

## Chapter 9

# Adverse Events and Medical Errors in Greece: Knowledge Creation and Capture Methods

Athanassios Vozikis  
University of Piraeus, Greece

### ABSTRACT

*For years, experts have recognized that medical errors exist and compromise healthcare quality. Much has been written worldwide about medical errors and improvements in their reporting and handling, with the proposals ranging from the implementation of nationwide mandatory reporting with public release of performance data to voluntary reporting and quality-assurance efforts that protect the confidentiality of error-related data. In the present chapter, the author first points out the lack of standardized nomenclature and a universal taxonomy-classification for adverse events and medical errors, which complicates the development of a response to these issues. The chapter also reviews a number of methods of and adverse events' and medical errors' knowledge management, each of which has evolved over time and been adapted to different contexts. Finally, the author assesses each of these methods, unveiling their particular strengths and advantages, and also weaknesses and limitations.*

### INTRODUCTION

For years, experts have recognized that medical errors exist and compromise health care quality, but the response to the November 30, 1999, release of the Institute of Medicine's (IOM) report, "To

*Err is Human: Building a Safer Health System*", brought medical errors to the forefront of public attention (IOM, 1999). In March 2001, the second IOM report, "Crossing the Quality Chasm: A New Health System for the 21st Century", was published (IOM, 2001). The 'chasm' report extends the findings of the 'error' report to other important dimensions of healthcare quality.

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The reports concluded that the majority of these errors were the result of systemic problems rather than poor performance by individual providers, and outlined a four-pronged approach to prevent medical mistakes and improve patient safety.

Much has been written worldwide about medical errors and improvements in their reporting and handling since then.

Recently, the Eurobarometer survey, which was released by the European Commission (*E.C., 2005*) found that almost half of those surveyed said that hospital patients should be worried about being victims of medical errors.

In this paper we first point out the lack of standardized nomenclature and a universal taxonomy-classification for adverse events and medical errors, that complicates the development of a response to these issues and we also review a number of methods of studying errors and adverse events, each of which has evolved over time and been adapted to different contexts. Moreover, we assess each of these methods unveiling their particular strengths and advantages, and also weaknesses and limitations.

In detailed, in sections 1 and 2, the definitions, context and the most accepted classifications of characteristics and consequences of *adverse events* and *medical errors* are given.

In sections 3 and 4, the framework for identifying medical errors, as well as the methods of medical errors' knowledge creation and capture, are presented.

Finally, in section 5, conclusions are drawn for medical errors and adverse events in Greece.

## **1. DEFINITIONS AND CONTEXT**

The lack of standardized nomenclature and a universal taxonomy for adverse events and medical errors complicates the development of a response to the issues outlined in this paper. A number of definitions have been applied to medical errors and patient safety.

The World Health Organization (WHO) Collaborating Centres for International Drug Monitoring defines an adverse drug event as follows (WHO, 1984):

- *Noxious and unintended and occurs at doses used in man for prophylaxis, diagnosis, therapy, or modification of physiologic functions.*

In *To Err is Human*, the IOM adopted the following definitions:

- An error is defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.
- An adverse event is defined as an injury caused by medical management rather than by the underlying disease or condition of the patient

In an effort to thoroughly consider all of the relevant issues related to medical errors, the QuIC expanded of the IOM definition, as follows (*QuIC, 2000*):

- An error is defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems.

## **2. CLASSIFICATIONS**

Most people believe that medical errors usually involve drugs, such as a patient getting the wrong prescription or dosage, or mishandled surgeries, such as amputation of the wrong limb. However, there are many types of medical errors. The following seven categories summarize types of medical errors that can occur (Bates et al., 2003):

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