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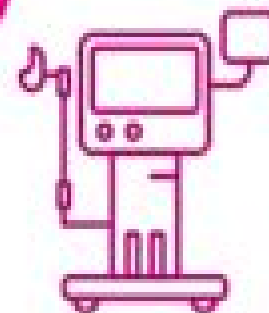
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Human Error In Medicine

Jack M. Winters, Molly Follette Story



Human Error In Medicine:

Human Error in Medicine Marilyn Sue Bogner, 2018-02-06 This edited collection of articles addresses aspects of medical care in which human error is associated with unanticipated adverse outcomes For the purposes of this book human error encompasses mismanagement of medical care due to inadequacies or ambiguity in the design of a medical device or institutional setting for the delivery of medical care inappropriate responses to antagonistic environmental conditions such as crowding and excessive clutter in institutional settings extremes in weather or lack of power and water in a home or field setting cognitive errors of omission and commission precipitated by inadequate information and or situational factors stress fatigue excessive cognitive workload The first to address the subject of human error in medicine this book considers the topic from a problem oriented systems perspective that is human error is considered not as the source of the problem but as a flag indicating that a problem exists The focus is on the identification of the factors within the system in which an error occurs that contribute to the problem of human error As those factors are identified efforts to alleviate them can be instituted and reduce the likelihood of error in medical care Human error occurs in all aspects of human activity and can have particularly grave consequences when it occurs in medicine Nearly everyone at some point in life will be the recipient of medical care and has the possibility of experiencing the consequences of medical error The consideration of human error in medicine is important because of the number of people that are affected the problems incurred by such error and the societal impact of such problems The cost of those consequences to the individuals involved in medical error both in the health care providers concern and the patients emotional and physical pain the cost of care to alleviate the consequences of the error and the cost to society in dollars and in lost personal contributions mandates consideration of ways to reduce the likelihood of human error in medicine The chapters were written by leaders in a variety of fields including psychology medicine engineering cognitive science human factors gerontology and nursing Their experience was gained through actual hands on provision of medical care and or research into factors contributing to error in such care Because of the experience of the chapter authors their systematic consideration of the issues in this book affords the reader an insightful applied approach to human error in medicine an approach fortified by academic discipline

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considered not as the source of the problem but as a flag indicating that a problem exists. The focus is on the identification of the factors within the system in which an error occurs that contribute to the problem of human error. As those factors are identified, efforts to alleviate them can be instituted and reduce the likelihood of error in medical care. Human error occurs in all aspects of human activity and can have particularly grave consequences when it occurs in medicine. Nearly everyone at some point in life will be the recipient of medical care and has the possibility of experiencing the consequences of medical error. The consideration of human error in medicine is important because of the number of people that are affected, the problems incurred by such error, and the societal impact of such problems. The cost of those consequences to the individuals involved in medical error, both in the health care providers' concern and the patients' emotional and physical pain, the cost of care to alleviate the consequences of the error, and the cost to society in dollars and in lost personal contributions, mandates consideration of ways to reduce the likelihood of human error in medicine. The chapters were written by leaders in a variety of fields including psychology, medicine, engineering, cognitive science, human factors, gerontology, and nursing. Their experience was gained through actual hands-on provision of medical care and/or research into factors contributing to error in such care. Because of the experience of the chapter authors, their systematic consideration of the issues in this book affords the reader an insightful applied approach to human error in medicine, an approach fortified by academic discipline.

Human Reliability And Error In Medical System B S Dhillon, 2003-09-05 Human reliability and error have become a very important issue in health care owing to the vast number of associated deaths each year. For example, according to the findings of the Institute of Medicine in 1999, around 100,000 Americans die each year because of human error. This makes human error in health care the eighth leading cause of deaths in the US. Moreover, the total annual national cost of the medical errors is estimated at between 17 billion and 37.6 billion. There are very few books on this subject, and none of them covers it at a significant depth. The need for a book presenting the basics of human reliability, human factors, and comprehensive information on error in medical systems is essential. This book meets that need. Human Reliability and Error in Medical System B. S. Dhillon, 2003 Human reliability and error have become a very important issue in health care owing to the vast number of associated deaths each year. For example, according to the findings of the Institute of Medicine in 1999, around 100,000 Americans die each year because of human error. This makes human error in health care the eighth leading cause of deaths in the US. Moreover, the total annual national cost of the medical errors is estimated at between 17 billion and 37.6 billion. There are very few books on this subject, and none of them covers it at a significant depth. The need for a book presenting the basics of human reliability, human factors, and comprehensive information on error in medical systems is essential. This book meets that need. To Err Is Human Institute of Medicine, Committee on Quality of Health Care in America, 2000-03-01 Experts estimate that as many as 98,000 people die in any given year from medical errors that occur in hospitals. That's more than die from motor vehicle accidents, breast cancer, or AIDS—three causes that receive far more public

