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M I S T A K E S

A Phenomenological
Interpretation of
Medical Work

M A R I A N N E A . P A G E T

Unity Of Mistakes A Phenomenological Interpretation

Marianne A. Paget



Unity Of Mistakes A Phenomenological Interpretation:

The Unity of Mistakes Marianne A. Paget, 2004 Marianne Paget's The Unity of Mistakes has long been considered a landmark text on the nature of medical error. Paget, who herself died because of a medical error, argued that mistakes are an intrinsic part of the clinical process. Encompassing a much wider range of error than the terms malpractice, incompetence, or negligence denote, The Unity of Mistakes takes an existential view of medical work in which things go wrong as a matter of course and probes what Paget called the complex sorrow that can result when things do go wrong. This new paperback edition contains a Foreword by Joan Cassell, anthropologist and author of Expected Miracles: Surgeons at Work. I began this study when I became aware of the anguish of clinical action and of the moral ambiguity of being a clinician, a person who acts, sometimes mistakenly, and therefore lives with the experience of being wrong. With this statement, Marianne Paget introduces her study of medical mistakes and their meaning. Using as her text in-depth interviews with forty doctors, she explores the subjective experience of physicians who inevitably make mistakes. Marianne Paget argues that mistakes are an intrinsic feature of medical work, which she calls an error-ridden activity. Mistakes involve action, and action contains risk. Since medical mistakes put at risk human beings, not just the acted-upon but the actors, her concern is with the subtle effects this endemic danger has upon clinical work. Through close textual analysis, the author examines the ways in which particular actions, which seemed right at the time, are recognized as errors and responded to. Her study encompasses a much wider range of error than the terms malpractice, incompetence, or negligence denote. She takes an existential view of medical work in which things go wrong as a matter of course and probes what she calls the complex sorrow that can result. Author note: Marianne A. Paget (1940-1989) was a sociologist and researcher who, in the course of her career, held positions at various universities and, at the time of her death, was a research associate in the Department of Sociology at Brandeis University. Joan Cassell is Research Associate in the Department of Anthropology at Washington University in St. Louis and the author of several books, including Expected Miracles: Surgeons at Work and The Surgeon in the Woman's Body: A Complex Sorrow. Marianne A. Paget, 1993 Medication Errors Michael Richard Cohen, 2007 In the second expanded edition of the acclaimed Medication Errors (1999), Michael R. Cohen brings together some 30 experts from pharmacy, medicine, nursing, and risk management to provide the best, most current thinking about medication errors. Their contributions make this the most comprehensive, authoritative examination in print of the causes of medication errors and strategies to prevent them. Medication Errors provides the health care community—acute care, long-term care, ambulatory care, the pharmaceutical industry, regulatory affairs, and academia—with practical guidance to make patients who take or receive medications safer. Key Features: Numerous insights into the causes of medication errors, including drug names, drug packaging and labeling, and error-prone abbreviations and dose expressions; In-depth analyses of prescribing errors, dispensing errors, drug administration errors, and errors related to drug delivery devices, using examples of actual errors for illustration; Detailed discussions of

specialty areas fraught with risk cancer chemotherapy pediatric and neonatal patients and immunologic drugs A comprehensive chapter on high alert medications those drugs most frequently involved in harmful events with precautions that should be taken to avoid such mishaps Dozens of tables and figures throughout plus a color plate section capturing key information concisely [Criminal Liability for Non-Aggressive Death](#) Sally Cunningham,2016-05-13 The crime of manslaughter exists as a catch all offence to punish those who are blameworthy in causing the death of another but whose culpability falls short of that required for murder Manslaughter is an extremely broad offence and it has a difficult task in ensuring that all those who warrant punishment for non aggressive deaths are convicted Simultaneously it should not be too broad in covering those who do not warrant punishment for such deaths There is little consistency in whether a particular dangerous activity leads to liability for a specific offence or for the generic offence of manslaughter when death is caused This book examines the current law and includes a variety of perspectives on the subject with chapters on specific modes of killing as well as issues that permeate all areas The first half of the book deals with issues such as how any special offences for non aggressive death should relate to a hierarchy of homicide offences The second half deals with issues specific to different activities which may or may not justify the creation of specific homicide offences The book includes a comparative chapter on Australian law **Understanding Patient Safety** Robert Wachter,2007-10-05 Everything you need to deliver safe patient care or to improve patient safety in your organization This easy to read book provides an excellent overview of the patient safety movement in the United States The author has written a useful book for the professional who needs a foundation in patient safety principles and theory The book also provides a multitude of resources for the professional interested in gaining a more in depth knowledge of the strategies and proponents of the patient safety movement Journal for Healthcare Quality Understanding Patient Safety is the essential book for anyone seeking to learn the key clinical organizational and systems issues in patient safety Written in a lively and accessible style by one of the world s leaders in the fields of patient safety and quality Understanding Patient Safety is filled with valuable cases and analyses as well as up to date tables graphics references and tools all designed to introduce the patient safety field to medical nursing pharmacy hospital administration and other trainees and to be the go to book for experienced clinicians and non clinicians alike Features Concise coverage of the core principles of patient safety All the key insights to help you understand and prevent a broad range of errors including medication errors surgical errors diagnostic errors errors at the man machine interface and nursing related errors A focus on how reporting systems teamwork training simulation the malpractice system and information technology can impact patient safety and quality A practical overview on how to implement an effective safety program in both hospital and ambulatory settings Realistic case studies that illustrate key points and clarify pivotal concepts A detailed glossary key references and useful tools websites tables and graphics [Heidegger's Interpretation of Kant](#) M. Weatherston,2002-10-14 Is there any justification for Heidegger s famous violence against Kant s philosophy An independent

