Interactive systems need safety locks

Harold Thimbleby Swansea University

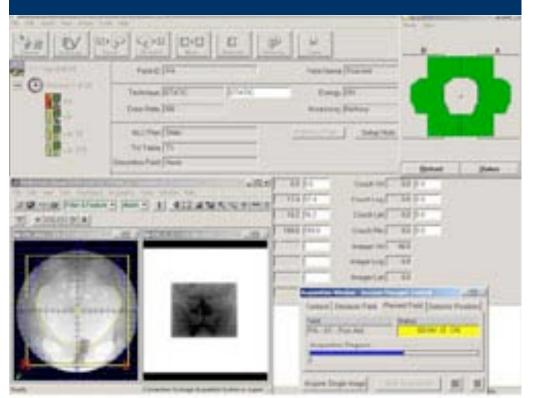












Panama incident, 2000–2001

18 patients died

2 radiologists imprisoned for manslaughter

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support bulletins, read FAQ's

routine.

The user must CAREFULLY check if results are correct BEFORE using in treatment.

A USER SHOULD VERIFY THE RESULTS THROUGH INDEPENDENT MEANS until the USER'S PROFESSIONAL CRITERIA IS SATISFIED.



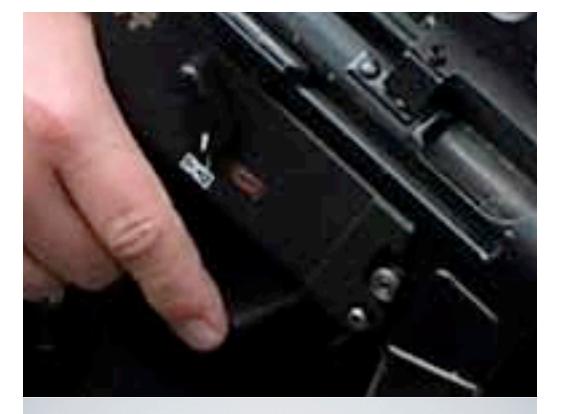
Paraphrased...

We make dangerous things.

There are no designed-in safety locks.

It's your fault if anything goes wrong.



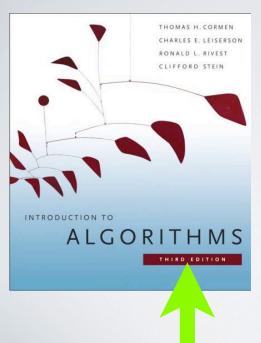


Why safety locks?

- I. People make slips
- 2. Safety locks stop some slips causing harm
- 3. Bad design allows slips to cause harm

Interactive systems need safety locks

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1292 pages "beautifully written introduction to design of algorithms" "the bible of the field" "best textbook ever seen"

> "We do not address error-handling"

Java

System.out.println(12345678 +87654321)

21111110

System.out.println(12345678 +8765432)

happens everywhere

Java

System.out.println(1111111111 +111111111)

-2072745074

Learned?

- Human slips get incorrect results
- Slips go undetected
- Applications do not provide "safety locks"
- Bad design causes errors

