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Preventable anesthesia mishaps: a study of human factors.

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Cooper JB, Newbower RS, Long CD, et al. Preventable anesthesia mishaps: a study of human factors. Anesthesiology. 1978;49(6):399-406.
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This study reports on the retrospective analysis of nearly 360 preventable incidents at an urban teaching institution and was a first in using human factors research methods in an anesthesia setting. To determine patterns of failure in anesthetic practice, the investigators conducted interviews with staff and anesthesiologists before performing a critical-incident analysis. This methodology aims to translate anecdotal experiences into systematic study of human performance. Findings attributed the majority of incidents to human error, with a relatively small percentage due to pure equipment failure. The authors suggest that their method of examining incidents may be effective to help pool similar data from other institutions and design system strategies for prevention.