Hospital leaders can play a crucial role in hospitalist program success

You’ve carefully crafted and outlined the goals of your hospitalist program. You’ve discussed the program with medical staff members and hospitalists and ensured the program meets the needs of both. You’ve provided training to your new hospitalists and educated hospital staff members and the community about the role of a hospitalist. Now your new hospitalist program is poised to run itself, right? Wrong.

Even after you carefully plan and craft all of your programs essential components, now is not the time to sit back and set your hospitalist program on cruise control, experts say.

Once the hospitalist program gets off the ground, it requires careful medical staff leadership oversight and a keen eye for anticipating changes to ensure success. Below, experts provide tips to ensure your hospitalist program succeeds and your medical staff leaders are on board for the ride.

Defining success

What makes a hospitalist program successful? According to Kenneth G. Simone, DO, founder and president of Brewer, ME–based Hospitalist and Practice Solutions, each organization’s definition of success will vary. “[Success] can be defined in many ways,” he says.

Success can mean:

➤ Achieving excellent clinical outcomes
➤ Working as a team and developing an effective practice culture
➤ Providing benefit to the community (e.g., providing care for the medically uninsured)
➤ Providing efficient and cost-effective care.

(For a complete list of goals, see “Elements of a successful hospitalist program” on p. 3.)

For the purposes of this article, a program’s success is defined as meeting set goals and upholding the organization’s mission statement.

In many cases, achieving this success begins at the top.

Leadership is crucial

Experts say that running an effective and successful hospitalist program requires hospitalist program managers and directors to look at the program as a whole and win small battles along the way. Hospitalist program managers and directors are instrumental to ensuring...
success because they contribute their expertise at every level and stage of the program, says Simone.

When the program begins, these leaders are responsible for developing program policies, procedures, and protocols. But when the program gets off the ground, their role becomes more critical if the program is to succeed. “Strong clinical director leadership is an essential component to successful hospitalist programs,” Simone says. “Effective hospitalist leaders have the ability to focus the providers on the goals and objectives of the program. They also can inspire and motivate the hospitalists to work as a team.”

A key step to ensure success is to continue networking and marketing the program, experts say.

In addition, program leaders must track:
➤ Clinical performance
➤ Customer satisfaction
➤ Financial performance (e.g., return on investments)

It is also important that clinical directors work together with key stakeholders in the healthcare delivery system and build consensus and a common vision regarding hospitalist objectives and deliverables, says Simone.

To achieve success, leaders should also:
➤ Establish an open line of communication
➤ Have regular hospitalist staff meetings
➤ Provide a stabilizing presence for the hospital through excellent leadership skills
➤ Openly share clinical and financial data (and discuss any limitations in its measurements)
➤ Establish frank dialogue regarding hospitalist performance
➤ Critically analyze the existing hospital systems and work as a team to create more efficient and seamless systems

Monitor progress
Simone says, ideally, the hospitalist program’s clinical director should monitor the progress in real time.

Developing reports on a weekly or monthly basis is a good way to recognize developing trends in the hospitalist program, Simone says.

Once data are acquired, leaders can use them to compare previous years, he says. You can break down the data in different ways to achieve different comparisons or to uncover trends (e.g., comparing quarterly, annual, or three- to five-year data).

To achieve buy-in from the hospitalists, you should develop a provider’s incentive plan and a hospitalist scorecard, and create a hospitalist performance committee. The clinical director, the head of the information systems department, the hospitalist practice manager,
Elements of a successful hospitalist program

A successful hospitalist program should practice all or most of the following elements, according to Kenneth G. Simone, DO, founder and president of Brewer, ME–based Hospitalist and Practice Solutions:

➤ Practice quality, evidence-based medicine and provide compassionate patient care
➤ Achieve excellent clinical outcomes
➤ Work as a team and developing an effective practice culture
➤ Provide benefits to the community (e.g., providing care for the medically uninsured)
➤ Provide efficient and cost-effective care (e.g. responsible and appropriate resource utilization)
➤ Provide cost savings for the healthcare system and a positive return on investment for the hospital (if they subsidize the program)
➤ Achieve high patient satisfaction
➤ Achieve high referring provider satisfaction
➤ Achieve high medical staff and hospital (e.g., nonphysician) staff satisfaction
➤ Achieve high hospital administration satisfaction
➤ Increase market share
➤ Expand hospitalist services offered (e.g., palliative care service, observation unit management, etc.)
➤ Act as leaders of the medical staff and hospital and exhibiting good citizenship
➤ Provide added value benefits for the hospital and medical staff, such as providing preoperative history and physicals, surgical co-management, participating on the code blue team, participating on the rapid response team, etc.