assessment of the worth of Heidegger's argument is also made all the more pertinent by the evident misgivings Heidegger had about his interpretation of Kant. We must ask of Heidegger's interpretation of Kant: 1. Is this good Kant? and 2. Is this good Heidegger?

Heidegger *The Theory and Practice of Bibliographic Failure, Or, Misinformation in the Information Society* David W. Bade, 2004

Understanding Patient Safety, Second Edition Robert Wachter, 2012-05-02

Gain a thorough understanding of the key principles of patient safety with the subject's pioneer text. Now in full color. This highly readable yet comprehensive book will appeal to every member of the healthcare team. It is a must for every physician's bookshelf. Abraham Verghese MD, Professor, Stanford University and author of the bestselling *Cutting for Stone*. Bob Wachter's quest to improve the safety of American healthcare represents the very essence of a physician's duty to put the patient first. His unflinching candor about the nature and magnitude of our current safety problems is matched only by his passion for improvement. Mark R. Chassin MD, MPP, MPH, President, The Joint Commission. Amazingly readable for such a wealth of important information. This book should be required reading for every health professional and every healthcare executive. Christine Cassel MD, President and CEO, American Board of Internal Medicine. In a single volume, Wachter accomplishes the seemingly impossible: furnishing the novice with a highly accessible, easy-to-read introduction to patient safety while providing a comprehensive, fully annotated reference for the experienced patient safety practitioner. All of the important issues are addressed in individual chapters, each with a lively and relevant clinical example and a key points summary at the end, bracketing full, balanced and lucid descriptions. A true gem destined to be a close companion for all of us who strive to make healthcare safe. Lucian Leape MD, Professor, Harvard School of Public Health and Chair, Lucian Leape Institute of the National Patient Safety Foundation. There is no more prominent authority on patient safety than Bob Wachter. And there is no more effective primer on patient safety than this one. Atul Gawande MD, MPH, Associate Professor, Harvard Medical School, staff writer for the *New Yorker* and bestselling author of *Complications* and *The Checklist Manifesto*. Compelling, a must read for all concerned with patient safety. Bob Wachter has a unique voice incorporating clinical experience, research expertise and policy implications, all with the patient front and center. Peter J. Pronovost MD, PhD, Professor and Director of the Armstrong Institute for Patient Safety and Quality, Johns Hopkins Medicine. *Understanding Patient Safety, Second Edition* is the essential book for anyone seeking to learn the core clinical, organizational and systems issues of patient safety. Written in an engaging and accessible style by one of the world's leading authorities on patient safety and quality, *Understanding Patient Safety* is filled with valuable cases and analyses as well as tables, graphics, references and tools. This classic reference is designed to make the patient safety field understandable to medical, nursing, pharmacy, hospital administration and other trainees, and to be the go-to book for experienced clinicians and non-clinicians alike. The second edition has been revised to include coverage of the latest issues and trends, including information technology, measurements of safety errors and harm, checklist-based interventions, safety targets, policy issues in patient safety, balancing no-blame and accountability. *Understanding Patient Safety, Second Edition*.

delivers key insights to help you understand and prevent a a broad range of errors including those related to medications surgery diagnosis infections and nursing care The crucial contextual issues including errors at the person machine interface the role of culture patient engagement in their own safety and workforce and trainee considerations are also well covered Finally the book provides a practical overview of how to organize an effective safety program in both hospitals and clinics

