Electronic medical record systems are having an impact along with standardization of some medical practices to improve safety.

This issue synthesizes the latest thinking on medical errors and suggests how to create a culture of patient safety in your practice. Reducing errors enhances the satisfaction of patients, doctors and staff and averts the prospect of expensive, demoralizing malpractice suits.

Your response is vital to the success of this reference series. Please write, call or e-mail us (publisher@doctorsdigest.net) or post a comment on our Website. Tell us what you like, dislike or want to see in future editions. Log on to www.doctorsdigest.net to receive bimonthly e-newsletter updates on all our annual topics (please insert code #010105) or a quarterly e-newsletter written expressly for your staff (use code #101105a).

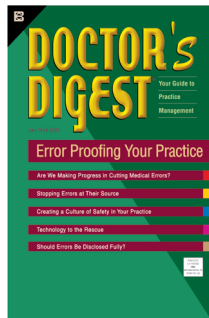
We pledge to give you what you need to improve your practice, allowing you more quality time with your patients and your family.

Sincerely,

A handwritten signature in cursive script that reads "Jeannette".

Jeannette Brandofino
Publisher

e-mail: publisher@doctorsdigest.net



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The subject of medical errors has been in the news since the 1999 report from the Institute of Medicine, entitled “To Err Is Human,” created shockwaves when it reported that up to 98,000 deaths in U.S. hospitals each year could be attributed to medical errors. Since then the medical profession has moved from denying the extent of the problem to active engagement in the search for solutions.

This inaugural issue of Doctor’s Digest takes on this huge topic and offers concrete advice to physicians looking to eliminate patient-safety risks in their practices. To produce this manual, author Lynn Wagner culled dozens of studies and interviewed a broad range of experts in various fields. Among the patient-safety experts consulted for this project are: Dr. Lucian Leape, adjunct professor of health policy at Harvard School of Public Health and a member of the IOM panel that produced “To Err Is Human;” Dr. Robert Wachter, chief of the medical service at the University of California San Francisco Medical Center and author of a recent book on medical mistakes; Dr. Lee Hilborne, director of University of California Los Angeles’s Center for Patient Safety and Quality; Dr. Robert Phillips, director of the Robert Graham Center: Policy Studies in Family Practice and Primary Care, and Kathleen Mazor, Ed.D., assistant professor at the Meyers Primary Care Institute at the University of Massachusetts Medical School, who has led a number of studies on medical errors.

Ms. Wagner also sought input from representatives of medical organizations, such as Dr. Michael Fleming, chairman of the American Academy of Family Physicians and a member of the Future of Family Medicine task force; Christel Mottur-Pilson, Ph.D., director of scientific policy for the Philadelphia-based American College of Physicians (ACP), and Dr. William Jessee, president and chief executive officer of the Medical Group Management Association.

There were other sources as well, but they are too numerous to name them all here. Their input was invaluable and we thank everyone for their cooperation.

The need to reduce the rate of medical errors is a goal on which all stakeholders in the healthcare system can agree. Clearly there is a role for every physician in this worthy cause.

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