attention Indeed more people die annually from medication errors than from workplace injuries Add the financial cost to the human tragedy and medical error easily rises to the top ranks of urgent widespread public problems To Err Is Human breaks the silence that has surrounded medical errors and their consequence but not by pointing fingers at caring health care professionals who make honest mistakes After all to err is human Instead this book sets forth a national agenda with state and local implications for reducing medical errors and improving patient safety through the design of a safer health system This volume reveals the often startling statistics of medical error and the disparity between the incidence of error and public perception of it given many patients expectations that the medical profession always performs perfectly A careful examination is made of how the surrounding forces of legislation regulation and market activity influence the quality of care provided by health care organizations and then looks at their handling of medical mistakes Using a detailed case study the book reviews the current understanding of why these mistakes happen A key theme is that legitimate liability concerns discourage reporting of errors which begs the question How can we learn from our mistakes Balancing regulatory versus market based initiatives and public versus private efforts the Institute of Medicine presents wide ranging recommendations for improving patient safety in the areas of leadership improved data collection and analysis and development of effective systems at the level of direct patient care To Err Is Human asserts that the problem is not bad people in health care it is that good people are working in bad systems that need to be made safer Comprehensive and straightforward this book offers a clear prescription for raising the level of patient safety in American health care It also explains how patients themselves can influence the quality of care that they receive once they check into the hospital This book will be vitally important to federal state and local health policy makers and regulators health professional licensing officials hospital administrators medical educators and students health caregivers health journalists patient advocates as well as patients themselves First in a series of publications from the Quality of Health Care in America a project initiated by the Institute of Medicine

How to Think in Medicine Milos Jenicek, 2018-08-06 Mastery of quality health care and patient safety begins as soon as we open the hospital doors for the first time and start acquiring practical experience The acquisition of such experience includes much more than the development of sensorimotor skills and basic knowledge of sciences It relies on effective reason decision making and communication shared by all health professionals including physicians nurses dentists pharmacists and administrators How to Think in Medicine Reasoning Decision Making and Communications in Health Sciences is about these essential skills It describes how physicians and health professionals reason make decision and practice medicine Covering the basic considerations related to clinical and caregiver reasoning it lays out a roadmap to help those new to health care as well as seasoned veterans overcome the complexities of working for the well being of those who trust us with their physical and mental health This book provides a step by step breakdown of the reasoning process for clinical work and clinical care It examines both the general and medical ways of thinking reasoning argumentation fact finding and using evidence It explores

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Human Error in Aviation R.Key Dismukes,2017-07-05 Most aviation accidents are attributed to human error pilot error especially Human error also greatly effects productivity and profitability In his overview of this collection of papers the editor points out that these facts are often misinterpreted as evidence of deficiency on the part of operators involved in accidents Human factors research reveals a more accurate and useful perspective The errors made by skilled human operators such as pilots controllers and mechanics are not root causes but symptoms of the way industry operates The papers selected for this volume have strongly influenced modern thinking about why skilled experts make errors and how to make aviation error resilient

Error in Organizations David A. Hofmann,Michael Frese,2011-07-21 This volume is dedicated to creating a single source that both summarizes what we know regarding errors in organizations and provide a focused effort toward identifying future directions for research The goal is to provide a forum for researchers who have conducted a considerable amount of research in the error domain to discuss how to extend this research and provide researchers who have not considered the implications of errors for their domain of organizational research an outlet to do so

