

Contents

Acknowledgments	ix
About the author	xi
Abbreviations	xiii
1 An overview and introduction to concepts	1
1.1 Introduction	1
1.2 Medical error	2
1.3 Magnitude and epidemiology of health care errors.....	4
1.4 Conclusion.....	8
2 Perceptions of medical error and adverse events	11
2.1 Introduction	11
2.2 Perceptions by physicians.....	12
2.3 Perceptions by the public.....	13
2.4 Perceptions by health care staff	15
2.5 Perceptions by medical students.....	17
2.6 A sociological perception of medical error	19
2.7 Conclusion.....	20
3 Causes of medical error and adverse events	23
3.1 Introduction	23
3.2 The cognitive influence on error-generating behavior	27
3.3 Conclusion.....	28
4 Medical error and strategies for working solutions in clinical diagnostic laboratories and other health care areas	31
4.1 Introduction	31
4.2 Clinical diagnostic laboratories	32
4.3 Errors in different stages of analysis	34
4.4 Strategies for identification and prevention of errors.....	36
4.5 Errors in emergency medicine	38
4.6 Errors in intensive care medicine.....	41
4.7 Conclusion.....	45
5 Creating a culture for medical error reduction.....	51
5.1 Introduction	51
5.2 Education and professional development	52
5.3 Error reporting systems	57
5.4 Leadership and regulatory issues	59
5.5 Establishing a quality care council	60
5.6 Emotional impact of errors on health care professionals.....	61
5.7 Conclusion.....	61

6	Improving quality in clinical diagnostic laboratories	65
6.1	Introduction	65
6.2	Efforts and programs to ensure quality in clinical diagnostic laboratories	66
6.3	Proficiency testing in clinical laboratories	69
6.4	External quality assessment and proficiency testing programs.....	70
6.5	"No-fault" model	72
6.6	Conclusion.....	73
7	Barriers to open disclosure	77
7.1	Introduction	77
7.2	How to disclose	77
7.3	Disclosing errors to multiple patients	78
7.4	Bioethical viewpoints.....	79
7.5	Patient-physician relations.....	80
7.6	The dilemma of an apology	81
7.7	Barriers to full disclosure.....	83
7.8	Conclusion.....	84
8	International laws and guidelines addressing error and disclosure	87
8.1	Introduction	87
8.2	Disclosing preventable adverse events	87
8.3	International progress and initiatives	88
8.4	Conclusion.....	92
9	The value of autopsy in detecting medical error and improving quality	95
9.1	Introduction	95
9.2	Error in diagnostic medicine.....	95
9.3	Missed diagnosis and discordance	96
9.4	The value of autopsies	97
9.5	Autopsy decline and strategies to encourage autopsy	98
9.6	Conclusion.....	99
10	Total quality management, six-sigma, and health care	103
10.1	Introduction	103
10.2	New issues, newer solutions	104
10.3	The six-sigma structure	106
10.4	Six-sigma in clinical diagnostic laboratories	108
10.5	Conclusion.....	109
	Index.....	111