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Ergonomics Studies with



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DE MARTER MARSON

Joint Projects with Henning



Cockpit interface in bullet train



Interface design



Task observation





Operations and organisation for track maintenance trains

contract

Br. k

SC

00000000

JR Track

Hierarchical structure of track maintenance organisation

Branch a

UC a2

contract

Unit company aD

Subsidiary Company 1

Br. b)

Stressful conditions of train operations





Safety climate in railway (Itoh & Andersen, 1999; Itoh et al., 2001; 2004)



Contributions of motivation & morale to safety outcomes --- Company-based analysis ----

(Itoh et al., 2001; 2004)



Cross-cultural comparisons: JP vs. DK Dr. does NOT inform about event & risk to pt.



Pt. acceptance to Dr. apology *I will come to this hospital again, if Dr. would....*

(Itoh & Andersen, 2009)



Definitely not Probably not Neutral Yes, probably Yes, difinitely

Identical structure of error causes --- perceived by Pt., Dr. & Ns. ---

(Itoh & Andersen, 2007)

	Staff workload			Staff ability			Lack of mgt. effort		
Items	Pt.	Dr.	Ns.	Pt.	Dr.	Ns.	Pt.	Dr.	Ns.
 Working great workload 	0.60	0.76	0.57	-0.13	-0.04	-0.05	-0.05	0.05	0.04
Fewer nurses than required	0.86	0.62	0.79	0.09	0.18	-0.04	0.13	0.10	0.15
 Fewer doctors than required 	0.71	0.66	0.66	-0.04	0.11	0.04	0.14	0.10	0.14
Not responsible for task	-0.21	-0.03	-0.12	0.64	0.74	0.71	0.29	0.03	0.18
Not sufficiently competent	-0.07	0.08	-0.03	0.82	0.79	0.74	0.23	0.22	0.13
Inexperienced staff left	0.23	0.23	0.30	0.45	0.40	0.34	0.34	0.11	0.16
Bad doctors allowed to work	0.01	0.14	0.06	0.47	0.44	0.37	0.59	0.38	0.41
Mgts. do too little for safety	-0.03	0.02	0.08	0.29	0.06	0.21	0.74	0.81	0.84
Few resources allocated	0.16	0.18	0.29	0.13	0.23	0.12	0.45	0.62	0.53
Variance accounted for	34%	19%	30%	24%	33%	22%	10%	14%	11%
Cronbach's alpha	0.75	0.72	0.71	0.72	0.67	0.62	0.71	0.66	0.68

Figures: Factor loadings

Gaps of perceived error causes --- between patients and healthcare staff ---

(Itoh & Andersen, 2007)



Major barriers ag			•	
Identical construct elicited in Iceland, New Zealand & Nigeria Reasons for not reporting	ions oute	Lack	of enco tivation	ourage. JP
The medical licensing board	I	II	I	II
	0.813	-0.337	0.825	-0.226
The press might start writing	0.681	-0.292	0.810	-0.249
My career might suffer	0.811	-0.265	0.794	-0.230
I might get a reprimand	0.855	-0.261	0.763	-0.293
The patient may file a complaint	0.779	-0.176	0.718	-0.272
Fear of appearing incompetent	0.769	-0.020	0.715	-0.063
Lack of trust in our department	0.632	-0.020 0.319 0.489	0.630	0.348
Too cumbersome	0.391	0.489	0.579	0.422
Would not help the patient		0.120	0.564	0.391
Will lead not improvement in our ward		0.436	0.489	0.541
Don't know who is responsible	0.468	0.461	0.439	0.451
No tradition in department/ward		0.488	0.359	0.535
When I'm busy I forget it	0.352	0.415	0.341	0.582
Cronbach's alpha	0.894	0.756	0.890	0.801
Variance accounted	45%	11%	44%	13%

Stronger barriers for DK & JP --- Fear of sanctions is greater obstacle against reporting

(Itoh & Andersen, 2004)



Main reasons for Danish doctors

No tradition in my department

The press might start writing

Fear of appearing incompetent

I might get a reprimand

My career might suffer



Mann-Whitney test *: *p*<0.05 ***: *p*<0.001

Agree strongly Agree slightly

Current Joint Project with Henning: Daily Life Support by IT& Sensor Technology in Aging Society



Thank you, Henning, for your long-term cooperation!

I hope we are collaborating further.

References

- Itoh, K. and Andersen, H.B. (1999). Motivation and Morale of Night Train Drivers Correlated with Accident Rates. *Proceedings of the International Conference on Computer-Aided Ergonomics and Safety*, Barcelona, Spain, May 1999 (CD ROM).
- Itoh, K. and Andersen, H.B. (2004). Reasons for Not Reporting Adverse Events: The Views of Danish and Japanese Healthcare Staff. Paper presented in the *9th European Forum on Quality Improvement in Health Care*, Copenhagen, Denmark, May 2004.
- Itoh, K. and Andersen, H.B. (2007). Causes of Medical Errors as Perceived by Patients and Healthcare Staff. Proceedings of the European Safety and Reliability Conference 2007 -- ESREL 2007, Stavanger, Norway, June 2007 (In T. Aven and J.E. Vinnem (Eds.), Risk, Reliability and Societal Safety, Vol. 1: Specialisation Topics, pp.179-185, Taylor & Francis, London).
- Itoh, K. and Andersen, H.B. (2009). Patient Reactions to Staff Apology after Adverse Event and Changes of their Views in Four Year Interval. *Proceedings of the Working Conference on Human Error, Safety and Systems Development*, pp.16-30, Brussels, Belgium, September 2009.
- Itoh, K., Andersen, H.B. and Seki, M. (2004). Track Maintenance Train Operators' Attitudes to Job, Organisation and Management and Their Correlation with Accident/Incident Rate. *Cognition, Technology & Work*, 6(2), 63-78.
- Itoh, K., Andersen, H.B., Seki, M. and Hoshino, T. (2001). Safety Culture of Track Maintenance Organizations and Its Correlation with Accident/Incident Statistics. *Proceedings of the 20th European Annual Conference on Human Decision Making and Manual Control*, pp.139-148, Copenhagen, Denmark, June 2001.