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Nurse understaffing is ranked by the public and physicians as one of the greatest threats to patient safety in US hospitals. These findings also raise questions about whether characteristics of the hospital RN workforce other than ratios of nurses to patients are important in achieving excellent patient outcomes. Nurses constitute the surveillance system for early detection of complications and problems in care, and they are in the best position to initiate actions that minimize negative outcomes for patients. Specifically, we tested whether hospitals with higher proportions of direct-care RNs educated at the baccalaureate level or above have lower risk-adjusted mortality rates and lower rates of failure to rescue deaths in patients with serious complications. We also examined whether the educational backgrounds of hospital RNs are a predictor of patient mortality beyond factors such as nurse staffing and experience. These findings offer insights into the potential benefits of a more highly educated nurse workforce. Methods Data Sources, and Variables We analyzed outcomes data derived from hospital discharge abstracts that were merged with information on the characteristics of the treating hospitals, including unique data obtained from surveys of hospital nurses. Six of the excluded hospitals were Veterans Affairs hospitals, which do not report discharge data to the state. Twenty-six hospitals were excluded because of missing data, most often because their reporting to external administrative sources was done as aggregate multihospital entities. Ten small hospitals, most of which had 50 or fewer beds, had an insufficient number of nurses responding to the questionnaire to be included. This suggests similar response rates across hospitals and no response bias at the hospital level. Moreover, demographic characteristics of the respondents paralleled those of Pennsylvania hospital nurses in the National Sample Survey of Registered Nurses. The proportion of nurses in each hospital who held each type of credential was computed. Because the educational preparation of the 4. It was later verified that this decision did not bias the results. Two further variables were derived from the nurse survey. Nursing workload was computed as the mean number of patients assigned to all staff nurses who reported caring for at least 1 but fewer than 20 patients on the last shift they worked. Because nurse experience was an important potential confounding variable related to both clinical judgment and education, the mean number of years of experience working as an RN for nurses from each hospital was also calculated and used in the analyses. Three hospital characteristics were used as control variables: Hospitals without any postgraduate medical residents or fellows nonteaching were distinguished from those with 1: High-technology hospitals were those that had facilities for either open-heart surgery, major organ transplantations, or both. Patients and Patient Outcomes. A list of the diagnosis related groups studied was provided previously.

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Multivariate regression on each of the 4 outcomes controlled for characteristics of physicians administrative role, gender, seniority and patient panels size, case mix, age, gender. CONCLUSIONS Primary care physicians working fewer clinical hours were associated with higher quality performance than were physicians working longer hours, but with patient satisfaction and ambulatory costs similar to those of physicians working longer hours. The trend toward part-time clinical practice by primary care physicians may occur without harm to patient outcomes. As integrated delivery systems, managed care organizations, and other health services organizations have adapted to and innovated practices, the employment of part-time physicians has increased T. Syltebo, MD, in conversation, January Whether the reduction in hours is dictated by organizations, is a consequence of organizational changes, or is a personal choice of physicians, the impact of part-time practice on patient outcomes is unknown. Physicians reduce their clinical time for a wide variety of reasons. Others choose to care for family members, foster social causes, pursue avocations, begin entrepreneurial enterprises, or extend their education interviews conducted by Parkerton in Furthermore, the primary care role has been changed by the increased specialization of physicians, including the emergence of hospitalists, and the administrative demands and opportunities of managed care. While previous studies have assessed part-time practice, 10 , 11 they have neither enumerated nor evaluated direct patient-care hours as a continuous variable. Medical group physicians worked in 25 western Washington medical clinics, all of which provided primary care, radiology, laboratory, pharmacy, and business services and, in some of them, specialty services. The study population included all family practitioners or general internists providing ambulatory primary care services for at least 9 months of to a defined patient panel from , adult HMO members. Therefore, physicians providing urgent care exclusively were not included, as they did not have a patient population for which they were responsible. The medical group generated measures of individual physician performance from which the study outcome measures were derived. These measures have been distributed quarterly to the physicians since , encouraging data validation. In addition to patient outcomes, data included clinical hours, appointment access, panel composition, and case mix. Medical group human resources provided data on employment date, seniority, and administrative role. All physicians had 4 quarters of data. Data collected independently each quarter on ambulatory costs were averaged for the preceding year, producing annualized component measures. All other data were reported as averages of the previous twelve months. Funding sources placed no constraints upon this research and Group Health Cooperative of Puget Sound, the HMO, allowed access to the organization and its data without determining the topic of inquiry, its analysis, or interpretation. Part-time Status Physician part-time practice status was measured as the percent of full-time clinical hours minus full-time equivalent FTE. The HMO defined full time as 10 sessions, or 35 hours per week of patient appointment hours; fewer were considered part time. Three sessions were the fewest that primary care physicians could work and have their own designated patient panel and, therefore, be included in this study. The actual range of 0. Outcome Measurement Four types of outcomes and 4 corresponding aggregate measures were selected based on availability and frequency of reporting: These 4 measures are consistent with published conceptual models of quality of care, 17 â€” 19 have been validated and used widely, 20 are common enough for reliable assessment, 21 and represent different aspects of care. Table 1 contains their descriptive statistics.

Chapter 3 : VoyForums: "Sew help me!"

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Other information. Issued in 4 v. Issued by: Published in cooperation with the American Board of Medical Specialists. Formed by the union of: Directory of medical specialists, and: The Official American Board of Medical Specialties (ABMS) directory of board certified medical specialists, continuing the ed. numbering of the former.

Chapter 4 : Effect of Part-time Practice on Patient Outcomes

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