

Anatomy of Medical Errors: The Patient in Room 10



On November 28, 2000, 18-year-old Jody Henry checked into Methodist Hospital in Indianapolis for a routine appendectomy. By the next morning, she was dead.



Anatomy of Medical Errors: The Patient in Room 2

by Donna Helen Crisp JD MSN RN PMHCNS-BC

4.5 out of 5

Language : English

File size : 1791 KB

Text-to-Speech : Enabled

Screen Reader : Supported
Enhanced typesetting : Enabled
Word Wise : Enabled
Print length : 255 pages



Jody's death was the result of a series of medical errors, including:

- The surgeon who performed the appendectomy failed to properly identify and remove the appendix.
- The anesthesiologist failed to properly monitor Jody's vital signs.
- The nurses failed to properly care for Jody after the surgery.

Jody's death was a tragedy that could have been prevented. Her family was left devastated by her loss, and her death sparked a public outcry for greater patient safety.

In the aftermath of Jody's death, the Indiana State Department of Health conducted an investigation into the incident. The investigation found that the hospital had failed to follow its own policies and procedures, and that the doctors and nurses involved in Jody's care had made a number of errors.

The state's investigation led to the indictment of three doctors and two nurses on charges of reckless homicide. The trial of the accused began in 2003, and it lasted for several months. The jury ultimately found all five defendants guilty of reckless homicide.

The trial of the doctors and nurses involved in Jody's death was a landmark case. It was one of the first cases in which healthcare professionals were held criminally responsible for their actions.

The Anatomy of Medical Errors: The Patient in Room 10 is a gripping account of Jody's death and the subsequent trial of the 医師 responsible. The book is a must-read for anyone interested in patient safety and the importance of preventing medical errors.



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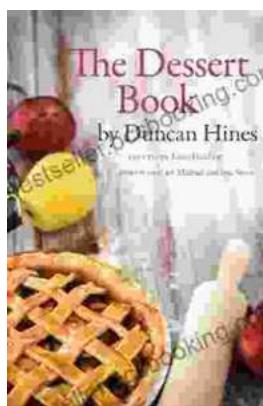
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