Intensive Care Unit Manual E-Book Paul N. Lanken,Scott Manaker,Benjamin A. Kohl,C. William Hanson,2013-09-26 Intensive Care Unit Manual is a practical hands on how to manual that covers the full spectrum of conditions encountered in the ICU guiding you step by step from your initial approach to the patient through diagnosis and treatment Compact affordable and comprehensive the ICU Manual puts all the critical care information you need right at your fingertips Stay at the forefront of critical care with a practice oriented relevant and well illustrated account of the pathophysiology of critical disease presented in a highly readable format Gain valuable insight into the recognition evaluation and management of critical conditions such as respiratory hemodynamic and infectious diseases management of ICU patients with special clinical conditions cardiovascular hematologic and neurological disorders poisoning and overdoses trauma and burns and much more Grasp the latest developments in critical care with extensive updates and revisions to several key chapters as well as brand new chapters on Alcohol Withdrawal Syndromes Acute Heart Failure Syndromes Noninvasive Ventilation and more ICU conditions Understand and apply the most important ICU practices including management of acute respiratory failure mechanical ventilation invasive hemodynamic monitoring and the care of patients with special needs AIDS

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Medical Instrumentation Jack M. Winters, Molly Follette Story, 2006-10-31 Two of the most important yet often overlooked aspects of a medical device are its usability and accessibility This is important not only for health care providers but also for older patients and users with disabilities or activity limitations Medical Instrumentation Accessibility and Usability Considerations focuses on how lack of usability

A Primer on Clinical Experience in Medicine Milos Jenicek, MD, 2012-08-08 Mastery of quality health care and patient safety begins as soon as we open the hospital doors for the first time and start acquiring practical experience The acquisition of such experience includes much more than the development of sensorimotor skills and basic knowledge of the sciences It relies on effective reasoning decision making and communication shared by all health professionals including physicians nurses dentists pharmacists physiotherapists and administrators A Primer on Clinical Experience in Medicine Reasoning Decision Making and Communication in Health Sciences is about these essential skills It describes how physicians and health professionals reason make decisions and practice medicine Covering the basic considerations related to clinical and caregiver reasoning it lays out a roadmap to help those new to health care as well as seasoned veterans overcome the complexities of working for the well being of those who trust us with their physical mental and spiritual health The book provides a step by step breakdown of the reasoning process for clinical work and clinical care It examines both general and medical ways of thinking reasoning argumentation fact finding and using evidence Outlining the fundamentals of decision making it integrates coverage of clinical reasoning risk assessment diagnosis treatment and prognosis in evidence based medicine It also Describes how to evaluate the success effectiveness and cure and failure error and harm of clinical and community actions Considers communication with patients and outlines strategies successes failures and possible remedies including offices bedside intervention and care settings Examines strategies successes failures and possible remedies for communication with peers including interpersonal communication morning reports rounds and research gatherings The book describes vehicles opportunities and environments for enhanced professional communication including patient interviews clinical case reports and morning reports It includes numerous examples that demonstrate the importance of sound reasoning decision making and communication and also considers future implications for research management planning and evaluation

Patient Safety and Risk Management in Medicine Yaron Niv, Yossi Tal, 2025-06-15 This book is a comprehensive guide for citizens who want to understand how to conduct themselves effectively and safely in the healthcare system and for the healthcare professionals educators and researchers involved in designing and delivering medical care The book was designed to provide in depth knowledge about patients rights and obligations how to understand the medical information received and how to communicate effectively with medical professionals The book is based on the extensive experience of the authors in practicing and teaching patient safety

