Good example of medical errors and proposed solutions essay

Business, Strategy

Medical errors are unavoidable, even with the best possible human intervention, preventative measures and system input, as is witnessed through the many deaths associated with hospitalization and medical care. A medical error pertains to the failure of a given prescribed treatment procedure, which has the potential of causing the patient harm. Causes are often varied, interrelated, and in ways in which a single individual or system device cannot be solely blamed. Towards preventing medical errors, proposed solutions exist through varying avenues: enhanced medical staff training and error awareness, as well as the general improvement of the prevailing monitoring systems present. This would require co-relational input from various sectors pertinent to a prevailing health and medical system (Lucian, Berwick, & Bates, 2002).

Odwazny (2004) states that medical errors are not entirely attributable to human input as the adverse effects would showcase. Rather, some adverse complications are often the result of various medical contexts as exemplified by high-risk operations, patient condition prior to operational procedures, facilities and medications present, amongst others. With human fallibility and system complexity being some of the reasons for the inevitability of medical errors, the improvement of patient safety is requisite, through three core strategies. Consequently, it is vital to recognize that the multiplicity of factors, especially in a system as complex as the medical arena, are core reasons for eventual medical errors and the resultant fatalities (Odwazny, 2004).

Pertinent to better understanding the above medical contexts would be an analysis of the Medical Error theory. This theory provides for various issues

and factors that influence the resulting errors experienced. In addition there is provision of strategies with which to improve overall patient safety and care. Strategies are majorly categorized into three: First would be concerning the point of care because there is need to prevent errors by way of forcing functions, in addition to providing reminders as well as reducing overall system complexity. Secondly, all concerned professions in the medical field, should be able to not only identify, but also eliminate potential (latent) errors, prior to their negative effects on patients. Third, would be the core aspect of establishing requisite defensive barriers, crucial in intercepting such potential errors, and further aid in their mitigation or alleviation (Gluck, 2008).

There should be a better understanding and distinction of various medical drugs, especially pertaining to their inherent active components, in relation to the whole product itself. Additionally, evidence based research should be increased so as to better understand the existent variations of drug component effects, under various medical conditions and procedural measures. By better understanding medical prescriptions, dosages and effects, the medical fraternity will be further enhanced by way of utilizing technologies. These technologies, for example, computerized provider order entry systems, would reduce overall patient harm and unfortunate deaths (Karsh, 2004). Pertinent to this would be greater development in the human engineering aspect of such systems, to complement medical professions' overall input.

References

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