Less-evolved programs may define success on a smaller scale. Examples may include:

➤ Being able to fully staff a 7 a.m.–7 p.m. hospitalist program
➤ Covering unassigned emergency department call
➤ Stabilizing the medical community by providing nighttime hospital call (admissions and floor call) for the community providers

Do you know a hospitalist who has gone above and beyond and deserves to be recognized? Let us know about it, and he or she could be featured in an upcoming Hospitalist Management Advisor! E-mail Executive Editor Erin E. Callahan at ecallahan@hcpro.com.
Hospitalists and the ED

A defined process is the best remedy for strained handoff communication between different departments

The emergency department (ED) is a 24-hour, seven-day-a-week environment in which unpredictability reigns. That uniqueness can make the jobs of the clinical staff members critical and rewarding but maddening and stressful at the same time.

The problem is that no one likes unpredictability—especially ER physicians who are used to working at their own pace—and quality patient care often relies on the precise coordination of ER physicians and hospitalists.

These practitioners must hand off patients in an organized fashion; it’s the disorganized nature of the ER that complicates matters.

The possibility for conflict between physicians and hospital-employed hospitalists can and will become exacerbated if process is missing, says Ronald Greeno, MD, FCCP, chief medical officer, and Beth Hawley, MBA, senior vice president of The Cogent Group in Irvine, CA.

“Hospitalists see a lot of unassigned patients, and it’s these patients—the ones you know so little about—that can cause tension between [ER physicians and hospitalists],” says Hawley. “The handoff is a sensitive process.”

Recognize the problem

The biggest complaint among hospitalists is that ER physicians—by the nature of their job of providing critical care to those who need it most—often dump patients off to hospitalists and move on to the next patient.

Because ER physicians don’t usually conduct follow-up assessments of any subsequent testing, they often leave that responsibility to the hospitalist on duty, who may or may not be available.

The solution, say Hawley and Greeno, sounds simple; making it work is not. Hospitals need a three-tiered approach: hard rules written somewhere that medical staff can refer to, an organizational assessment of the handoff process, and a benchmarking strategy.

This is no longer just a concern among those in the trenches. Today’s consumer-driven healthcare has administrators paying close attention to customer service ratings and ER wait times in addition to cost, and any and all problems in the presence of the patient is a red flag and considered bad business.

Take the first step

The first task Greeno suggests is for administrators to determine the goals of the hospitalist program. To that end, ask yourself the following questions:

➤ What is the hospitalist program expected to accomplish in your hospital?
➤ Is it only designed to take the patients who do not have doctors?
➤ Is it designed to take stress off the ED?
➤ Is it to drive length of stay on the floor of the hospital?
➤ Is throughput the biggest concern?
➤ Is improving quality the top priority?
➤ What types of patients are you admitting?

Once you clearly delineate this information, administrators should meet with leaders from the hospitalist program and the ED separately to discuss what is working and what is not. “This is necessary information to hear from the outset,” said Hawley. “It’s a good starting place.” A subsequent meeting should include medical staff members from both sides of the discussion, including, but not limited to:

➤ Administrators
➤ The lead physician on the hospitalist team
➤ Program leaders
➤ The medical director

The goal of this meeting should be to air out concerns and develop a compact in a slower-paced, less-stressful
environment. “Ultimately, they all want great patient care,” says Hawley, “so it’s important to have each person understand each other’s world and what each can bring to the table.”

Define your processes

Friction among medical staff members with different responsibilities in a hectic environment is always a possibility.

“There’s always a personal factor when dealing with people,” Greeno says. “But defined processes markedly lower the chance of interpersonal friction.”

Common resolution areas could center on the following:

► **Scheduling:** Are the hospitalist staff members changing shifts at a typically busy time?
► **Communication:** When will the ER physicians call upon the hospitalists? What are the expectations of response times?
► **Responsibilities:** What kinds of workups can you get done on the floor instead of in the ED?

“Every ED is created differently,” says Hawley, “but it’s important to determine those processes that can be black and white.”