and risk management in medicine and conducting research in this field The book was written to bridge the deep gap between patients and caregivers and thus enable better and safer care Areas addressed include informed consent medical errors doctor patient and patient doctor perceptions continuity of care pharmacy patient compliance legal issues and consequences and the uses of AI in medical care *Handbook of Human Factors and Ergonomics in Health Care and Patient Safety* Pascale Carayon,2006-09-08 A complete resource this handbook presents current knowledge on concepts and methods of human factors and ergonomics and their applications to help improve quality safety efficiency and effectiveness in patient care It provides specific information on how to analyze medical errors with the fundamental goal to reduce such errors and the harm t Risk Management in Medicine Walter Merkle,2015-12-14 To err is human yet nobody wants to accept this fact This is especially true in medicine This book focuses on how human failures can be avoided in the medical context Experts from different disciplines discuss the underlying causes of such failures and explain the techniques required to reduce their frequency The principles of risk management are clearly described and lessons to be drawn from risk management in other sectors such as aviation are identified Detailed consideration is given to all relevant risk management systems and tools including Crew Resource Management CRM Failure Mode and Effects Analysis FMEA Critical Incident Reporting System CIRS Team Time Out TTO and Observational Teamwork Assessment for Surgery OTAS International legal experts discuss aspects of law relevant to risk management in medicine in the United States and Europe and careful attention is also paid to economic factors bearing in mind that risk management saves not only lives but also huge amounts of money This book will be of value to all individuals organizations and authorities concerned with effective implementation of risk management in hospitals including doctors hospital administrators insurance companies and government departments **Yearbook of Anesthesiology - 9** Raminder Sehgal,Anjan Trikha,2019-09-02 Yearbook of Anesthesiology 9 is an up to date guide to the latest advances in anaesthesiology practice Comprising 25 chapters covering all three specialties associated with anaesthesiology regional and general anaesthesia pain and intensive care this book presents the most recent information in the field in a concise and highly illustrated format The book covers the complete field from techniques and post surgical recovery to pharmacology non technical skills and medicolegal issues This new volume features chapters on anaesthetic issues in the management of elderly or paediatric patients the status of platelet rich plasma in chronic pain conditions and degenerative diseases and double lumen endotracheal tubes and gas embolism The final chapter of the book Journal Scan covers recent articles published in respected journals accompanied by reviews and interpretations by experts in the field Key points Up to date guide to latest advances in anaesthesiology In depth coverage of all three sub specialties regional and general anaesthesia pain and intensive care Features new topics including management of elderly or paediatric patients the status of platelet rich plasma in chronic pain conditions and degenerative diseases and double lumen endotracheal tubes and gas embolism Includes recent journal articles with reviews and interpretations by experts in the field Medical Error and

Harm Milos Jenicek,2010-07-02 Recent debate over healthcare and its spiraling costs has brought medical error into the spotlight as an indicator of everything that is ineffective inhumane and wasteful about modern medicine But while the tendency is to blame it all on human error it is a much more complex problem that involves overburdened systems constantly changing techno

Fundamentals of Patient Safety in Medicine and Surgery S P Stawicki,2015-01-01 This book presents a practical approach to patient safety issues with a focus on evolution and understanding the key concepts in health care and turning them into implementable actions With its contemporary approach and lucid presentation this book is a valuable resource for practicing doctors in medicine and surgery to treat their patients with care diligence and vigilance and contribute to a safer practice in health care

Ethics and Error in Medicine Fritz Allhoff,Sandra Borden,2019-10-17 This book is a collection of original interdisciplinary essays on the topic of medical error Given the complexities of understanding preventing and responding to medical error in ethically responsible ways the scope of the book is fairly broad The contributors include top scholars and practitioners working in bioethics communication law medicine and philosophy Their contributions examine preventable causes of medical error disproportionate impacts of errors on vulnerable populations disclosure and apology after discovering medical errors and ethical issues arising in specific medical contexts such as radiation oncology psychopathy and palliative care They also offer practical recommendations for respecting autonomy distributing burdens and benefits justly and minimizing injury to patients and other stakeholders Ethics and Error in Medicine will be of interest to a wide range of researchers students and practitioners in bioethics philosophy communication studies law and medicine who are interested in the ethics of medical error

Errors in Veterinary Anesthesia John W. Ludders,Matthew McMillan,2016-11-09 Errors in Veterinary Anesthesia is the first book to offer a candid examination of what can go wrong when anesthetizing veterinary patients and to discuss how we can learn from mistakes Discusses the origins of errors and how to learn from mistakes Covers common mistakes in veterinary anesthesia Provides strategies for avoiding errors in anesthetizing small and large animal patients Offers tips and tricks to implement in clinical practice Presents actual case studies discussing errors in veterinary anesthesia

Developments in Agricultural and Industrial Ergonomics (General Studies, Vol. 1) L.P. Gite,C.R. Mehta,Nachiket Kotwaliwale,Joydeep Majumder,2009-10-14 This book is a compilation of papers presented in the International Ergonomics Conference HWWE 2007 held at Central Institute of Agricultural Engineering Bhopal during December 10 12 2007 The proceedings of HWWE 2007 titled Developments in Agricultural and Industrial Ergonomics has been brought out in two volumes Vol 1 General Studies and Vol 2 Women at Work This volume contains section on Anthropometry and Work Place Design Work and Sport Physiology Physical Environment Cognitive Design Ergonomics Ergonomics in Agriculture Ergonomics in Industry and Occupational Health and Safety

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