# Index

**A**  
accountability see responsibility and accountability  
Accountable Care Organizations (ACO), 128  
admiration, 34  
advanced practice nurses, 70, 79  
adverse events, 145–57  
advocacy, 26, 104, 107, 147, 158, 159, 167–71  
Afro-American (black) patients, 116–17  
alarm fatigue, 140  
algorithm (template) for dealing with mistakes, 153  
American College of Surgeons Commission on Cancer (CoC), 77  
American Society of Clinical Oncology (ASCO), 77, 79, 80, 81, 92, 94, 95, 97, 98, 145, 155  
American Society of Health System Pharmacists (ASHP), 77, 79, 81  
apology, 11, 106, 117, 150, 154  
armbands, 69, 77–8  
arrogance, 11–12, 175  
attributions to disclosure, 150  
cultural, 6–8  
to patient safety, 164–5  
see also beliefs  
authority/power/dominance (medical), 137, 159–60, 164  
averse, 30–1

**B**  
barcoding, 78  
beliefs and traditions  
cultural, 115–16  
religious, 41  
see also attitudes  
bevacizumab, 74  
bias, 116–17, 177  
cognitive, 33  
cross-cultural communication and, 116–17  
black patients, 116–18  
blame, 136  
culture of, 3, 10–11  
bortezomib, 76  
breast cancer, 69, 72, 87–8, 101, 113, 149  
avocacy, 167–8  
brathing difficulties, nurses’ failure to respond to, 22–4  
brutality, 61  
burnout, 37–8, 38, 43, 44, 174

**C**  
calculation errors (drug), 74, 80, 81, 149  
capetatinib, 75  
carboplatin, 73, 74, 75  
Center for Patient partnerships, 168–9  
cervical cancer, 73  
charts (medical), 78  
chemotherapy planning, 93  
checklists, 43, 97  
chemotherapy, 81  
infections and sepsis, 134, 140  
chemotherapy see drugs  
Christianity, 41, 42  
cognitive bias, 33  
cognitive dissonance, 33  
collaboration and cooperation, 35, 37, 59, 77, 97, 98, 176  
colon cancer, 30, 74, 75  
communication, 5, 9–10, 97, 98, 107, 109, 138, 146, 151–4, 175–6  
cross-cultural, 20, 116–17, 117  
devastating/bad news, 7, 103, 105, 108, 109, 149  
feeling of excommunication, 59  
lack of/faulty/failed/pitfalls in/difficulties, 24, 97, 98, 102–3, 117, 147  
training in, 107–9  
when/where/who, 151–2  
see also disclosure  
compassion, 33, 41  
compassion fatigue, 38–9  
complications of treatment and life, 56–7  
computerized provider order entry (CPOE), 68, 91