Name: ID: Prep:	(Orientation of Patient:		HFS Head First Subine HFP Head First Prone FFS Feet First Prone FFP Feet First Prone		Modality: 6MV X-ray			_	-		
Date: 19-Jun-10	Coo	rdinates of I	encentre:	9.3	-0.3	-1.7	Cm			4	12	. 4
Chkd: Date:		inates of No		11.9	-0.3	-5.5	cm			L	4	
				Field 1	Field 2	Field 3	Field 4		-	1	*1	
		Gant	try Angle:	302	126	0	0	degree	-	1	2.1	
		Collimator Angle: Turntable Angle:			280 0	0	0	degree degree	-	1		
									-	-		
		Norm Point Depth:		5.0	5.0	5.0	5.0	cm	=	*	, Z' Z,	4
		SSD for Norm Point: Open OAR _n :			90.7 1.017	98.8 1.026	98.8 1.026	cm	X1		4	
									-		•1	
	Radial Distance: In-plane Wedge OAR _{wv} :			1.8	1.6	2.5	2.5	cm	-		· ·	
				1.183	1.168 1.6 1.002	1.000 0.0 1.014	1.000 0.0 1.014	cm	F	-		-
YI Y2	0/	OAD in Y1-Y2 direction: Cross-plane Wedge OAR _{wx} :							Ξ	2	$ Z_i \ge$	
	Cross											
X2	04	OAD in X1-X2 direction:		-0.3	0.3	2.5	2.5	cm			.1	
	Con	Combined Wedge OARw:			1.168	1.014	1.014			1	2	
		Radial Distance:		1.8	1.6	2.5	2.5	cm		-		
•				Field 2		Field 3		Field 4		÷.	217	
		Y	x	Y	X	Y	X	Y	X	1	. 1	
orm Point at Isocentre Level		1.7	-0.3	1.6	0.3	0.0	2.5	0.0	2.5		¥1	_
		_		_	<u> </u>	_		-		-		
ff-axis Ratio	OAR	1.184	1.018	1.168	1.017	1.014	1.026	1.014	1.026			



267 () POL



- Errors **always** happen
- Safety locks **reduce** errors and their consequences

93% of nurses make numerical errors

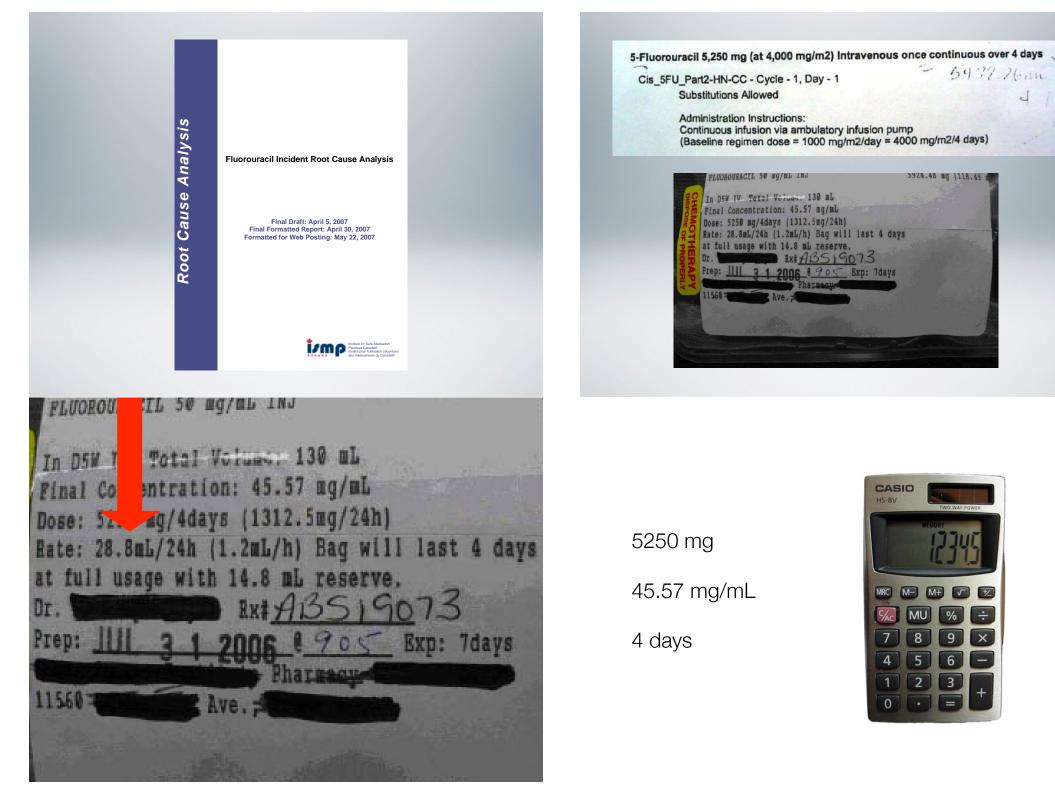
I D Kapborg, "Calculation and administration of drug dosage by Swedish nurses, student nurses and physicians," *Int J Quality in Healthcare*, **6**(4):389-395, 1994.

