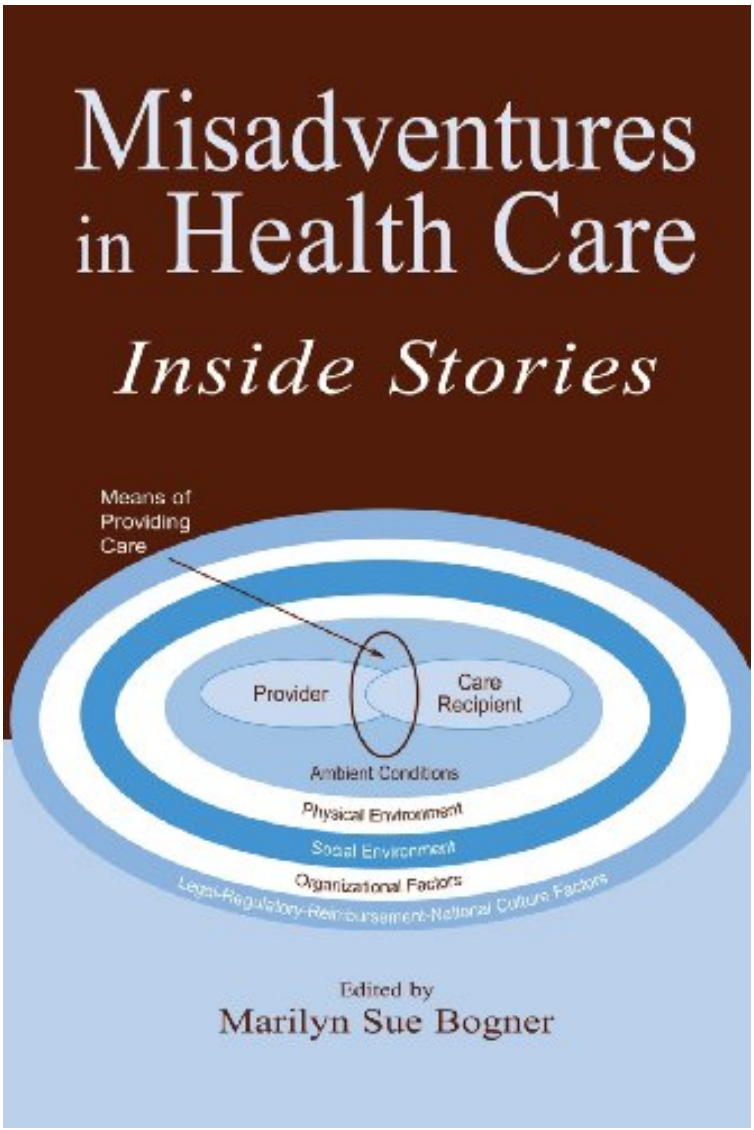
Misadventures in Health Care: Inside Stories (Human Error and Safety)

Marilyn Sue Bogner
*audiobook | *ebooks | Download PDF | ePub | DOC*



#1531188 in Books Psychology Press 2003-08-03Original language:EnglishPDF # 1 9.00 x .60 x 6.00l, .98 #File Name: 0805833781266 pages | File size: 19.Mb

Marilyn Sue Bogner : Misadventures in Health Care: Inside Stories (Human Error and Safety) before purchasing it in order to gage whether or not it would be worth my time, and all praised Misadventures in Health Care: Inside Stories (Human Error and Safety):

0 of 0 people found the following review helpful. Very GoodBy Jenni KoetjePurchased for a class. It was an easy read and very enjoyable!! I work at the beside in healthcare and this book was very enlightening0 of 0 people found the

following review helpful. Oldie but VERY goodie!By Leah KayGreat insights. Might be an older title, but it is the highest quality work of its type. Each chapter is short, and concise. It is chock full of hearty information that students and professionals can use to move forward with their career. We develop a sense of how our actions as health care professionals directly effect those around us.0 of 0 people found the following review helpful. Boring book.By Bob WallaceUsed this as a textbook for school. Probably the instructors fault for picking a book that didn't enforce his lectures. Boring book.

Misadventures in Health Care: Inside Stories presents an alternative approach to attributing the cause of medical error solely to the health care provider. That alternative, the systems approach, pursues why an incident occurs in terms of factors in the context of care that affect the care provider to induce an error. The basis for this approach is the fact that an error is an act, an act is behavior, and behavior is a function of the person interacting with the environment. Eleven vignettes illustrate the importance of the systems approach by describing health care incidents from the perspective of the care providers--the perspective that can identify the factors that actually affect the provider. These stories provide general readers with opportunities to apply their knowledge in analyzing incidents to identify error-inducing factors. This book is important reading for policymakers, researchers and practitioners in law and in all medical specialties, and professionals in the social sciences, human factors, and engineering. In addition to sensitizing the reader to the importance of contextual factors in error, Misadventures in Health Care is a case study reference to supplement texts in professional schools such as law and medicine, as well as the full range of academic disciplines. It also is important reading for the general public because it presents an approach for addressing a very pressing social problem-- that of misadventures in health care.

This wonderful collection reminds us that improving patient safety is a matter of life and death.Donna E. ShalalaPresident, University of Miami, Former Secretary of Health and Human ServicesMedical error kills. Common sense says to punish those responsible. Common sense is wrong, as this book so powerfully demonstrates. Each chapter starts with a gripping case history. Each demonstrates that it is the system that is at fault, that the people now being blamed and punished are often victims, not culprits, and that no progress will be made until attitudes--and the entire system--are changed. This important book should be required reading of everyone concerned with medical safety, which means everyone: anyone involved in treatment, anyone who might someday get sick.Don NormanNorthwestern University, Nielson Norman Group, Author of The Design of EverydThis book should be widely read not only by researchers and practitioners in all the medical specialties, but also by professionals in the social sciences, human factors, and engineering. Indeed, it should be read by lay persons as well because it contains messages for everyone interested in the integrity of medical care and practice. And who, these days, is not?Alphonse ChapanisProfessor Emeritus, Johns Hopkins UniversityAbout the AuthorMarilyn Sue Bogner, Ph.D. is President and Chief Scientist of the Institute for the Study of Human Error, LLC. Dr. Bogner is editor of Lawrence Erlbaum Associates (LEA) book series on Human Error and Safety and the sub-series on Patient Safety. She edited and contributed to the book Human Error in Medicine published by LEA in 1994. She also has contributed chapters to 11 books, is on the editorial board of the journal Human Factors and a reviewer for 7 professional journals. Dr. Bogner has published on error and performance issues in numerous professional publications and has spoken extensively at professional meetings in the U.S. and abroad. She is a Fellow of the American Psychological Association, the Human Factors and Ergonomics Society, and the Washington Academy of Sciences.