© 2015 John Wiley & Sons, Inc. Published 2015 by John Wiley & Sons, Inc.
CONES protocol, 105–7
confused drug names (look-alike sound-alike/"LASA" drugs), 71, 81
connection, 29–30
consequences of errors disclosing, 152
   systems failures and, 161–2
   cooperation and collaboration, 35, 37, 59, 77, 97, 98, 176
cost, error prevention and, 17, 160
Cost Conundrum (New Yorker), 130
critical thinking, 34, 138
cross-cultural differences see culture
disclosure of errors and, 4–5, 6–7, 111–24
   occurrence of errors and, 111–24
   reducing errors and, 118–20
   of disclosure, 154–5
   of safety, 97, 98, 118, 132, 133, 137, 140, 154, 159
   of support, diverse patient populations and, 118–19
cyclophosphamide, 87–8
D
dartmouth health care atlas, 129–30
denial of error, 1, 31, 109, 161
diagnosis, 173
   of recurrence, failed, 18–19
   disclosure, 4–5, 6–7, 101–10, 146–55, 174–6
   arguments against, 146–7
   arguments for, 146, 147–8
   cultural factors, 4–5, 6–7, 111–24
   culture of, 154–5
doctors’ reasons for non-disclosure, 103
dominance/power/authority (medical), 137, 159–60, 164
education, 6, 79, 176–8
   see also training
etchnology, 3, 68, 78, 98, 120, 128, 133–6
   ability to identify/understand/manipulate one’s own and other people’s, 35
   addressed in error disclosure, 105, 106, 107, 152, 154
empathy
   causes of decrease in, 38
   in error communication/disclosure, 34, 105, 106, 107
   teaching, 109, 176
endoscopy of throat cancer
   and failure to detect recurrence, 18–19
   and failure to remove recurrent tumor, 20, 21
   engagement (involvement)
   Mozart effect and, 45
   patient, 31, 32, 82–3, 98–9, 116, 117, 119, 131, 163–7
   physician, 133
ethical issues, 3, 5, 10–11, 145–57
   for safety, 97, 98, 118, 132, 133, 137, 140, 154, 159
   of support, diverse patient populations and, 118–19
discussion, 161
   distancing, 161
doctors see oncologic physicians
documentation see reporting
dominance/power/authority (medical), 137, 159–60, 164
dose-related errors
drug see drugs
double-checking with chemotherapy, 82, 83, 90
   drug calculations, 81
doxorubicin, 72, 81
drugs/medications (incl. chemotherapy), 69–76, 87–92
   breast cancer, 69, 72, 87–8, 101, 113, 149
   errors, 69–76, 87–92
   dose administration, 69, 72–3, 117
   dose calculation, 74, 80, 81, 149
   institutions/organizations/systems and, 71, 79–80, 134, 137
   prevention, 79–82
   route of administration, 75–6, 82
   scheduling, 74–5, 80
   wrong drug, 71–2, 81, 89–90
   quality assurance, 92–4
   safety, 89–92
   recommendations for safer care, 97–8
   targeted, 91
E
education, 6, 79, 176–8
   see also training
electronicaly medical records, 3, 68, 78, 98, 120, 128, 133–6
   emotions
   ability to identify/understand/manipulate one’s own and other people’s, 35
   addressed in error disclosure, 105, 106, 107, 152, 154
empathy
   causes of decrease in, 38
   in error communication/disclosure, 34, 105, 106, 107
   teaching, 109, 176
endoscopy of throat cancer
   and failure to detect recurrence, 18–19
   and failure to remove recurrent tumor, 20, 21
   engagement (involvement)
   Mozart effect and, 45
   patient, 31, 32, 82–3, 98–9, 116, 117, 119, 131, 163–7
   physician, 133
ethical issues, 3, 5, 10–11, 145–57
   for safety, 97, 98, 118, 132, 133, 137, 140, 154, 159
   of support, diverse patient populations and, 118–19
discussion, 161
   distancing, 161
doctors see oncologic physicians
documentation see reporting
dominance/power/authority (medical), 137, 159–60, 164
dose-related errors
drug see drugs
double-checking with chemotherapy, 82, 83, 90
   drug calculations, 81
doxorubicin, 72, 81
drugs/medications (incl. chemotherapy), 69–76, 87–92
   breast cancer, 69, 72, 87–8, 101, 113, 149
   errors, 69–76, 87–92
   dose administration, 69, 72–3, 117
   dose calculation, 74, 80, 81, 149
   institutions/organizations/systems and, 71, 79–80, 134, 137
   prevention, 79–82
   route of administration, 75–6, 82
   scheduling, 74–5, 80
   wrong drug, 71–2, 81, 89–90
   quality assurance, 92–4
   safety, 89–92
   recommendations for safer care, 97–8
   targeted, 91
E
education, 6, 79, 176–8
   see also training
electronicaly medical records, 3, 68, 78, 98, 120, 128, 133–6
   emotions
   ability to identify/understand/manipulate one’s own and other people’s, 35
   addressed in error disclosure, 105, 106, 107, 152, 154
empathy
   causes of decrease in, 38
   in error communication/disclosure, 34, 105, 106, 107
   teaching, 109, 176
endoscopy of throat cancer
   and failure to detect recurrence, 18–19
   and failure to remove recurrent tumor, 20, 21
   engagement (involvement)
   Mozart effect and, 45
   patient, 31, 32, 82–3, 98–9, 116, 117, 119, 131, 163–7
   physician, 133
ethical issues, 3, 5, 10–11, 145–57
   for safety, 97, 98, 118, 132, 133, 137, 140, 154, 159
   of support, diverse patient populations and, 118–19
discussion, 161
   distancing, 161
doctors see oncologic physicians
documentation see reporting
dominance/power/authority (medical), 137, 159–60, 164
dose-related errors
drug see drugs
double-checking with chemotherapy, 82, 83, 90
   drug calculations, 81
forgiveness, 11, 12, 40, 176
friends as interpreters, 114–15
front-line staff and operations, 135, 137, 138

