Chapter 47
The Perspectives of Medical Errors in the Health Care Industry

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ABSTRACT

This chapter presents the overview of medical errors; drug prescription errors and prescribing; the overview of medical error disclosure; medical errors and telemedicine; medical errors and medical education; the overview of nursing medication errors; and the aspects of medical errors in the health care industry. Reducing medical errors, increasing patient safety, and improving the quality of health care are the major goals in the health care industry. Medical errors are caused by mistakes in drug prescription, dosing, and medical administration in inpatient and outpatient settings. Heath care-related guidelines, institutional safety practices, and modern health care technologies must be applied in hospitals, clinics, and medical offices to reduce the occurrence of medical errors. The chapter argues that understanding the perspectives of medical errors has the potential to enhance health care performance and reach strategic goals in the health care industry.

INTRODUCTION

Health care organizations face a wide range of internal and external factors that enable their ability to provide safe, quality, and reliable health care services (Pate & Swofford, 2016). Medical errors are one of the major threats for patient safety in all countries (Pazokian, Tafreshi, & Rassouli, 2014). Medical errors remain the most commonly occurring error in the health care area (Absulem & Hardin, 2011). The avoidable sources of medical errors include the failure to take a biopsy despite suspicious clinical findings, or incorrect clinicopathological correlations resulting in deleterious effects for the patient (Lehmann, Wesselmann, Weber, & Smentkowski, 2015). Clinicians involved in medical errors can experience significant distress (McLennan et al., 2015). The review and analysis of medical errors have emphasized their preventable potential for reoccurrence (Olaniyan, Ghaleb, Dhillon, & Robinson, 2015).

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There is evidence that providers are reluctant to make the compensation for medical errors until a lawsuit is filed (Gawande, 2007). The rising health care costs, partially due to preventable medical errors, lead many hospitals to redouble their process improvement efforts (Gowen, McFadden, & Settaluri, 2012). The impact of digitization has important effect on teleexpertise, where a medical professional can remotely ask health care advices through the utilization of information and communication technology (ICT) toward providing medical treatment to a patient in remote environment (Doumbouya, Kamsu-Foguem, Kenfack, & Foguem, 2015). However, the outcome of such advice remotely obtained can lead to medical errors. It is important to determine whether the causes of the errors can be avoidable or not for the purposes of establishing the truth and assuring justice for the victims of medical errors (Doumbouya et al., 2015).

Providing effective health care service gains an increasing attention over the past few years (Chetouane & Ibraheem, 2016). There is an increasing need for the process improvement in health care systems regarding quality, safety, effectiveness, suitability, speed, efficiency, and uniformity (Institute of Medicine, 2001). Health care managers can make a major impact on safety culture development by promoting the patient safety-related strategies and fostering their employees' motivation to implement the health care improvement programs at the individual and departmental levels (Kagan & Barnoy, 2013). To improve patient safety, hospital managers should establish the reporting mechanisms at the national and international levels (Brady, Malone, & Fleming, 2009).

The chapter is based on a literature review of medical errors. The extensive literature of medical errors provides a contribution to practitioners and researchers by presenting the advanced issues of medical errors in order to minimize the medical errors in global health care.

BACKGROUND

For years, health care experts have recognized that medical errors exist and compromise health care quality (Vozikis, 2012). Errors are defined as any deviation from established standard operating procedures (Maskens et al., 2014). Studies of medical errors demonstrate that errors and adverse events are common in hospitals (Shah et al., 2009). Preventable error, malpractice, and complications can be considered as adverse events (Zientek, 2010). The adverse events rates and medical lawsuits are on the rise, whereas many medical errors are mostly due to negligence or malpractices which are preventable (Wong & Balasingam, 2013). Being able to understand health information and make decisions from that information is vital to patients' well-being (Kasemsap, 2017a).

Medical errors are the medical mistakes that can lead to serious consequences and even death of patients (Pazokian et al., 2014). Ammouri et al. (2015) indicated that patient safety is considered to be crucial to health care quality and is one of the major parameters monitored by all health care organizations around the world. Patient safety is a central issue of health care provision (Lehmann et al., 2015). Many quality improvement education programs have been introduced over the last decade with the purpose of enhancing patient safety (Gordon, Darbyshire, & Baker, 2012).

Patient safety remains a global challenge affecting many patients throughout the world (Schwappach, 2014). There are various approaches toward improving health care provision and patient safety in the health care industry (Lehmann et al., 2015). Critically ill patients need life saving treatments and are often exposed to medications requiring careful titration (Manias, Williams, & Liew, 2012). Improving patient safety hinges on the ability of health care providers to accurately identify, disclose, and report