If we know that, why aren't there safety locks?

Denise Melanson 22 August 2006



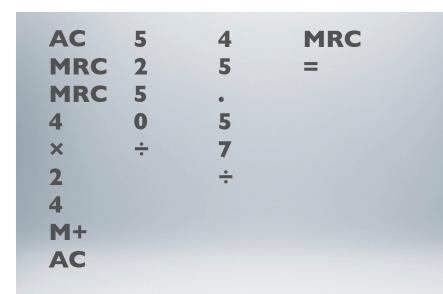




 $\frac{5,250 \text{ mg}}{45.57 \text{ mg per mL}} / (4 \text{ days x } 24 \text{ hours per day})$

Four problems

- Calculators are different
- People make slips
- Calculators don't detect or block errors
- Things will go wrong



22 keystrokes



only blocks 2 errors



I SELECT M9/ML 3 SELECT M2/ML 3 SELECT M2 M SP B A 1 M SP B A

Safety locks block slips



Safety locks block slips

 Press I.2 3

 Abbott 999, I23, I.2, I:23AM, I:23PM

 Graseby 3400 I.3

 Casio HS8V, HS85 I.23

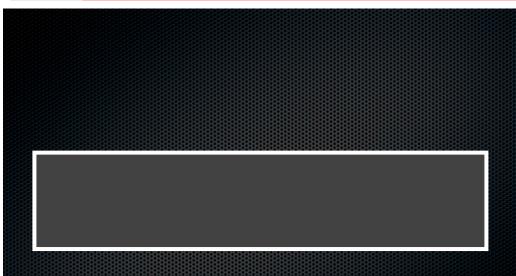
 Mathematica 0.36

 Excel 0

 Word I.5

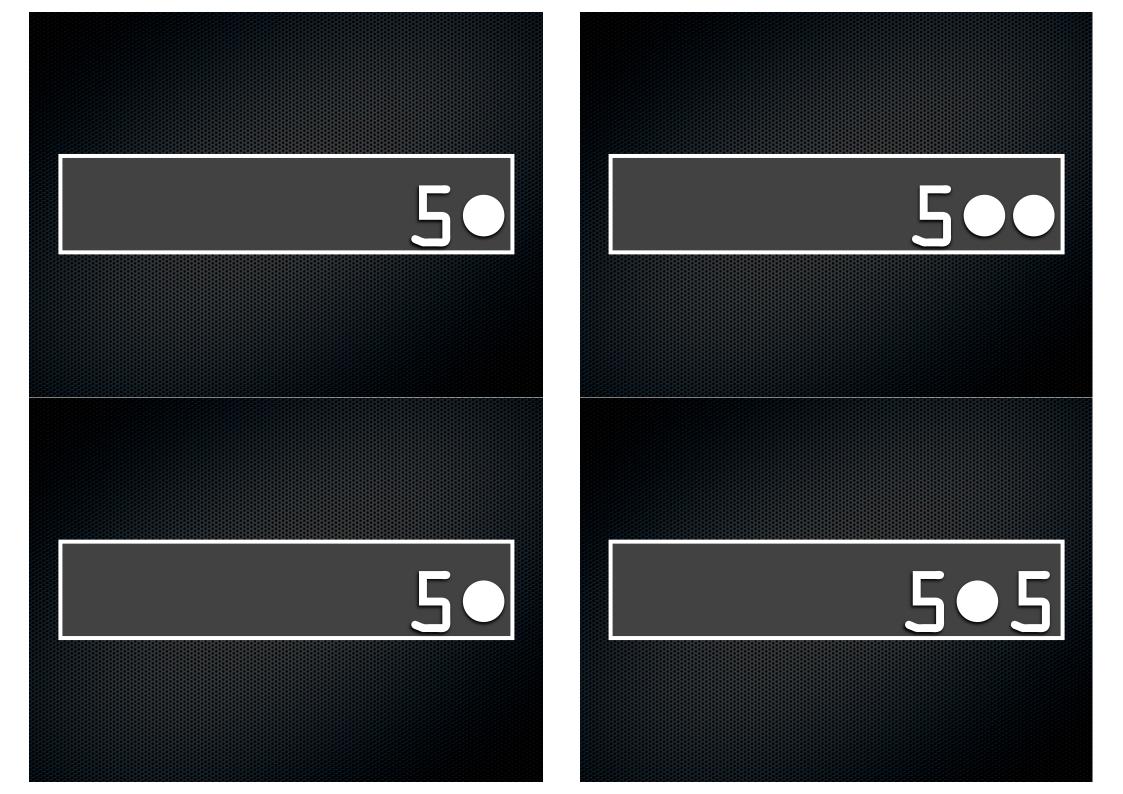
 Alpha 6

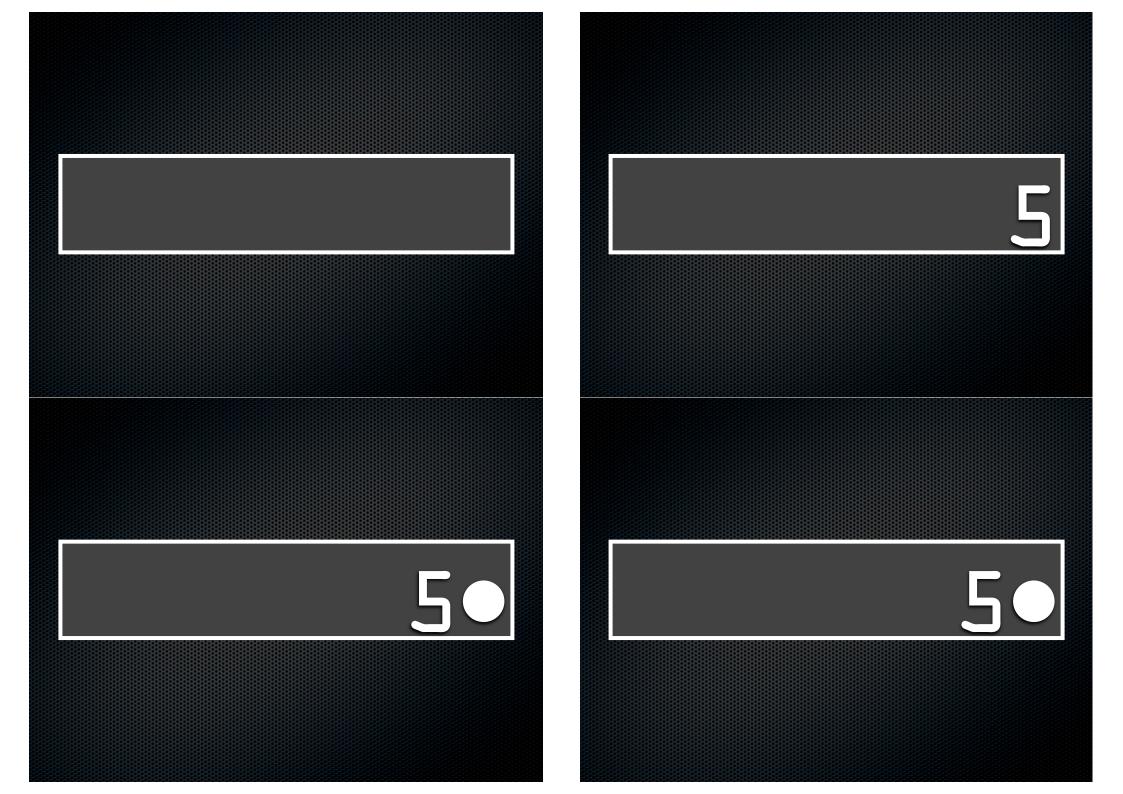
Keys	Me	Ji	J2	Gr	Nı	N2	J3	J4
.0000001								true
.1								
0.25								true
0666								true
8.0								true
87.23								true
99								true
123								false
1.2.3								false
.1.2.3.								false
.1								false
Text!								false
								true
+3	error	3	3	0	0	NaN	false	true

