Record Nr. UNINA9910460215503321 Accountability [[electronic resource]]: patient safety and policy reform **Titolo** // Virginia A. Sharpe, editor Pubbl/distr/stampa Washington, D.C.,: Georgetown University Press, c2004 **ISBN** 1-58901-230-5 Descrizione fisica 1 online resource (279 p.) Collana Hastings Center studies in ethics SharpeVirginia A <1959-> (Virginia Ashby) Altri autori (Persone) Disciplina 362.1/0425 Soggetti Medical errors - United States Health care reform - United States Electronic books. Lingua di pubblicazione Inglese **Formato** Materiale a stampa Livello bibliografico Monografia Note generali Description based upon print version of record. Nota di bibliografia Includes bibliographical references (p. 235-261) and index. Nota di contenuto Introduction: Accountability and justice in patient safety reform / Virginia A. Sharpe -- Writing/righting wrong / Sandra M. Gilbert -- Life but no limb: the aftermath of medical error / Carol Levine -- In memory of my brother, Mike / Roxanne Goeltz -- Error disclosure for quality improvement: authenticating a team of patients and providers to promote patient safety / Bryan A. Liang -- Prevention of medical error: where professional and organizational ethics meet / Edmund D. Pellegrino -- Medical mistakes and institutional culture / Carol Bayley -- "Missing the mark": medical error, forgiveness, and justice / Nancy Berlinger -- Is there an obligation to disclose near-misses in medical care? / Albert W. Wu -- God, science, and history: the cultural origins of medical error / Kenneth De Ville -- Reputation, malpractice liability, and medical error / William M. Sage -- Ethical misfits: mediation and medical malpractice litigation / Edward A. Dauer -- On selling "nofault" / David M. Studdert -- Medical errors: pinning the blame versus blaming the system / E. Haavi Morreim. Sommario/riassunto According to a recent Institute of Medicine report, as many as 98,000 Americans die each year as a result of medical error-a figure higher

than deaths from automobile accidents, breast cancer, or AIDS. That astounding number of fatalities does not include the number of those serious mistakes that are grievous and damaging but not fatal. Who can forget the tragic case of 17-year-old Jesica Santillan, who died after

receiving a heart-lung transplant with an incompatible blood type? What can be done about this? What should be done? How can patients and their families regain a sense of trust in th