G
gender, 58, 116
generic drug names, 71, 72, 81

H
hand hygiene/washing, 134–5, 153
harmful medical errors, 145–57
health records see records
high reliability (organizations), 131, 139–40, 141
Hinduism, 41
honesty, 22, 27, 62, 104
hospital infections acquired in see infections
origin of word, 61
Hospitals, Language, and Culture study (Joint Commission), 120
humanity, 11–12, 39, 45, 46
humility, 11–12, 34, 46, 62, 175, 176
hypopharyngeal cancer, physician's experience as patient with, 18–27

I
identification errors, 68–9, 77–8
immunocompromised/immunosuppressed patients, 135
individuals (professionals as) as contributing factor to medication error, 71
and feelings of responsibility for errors, 162
inductive reasoning, 33
infections (hospital acquired), 112, 134–5
hand hygiene/washing in prevention of, 134–5, 153
information see communication; disclosure; records; reporting
infusion pumps, 73, 75, 82
Institute for Safe Medication Practice (ISMP), 71, 76, 88, 138
Institute of Medicine (IOM) Report "To Err is Human", 1, 10, 159, 160
institutions/organizations/systems, 5, 10, 79–80, 127–44
disclosure policy, 155
drug errors relating to, 71, 79–80, 134, 137
prevention and, 5, 10, 79–80, 127–44
safety and, 5, 127–44
intensity modulated radiation therapy, 95–6
intensive care unit, surgical, breathing difficulties and nurses' failure to respond in, 22–3
interpreters, 118–19, 120, 121, 122
family and friends as, 114–15
professional/trained, 113, 114–15, 118, 120, 121, 122
staff (nonqualified/untrained) as, 114–15, 115
Islam, 42–3

J
Jewish religion, 41–2
Joint Commission (JNC), 76, 82, 92, 97
Hospitals, Language, and Culture study, 120
Speak Up, 98–9, 163
Speak Up initiative, 98–9, 163
Judaism, 41–2
Just Culture initiative, 137, 137–8

L
laboratory tests/findings, 68, 69, 73, 78
language culture and, 114–16, 120
discordant encounters, root causes resulting from, 121–2
Joint Commission's report, 120
majority/dominant (English in practice), 111, 112, 118
low/limited English proficiency (LEP), 111, 112, 114, 115, 118–19, 119–20, 121, 122–3
laryngeal cancer, physician as patient with, 18–27
laryngectomy, premature oral feeding after, 24
laser removal of tumor, failed, 19–22
lawsuit decisions, 4, 8–10, 51–63, 150–1
leaders and leadership, 97, 98, 132–3, 137, 139, 140, 173, 177
legal issues (litigation etc.), 4, 8–10, 51–63, 150–1
liking one's doctor, 53–5
limited/low English proficiency (LEP), 111, 112, 114, 115, 118–19, 119–20, 121, 122–3
litigation decisions, 4, 8–10, 51–63, 150–1
look-alike sound-alike ("LASA") drugs, 71, 81
lung cancer, 73, 75, 90, 116
lymphoma, non-Hodgkin's, 76, 147