Specificities surrounding handoffs is of the utmost importance. For example, if a patient arrives at the ED extremely ill and it is clear the hospital will admit the patient, you may want to design a process specific for this situation.

“In that case, the hospitalist comes in immediately,” Greeno says. “It’s much more straightforward.”

In other cases, the hospital may decide that the patient should get most of his or her workup done in the ED.

“That’s fine, but the point is it should be well defined,” says Greeno. “It really is surprising how little is defined in hospitals.”

Put it in writing

The next big step is to formally put your decisions in writing.

“Most hospitals work best with written policies and procedures,” Hawley says. “Leaving it to hearsay is not in anyone’s best interest.”

Create a work flow that includes other subspecialties, such as cardiology. “Determine [for] which patients the cardiologists wish to be called upon,” Greeno says. Make sure you include the key groups of diagnoses, such as stroke and transient ischemic attack. “You can go into almost any program and see potential for contention, but if you tackle five or six [of the key diagnoses], you’ll cover the vast majority where there are disagreements. That covers about 80% of admissions,” he says.

Next, focus on a strategy to disseminate this information. The best course of action really depends on the facility, considering the inconsistent staffing nature of ER physicians.

“Most of the ER physicians are a core group, but the hospital may have people who come in one or two days a month,” says Greeno. “That can make it a little more challenging.”

Lastly, ensure that you use your resources efficiently and that medical staff members understand it’s a team effort. Consider whether you want the hospitalists running around, or whether it’s smarter for the ER physicians to do more and keep the hospitalists on the floor to get the patients ready for discharge.”

Address long-term personal problems

If personal problems persist among staff members after you have defined your processes, identify whose personalities are getting in the way. It’s important to recognize there is a problem and then take appropriate action.

“Most administrators just assume everyone is working together in a collegial manner,” Hawley says. “They don’t recognize that there is a problem, and that’s when further problems can arise.”

Smothering any problem early is the best cure. And enforcing the process is the best solution.

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“The ED physicians and the hospitalists are so synergistic that they can appreciate the value that each bring. Clearly, there are personalities that may clash, but the more you can leave it to process and not to people, the better it will be,” Hawley says.

It may take time because it requires a culture change, Greeno says.

“Process is a completely foreign concept to most physicians. They are used to working alone. They may be in a group, but they work the way they want to work. That’s the traditional model in American medicine, and that has to be overcome,” he says. “Physicians, as a whole, are not trained to manage process. They are trained to take care of one patient at a time and make a clinical decision. That’s it.”

Further, administrators have long been subservient to the wishes of their medical staff members, even to the individual physician.

“Now they have to lead change that involves physicians, and they are not very good at it,” says Greeno. “They are very reticent to head in that direction.”

Benchmarking is an important tool

A final step in this process would be to identify metrics that would be part of a dashboard on ED performance. You may be able to analyze the following:

► Time to admit (from the ED)
► Percentage of patients not seen by a physician in the ED who “walk out”
► Amount of time the hospital ED is on divert status

“These are some clear markers that illustrate the performance of both groups,” says Hawley. “If you see there’s a problem, you dig deeper, and then you can invest some resources trying to understand where the bottleneck falls.”

Relocating? Taking a new job?

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In the spotlight

Hospitalist keeps program running between tours of duty

Tarboro, NC, where Heritage Hospital is located, is a few thousand miles from the Middle East.

The tiny town, population just over 10,000, is a world away from Iraq and Afghanistan, two places where death is an everyday reality and improvised explosive devices (IED) tragically are all too familiar.

They are also two places where Americans physicians are in demand, but where healthcare workers armed with scalpels are bombed with the same fervor as soldiers armed with guns.

It was in the late hours, from the center of a war, when Jon DuBose, MD, a lead hospitalist at Heritage Hospital, would e-mail his friends and coworkers a world away to ask about everyday normalcy, things like patient volume, hospital finances, and, true to his heart, the effectiveness of the hospitalist program he helped build.

DuBose, Heritage Hospital’s lead hospitalist since June 2006, says simple gestures such as e-mails from his coworkers, helped him get through rough times during his second tour of duty in Afghanistan from May to November 2007.

“They kept me sane in a place that’s really insane,” says DuBose, who served as a major in the Army and a brigade surgeon. “When I first went over there, there was no sewer system. You walk into hospitals you wouldn’t take your dog to, and then, on top of it all, you’re dealing with suicide bombers.”