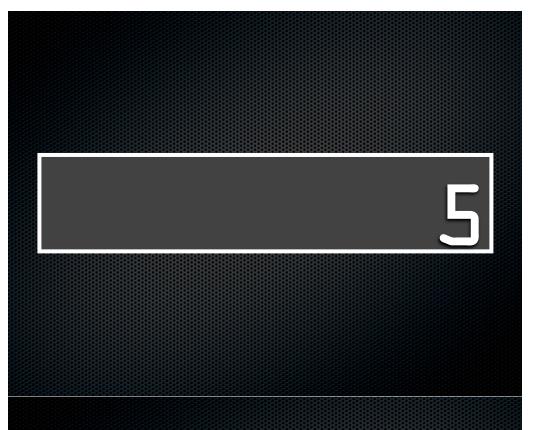


Task — enter 5.5 mg

Patient dies Log shows 55 mg Should be 5.5 mg Nurse at fault







Nurse thinks 5.5

Log shows 55

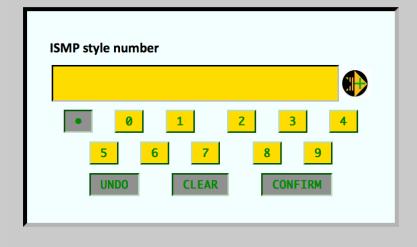
55

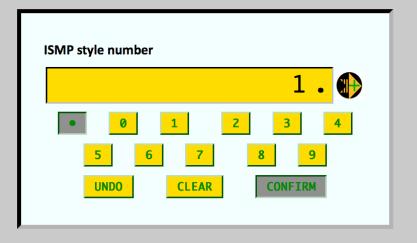
what can we achieve with safety locks?

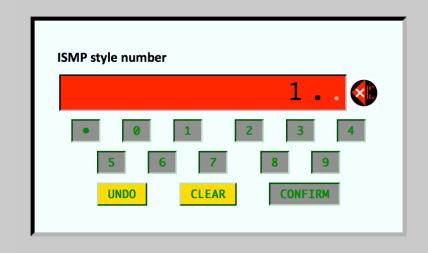


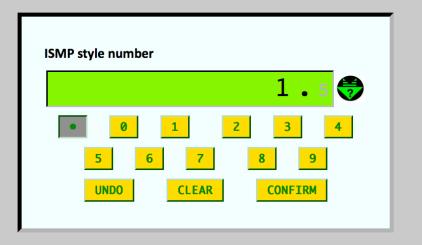








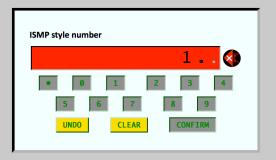






- Where's the safety lock?
- You cannot make data entry errors





is it any good?

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Reducing number entry errors: solving a widespread, serious problem

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Number entry is ubiquitous: it is required in many fields including science, healthcare, education, government, mathematics and finance. People entering numbers are to be expected to make errors, but shockingly few systems make any effort to detect, block or otherwise manage errors. Worse, errors may be ignored but processed in arbitrary ways, with unintended results. A standard class of error (defined in the paper) is an out by 10 error', which is easily made by miskeying a decimal point or a zero. In safety-critical domains, such as drug delivery, out by 10 errors generally have adverse consequences. Here, we expose the extent of the problem of numeric errors in a very wide range of systems. An analysis of better error management is presented: under reasonable assumptions, we show that the probability of out by 10 errors can be halved by better user interface design. We provide a demonstration user interface to show that the approach is practical.

To kill an error is as good a service as, and sometimes even better than, the establishing of a new truth or fact.

(Charles Darwin 1879 [2008], p. 229)

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Why safety locks?

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ideas

- 1. Safety locks work
- 2. They aren't difficult to program
- 3. They save lives
- 4. Go and put them in!

Press On Principles of interaction programming

MIT Press, 2007

Only 200K hb / 150K pb £25 hb / £18 pb



mitpress.com/presson

- \cdots Think of a dose
- ••• Say, 5•5
- •••*Sometimes* make slips
- ••• Enter 5•5 58 5••5 etc
- Classify out-by-ten errors