M
malpractice lawsuits, 4, 8–10, 51–63, 150–1
Massachusetts General Hospital (MGH), 30, 37, 89, 118
Medicaid, 129, 130
medical dominance/power/authority, 137, 159–60, 164
medical errors (general aspects), 159–62
definitions, 1, 52, 68, 158, 159, 160, 161
harmful see harmful medical errors
Medical Induced Trauma Support Services (MITSS), 154
medical records see records
Medicare, 102, 129, 130
medications see drugs
meditation and mindfulness, 44–5
Medscape Malpractice Report, 8–9
melanoma, 148, 149
mental exhaustion
patient, 55–6
mental exhaustion (continued)
  physician, 38
mindfulness, 44–5
misidentification of patients, 68–9, 77–8
monitoring
  quality assurance, 94
  safety of patients from minority groups or with
  language barriers, 121
moral issues, 10
  moral distress, 39
Mozart effect, 45
Muslims and Islam, 42–3

N
  navigation services, patient, 119
  non-Hodgkin’s lymphoma, 76, 147
  nurses, 67–86
  author’s experiences of errors, 22–4, 24–5
  instruction in error disclosure, 108
  prevention of errors, 4, 67–86

O
  oncologists, 5, 6, 7, 8, 87–100, 173–4
  nature of experience, 173–4
  responsibility and accountability, 3, 5, 7, 98,
  102, 104
  Oncology Nursing Society (ONS), 77, 79, 80, 81,
  92, 98
  oral chemotherapy concerns, 91–2, 98
  oral feeding after laryngectomy, premature, 24
  organizations see institutions
  otolaryngology ward, breathing difficulties and
  nurses’ failure to respond to, 23–4
  ovarian cancer, 73, 168
  over-simplification

P
  paclitaxel, 73, 75, 90
  palliative care, 135, 139, 175
  pancreatic adenocarcinoma, 116
  patients, 6, 173–4
  advocacy, 26, 104, 107, 147, 158, 159, 167–71
  attitudes and wishes when errors occur, 103–7
  author’s experience of errors as, 3, 17–27
  autonomy, 6, 146, 147, 148, 151, 168, 176–7
  engagement/involvement (and family), 31, 32,
  82–3, 98–9, 116, 117, 119, 131, 163–7
  misidentification, 68–9, 77–8
  nature of experience, 173–4
  navigation services, 119
  other writers’ experiences, 11, 12
  safety see safety
  trust in physician relationships with, 51–63,
  104
  peer support after errors (other
  professionals/colleagues), 45–6, 104
  pemtrexed, 89–90
  personal self-care, 43–4
  physical exhaustion
  patient, 55–6
  physician, 38
  physicians (doctors)
  as author
    on loved one as patient, 4, 57, 59–60
    on own experience as patient, 3, 17–27
  autonomy, 141
  as individuals and their feelings of their
  responsibility for errors, 162
  non-disclosure by, reasons, 103
  trust in relationships with patient and family,
  51–63, 104
  see also oncologists
  positive outcome, unexpected, 56–7
  power/dominance/authority (medical), 137,
  159–60, 164
  practical skepticism, 34
  prescribing drugs see drugs
  prevention or reduction of errors, 11, 118–22
  chemotherapy, 79–82
  culture and, 118–22
  institutions and, 5, 10, 79–80, 127–44
  nurses and, 4, 67–86
  oncologists and, 87–100
  primary care, 54, 116, 128, 131, 148
  professional(s) see individual; staff
  professionalism, 39
  programming of radiation therapy, faulty, 96
  prostate cancer, 95, 130
  psychological impact, 3–4, 29–50
  pumps, infusion, 73, 75, 82