Wick Baker, DuBose’s boss and friend at Heritage Hospital, knew DuBose was in danger and tried to comfort him by sending e-mails of support.

Leaving war and big medical center behind

In July 2006, Baker began looking for someone to head up the hospital’s new hospitalist program. As president of Heritage Hospital, one of seven facilities under University Health Systems (UHS) of Eastern Carolina, he was familiar with DuBose from his work in the hospitalist program at Pitt County Memorial Hospital (PCMH), another UHS facility in Greenville, NC.

PCMH has 800-plus beds, compared to Heritage’s 117 beds, so Baker knew DuBose was qualified to lead the hospitalist program at Heritage. He didn’t know DuBose would be a perfect fit.

“He’s one of these guys who is down in my office complaining that he needs more work. Because of that quality, he’s a great leader for our medical staff,” Baker says. “And he’s one of those physicians who has fabulous medical skills and can straddle both the clinical and administrative management worlds. He’s an ambassador for the hospital and the hospitalist program.”

Improving program efficiency and teamwork

Although DuBose was the right man for the job at Heritage Hospital, the job was no cakewalk. Before DuBose signed on, Baker says, the hospitalist staff had a shift mentality.

“When 7:00 came around, people took off instead of working as a team,” says Baker. “Jon has fixed that. Everyone covers each other, cares about each other, and makes sure service is covered.”

The second challenge of the program from the outset was the hospital’s focus on quality indicators, for which Baker says DuBose has done an outstanding job.

DuBose, who manages a team of four other hospitalists, also helped engineer a medical comanagement with Heritage Hospital’s orthopedists. “It has made the lives of our orthopedists better, and [DuBose] has made that work,” says Baker.

DuBose has also managed the program as patient volume rose. Heritage Hospital saw a 12% increase in 2006, and a 6% increase the year before. “He’s had to focus on managing those increasing volumes without compromising patient satisfaction and quality,” Baker says.

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The Iraq tour

The tough job in the United States couldn’t compare to his tough job overseas, so DuBose has never had a problem with perspective. The year before he joined Heritage Hospital—from July 2004 to October 2005—DuBose served a tour of duty in Iraq. It was a traumatic year for DuBose, who on three occasions was traveling in a vehicle that was struck by an IED. On one occasion, DuBose and others were able to drive away from the scene; the other times, the engine block exploded, leaving the group vulnerable to an ambush.

“It actually does occur in slow motion. You see everything coming at you, and the next thing is you just kind of realize that you’re still alive,” he says. “In truth, there are probably a couple of milliseconds of intense gratitude. But once that’s over, you start to worry about [an ambush].”

A small-town physician goes home

Those who know DuBose are not surprised he left the much larger PCMH for the more quaint Heritage Hospital after his tour in Iraq. The self-proclaimed “prototypical Southerner,” with the charm to match, wanted to return to his roots—small-town, personal care with a familiar face to it. “I wanted to work with people I know, people I like. I prefer knowing people,” he says.

He says the return is hearing from patients who like their physicians. “Here, you deal with a population that thinks doctors are worth a hoot. They are usually pretty grateful, and you don’t always get that,” he says. “In a small town, you can ask people what’s going on, you can know about their lives. It’s more personal, and I enjoy that.”

Baker notes that the patients seem to enjoy DuBose as much as he enjoys them. “He’s one of those doctors that comes into a room, sits on the patient’s bed, and makes the patient feel like he or she is the only patient on his mind,” says Baker. “He has that talent to put folks at ease and get the diagnosis right.”

Professionally, the job has allowed DuBose to grow as well. At PCMH, DuBose says, “they have every specialty under God’s green earth.”

There, a physician who is not good at a procedure can easily find someone else to perform it.

“Here, you’re more self-reliant, and I like that. You have to run the gamut,” he says. “I can increase my scope of knowledge, but even more importantly, I am able to very quickly get a patient somewhere else because I recognize things quicker.”

He has also learned to balance the administrative aspects of his job. He’s working on enhancing communication with private doctors, namely informing them more efficiently about admissions and discharges. And he’s preparing to implement a new clinical documentation system that will go live in April.

And he’s doing it all with the possibility in the back of his mind that he may get called back to duty in April 2009. “There’s not much I can do about it, so I can’t worry about it,” DuBose says.