The Unity of Mistakes Marianne Alice Paget,1978 *Florida State University Law Review* Florida State University. College of Law,2007 *Journal of Contemporary Ethnography* ,1990 Medical Mishaps Marilynn M. Rosenthal,Linda Mulcahy,Sally M. Lloyd-Bostock,1999 *Medical Mishaps* explores what is known about the incidence causes and aftermath of medical errors Mishaps are traced from their genesis through to their impact on doctors patients managers and those responsible for complaint resolution **Nursing Ethics** Anne H. Bishop,John R. Scudder,1996 Although ethics is an integral aspect of nursing practice courses in nursing ethics all too often teach ethics through traditional philosophical theory This text explores the ethics that stems directly from the moral dimension of nursing as it is rooted in everyday practice Using practical examples that present ethical issues as they naturally arise the authors demonstrate that integrating the motivation to care and the practice of care will help nurses fulfill the moral sense of their jobs as caretakers The last chapter is a dialogue between the authors in which they discuss and interpret the major cases presented in the previous chapters This practical interpretive text provides a unique approach to nursing ethics that bridges the gap between philosophical study and nursing practice **RQ** ,1990 *Health Care Law and Ethics* Mark A. Hall,Mary Anne Bobinski,David Orentlicher,2003 *HEALTH CARE LAW AND ETHICS* was one of the first casebooks to face the formidable task of providing adequate coverage of the multiple areas where law and medicine intersect the Sixth Edition continues that tradition by being well suited for use in a survey course in health care law or a more focused study of malpractice or bioethics material is logically organized into three main parts The Patient And The Provider The Patient The Provider And The State Institutions Providers And The State the crucial issues of quality ethics access and cost are considered throughout the book strong coverage of bioethics provides important contextual background for discussions of the right to die reproductive rights organ transplantation the authors address cutting edge issues such as genetics and managed care along with such standard topics as confidentiality medical malpractice public health law and health care financing and regulation clear author notes provide context and background information and smooth the transitions between cases helpful introduction supplies an overview of the health care system to help students navigate this complicated area Changes For The Sixth Edition heighten classroom effectiveness while keeping pace with rapid developments in the law new coverage of today's most urgent issues oversight of medical research including genetic research and cloning HMO liability Patient Bill of Rights and new privacy rules and bioterrorism improved and expanded treatment of ERISA preemption reorganized Part Three for greater clarity In response to user feedback major new cases including *Rush Prudential v Moran* and *Pegram v Herdich* regulation of managed care *Ferguson v City of Charleston*

reporting drug test results to law enforcement J B v M B disposition of frozen embryos an authors website where a detailed Table of Contents is hyperlinked To The latest updates [Medical Liability and Treatment Relationships](#) Mark A. Hall, Mary Anne Bobinski, David Orentlicher, 2005 The authors blend material from Part I of their survey book with additional information specific to these topics the text covers the full range of issues arising in the treatment relationship from formation to termination plus professional licensure and regulating access to drugs a detailed chapter on medical malpractice incorporates new material Daubert v Merrell Dow Pharmaceuticals Inc Forensic Medicine and Epidemiological Evidence Discovery and Evidentiary Rules in Malpractice Cases The Supreme Court s latest decision in Aetna Health Inc v Davilla Medical Liability and Treatment Relationships shares the strengths that make the authors survey text so popular the text integrates legal practice public policy and doctrinal issues and features clear notes a thorough Teacher s Manual created specifically for this book the website www.healthlaw.org provides background materials updates of important events additional relevant topics and links to other resources *Internal Bleeding* Robert M. Wachter, Kaveh G. Shojania, 2004 Imagine an epidemic that kills over one hundred Americans every day Now stop imagining Each year doctors and nurses kill nearly one hundred thousand Americans By mistake They operate on the wrong patients prescribe the wrong drugs and leave instruments inside body cavities after surgery Meanwhile hospitals spend billions on new gadgets marble lobbies and slick billboards even as safety continues to be ignored Until now Internal Bleeding exposes the dark secrets behind the glistening facade of modern medicine Doctors Robert Wachter and Kaveh Shojania professors at one of America s leading medical schools and two of the world s foremost authorities on medical mistakes shatter the silence to tell the dramatic and compelling stories of real patients betrayed by a system they trusted to save them Through these stories the authors reveal the inner workings gut wrenching dilemmas and heartbreaking tragedies of our overburdened understaffed health care system Internal Bleeding provides an insider s view of how professional caregivers think feel and operate facts that every patient and family must know to avoid becoming just another mistake In the groundbreaking tradition of Fast Food Nation Internal Bleeding paints a vivid and unforgettable picture of a system gone terribly wrong and what doctors nurses hospital CEOs and policy makers must do to make it right **The Social Construction of Illness** Jens Lachmund, Gunnar Stollberg, 1992 **Medical Humanities Review** , 2003 *When Doctors Say No* Susan B. Rubin, 1998-10-22 The medical situation is critical even life threatening The doctor refuses to offer or to continue providing futile medical treatment The patient or the patient s family insists that everything possible must be done Who should decide In this book philosopher and bioethicist Susan B Rubin examines this controversial issue

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