Q
  quality assessment tools, 92–5
  Quality Oncology Practice Initiative, 92–4

R
  racial minorities see culture
  radiation oncology, 95–6
  rapid response teams, 103, 135, 140
  records (medical/health), 24, 57, 68, 78, 94, 148,
  149
  electronic, 3, 68, 78, 98, 120, 128, 135–6
  recovery (patient), 55–6
  recurrence and relapse, 173
  failed diagnosis, 18–19
  failed removal, 19–22
  regained wellness, 55
  regret, expressing, 12, 104, 154
  relapse see recurrence
  reliability (in organizations)
    definition, 139
    high, 131, 139–40, 141
Index

religion, 39–43
reporting and documenting of errors, 98
  minority populations in, 119, 120–1
see also charts
research (on errors in general), 1–2, 4, 160, 177
resilience, 35–6, 140
respect, 33, 34–5, 61–2, 151, 176
responding to errors, 2
responsibility and accountability
  ethical, 3, 5, 10–11, 145–57
  institutional, 128, 131
  professional (doctors etc.), 5, 145–57, 162
  oncologists, 3, 5, 7, 98, 102, 104
Rich, Katherine Russell, 12
rites and rituals, 43
role play, 107–8, 109
root causes
  analysis, 90, 98, 103, 138
  language discordance and addressing of, 121–2
route of administration
  errors, 75–6, 82
  safety concerns, 91
S
safety (patient), 4–5, 66–144, 168
  chemotherapy see drugs
  culture of, 97, 98, 118, 132, 133, 137, 140,
    154, 159
  initiatives, 162–7
  social forces threatening, 162
  institutions and, 5, 127–44
  of minority groups/patients with language
    barriers, 118–19
  monitoring, 121
  nurses and, 4, 67–86
  positive, climate of, 77
  recommendations for safer care, 97–9
sample specimen labeling, 69, 78
satisfaction (short of suing), 56, 57
scheduling errors (drug), 74–5, 80
self-care, 43–4
shame, 32, 32–3
skepticism, practical, 34
smart pump, 82
social forces threatening patient safety initiatives, 162
social networks, 36–7
SorryWorks!, 154
Speak Up initiative, 98–9, 163
specimen labeling, 69, 78
SPIKES protocol, 105
spirituality, 39–43
staff/professionals/workforce
  front-line, 135, 137
  responsibility see responsibility
  support after errors, 45–6, 104
  as untrained/non-qualified interpreters,
    114–15, 115
see also individuals; leaders; nurses;
  oncologists; physicians; team
stress, 38, 39, 40, 50, 174
  reducing, 44–5
suffering and religion, 41–2
suing decisions, 4, 8–10, 51–63, 150–1
support after errors
  diverse patient populations and culture of,
    118–19
  of professionals/colleagues, 45–6, 104
surgical oncology errors, 3–4, 17, 96–7
  author’s experience as patient, 3, 17–27
Swiss cheese model of accident causation, 90
systems see institutions
T
talion law, 41–2
Tall Man Letters, 81
tame vs. wicked problems, 162
targeted therapeutics, 91
teams and teamwork, 115, 117, 138, 140, 146,
  152, 159, 176
see also leaders
TeamSTEPPS, 138
tenderness, 60, 61, 62
thankfulness, 45
time-out, 78, 82, 138
“To Err is Human” (IOM report), 1, 10, 159, 160
Torah, 41–2
trade names of drugs, 71, 81
traditions see beliefs and traditions
training in error management, 160–1, 176–8
disclosure, 107–9, 154–5
see also education
transparency, 39
trastuzumab, 72
triple aim concept, 128, 131, 132
trust in physician–patient–family relationships,
  restoring, 51–63, 104
U
ultra-safe care, 132, 136, 140
uterine sarcoma, 72
V
validation
  achieving (short of suing), 56, 57
  in error disclosure, 107
value (healthcare), 128–9, 139
  high-value, 122, 123
vesicant chemotherapy, 75–6
Veterans Affairs/Administration, 97, 139, 140
vincristine, 72, 76, 81, 82
vulnerability, 6, 31–2, 36
**Index**

| W | wisdom, 45  
|   | work interruptions and drug errors, 70  
|   | workforce see staff  
| Y | You CAN, 98  

| W | walk rounds, 133, 137  
|   | wellness, regained, 55  
|   | Wellness Wheel, 43  
|   | wholeheartedness, 31–2  
|   | wicked vs. tame problems, 162  