Still, his experiences overseas leave him grateful about life in the United States. He believes every American should spend time in a third-world country to understand how fortunate he or she is.

“We take for granted that the lights will go on. We take for granted that when you flush the toilet, that it will go far away. We take for granted that when you get sick, you will go to a good place where people will care for you,” he says. “And we take for granted that you will not die from something that you should never die from.”
Recruiting tip of the month

Attracting the younger physician

In the coming years, young medical professionals will be filling the positions that are currently occupied by physicians in the generations known as “baby boomers” and “matures.”

According to the AMA, roughly 33% of practicing physicians are 27–41 years old, representing the “Gen X” segment. Within this generation of physicians, 58% are male and 42% are female.

“Millennials,” born after 1980, are just now emerging from medical school.

Although few in number at this point, 54% are women. This is the first segment in the history of modern medicine in which women will represent the majority of physicians.

These young physicians will bring with them new values, needs, and expectations. A number of key strategies can help you be more effective in recruiting and retaining this new generation of physicians, including the following:

➤ Align physician recruitment strategies with retention initiatives. Hire the right physician who fits well within your culture and then immediately focus on retention initiatives. This includes fostering relationships among peers, the larger practice, and the community.

➤ Establish clear expectations. Younger physicians expect an accelerated partnership track, one that includes a reasonable buy-in and early sharing or equity participation in ancillary revenue sources. They want to see the specifics of how much and when spelled out clearly in their employment contract.

➤ Be ready to address details—the realities of the practice—during the interview process. This includes productivity goals, the compensation model, call coverage, clinival hours, and patient volumes.

Young physicians generally have strong time management skills and use technology to increase efficiency. They understand the value of teamwork and thrive in an environment in which they receive frequent feedback and mentoring.

Don’t hesitate to structure the opportunity to leverage these strengths for the benefit of all.

Editor’s note: This tip was submitted by Paul Smallwood, vice president of physician search with St. Louis–based Cejka Search, a nationwide firm specializing in physician and healthcare executive recruitment. For more information about recruiting and retaining hospitalists, go to www.cejkasearch.com or call 800/678-7858.
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News in brief

The meteoric rise of the physician assistant
Since the profession’s tenuous beginnings in 1967, the role of the physician assistant (PA) has grown in both scope and relevance in today’s healthcare environment.

Hospitalists programs are increasingly forming partnerships with PAs to lighten increasing workloads and improve efficiencies in day-to-day operations, and hospitalists are not alone in doing so, according to a new study in the Journal of Allied Health.

The study, “Growth and Change in the Physician Assistant Workforce in the United States, 1967–2000,” not only charts the relatively meteoric rise in the position’s popularity but also challenges some of the early stereotypes about who seeks out PA positions, where they work, and the profession’s long-term sustainability.

For example, the study shows that the number of PA program graduates grew from 282 in 1972 to nearly 4,000 by the year 2000, despite strong and even hostile opposition to the position in the formative years, the authors note. The data also show that despite almost exclusively male graduating classes in the late 1960s and early 1970s, 67% of 2000 graduates were women. Early conceptions that the position would work primarily in rural environments also proved to be untrue; between 1980 and 2000, the PA population was “fairly evenly distributed,” the study says.

Despite the dearth of information regarding the growth of the PA position in the past four decades, the study authors write that there are many important aspects of the PA profession yet to be thoroughly explored, including:

➤ The number of PAs and PA programs the work force can sustain
➤ Specialty roles for PAs
➤ Long-term effects of women’s increased role in the profession
➤ Changing academic requirements

To read the study, visit: www.asahp.org/pdf/JAH_34%20-%203%20-%2020121_Larson.pdf.

Do as physicians say, not as physicians do?
A new survey conducted by the Annals of Internal Medicine suggests that in some situations, physicians will act inconsistently with their beliefs, according to a December 4, 2007, article in The Boston Globe.

In one such instance, nearly half of physicians surveyed indicated that they did not “report an impaired or incompetent colleague or a serious medical error,” the article says, despite believing such actions to be contrary to their professional duties.

According to the Annals of Internal Medicine Web site, the survey sought to explore the “prospect of improving care through increased professionalism” by collecting relevant data about physician attitudes.

To read the article, visit www.boston.com/news/health/articles/2007/12/04/doctors_dont_report_colleagues_errors.

To access the survey (subscription required), go to: www.annals.org/cgi/content/full/147/11/795.