Medical errors are very popular in mass media. They cover newspaper front pages and make simple people lose their trust in health professionals and mainly in doctors. Patients have always been seeing doctors as magicians. They really don’t think about the possibility of having a bad outcome during their therapy. They cannot imagine that they will suffer from a complication after an operation. They usually do not want to accept the possibility of death for their beloved person who is admitted in the Hospital. Thus, medical errors should firstly be seen as unexpected events.

Medical errors are unexpected by many doctors, too. Most doctors believe that their patient will be successfully treated after his operation, will not present a complication and will certainly not die. This belief makes medical complications become unexpected by medical doctors, too. The problem is that if you do not think about the complication, you may also not search for it. If you do not search for complications, then you may discover them later than normal!

If medical errors were not considered unexpected by both medical doctors and patients, then things would be more simple. For example, many patients are fond of operations raising their earnings or for teaching more trainees in the operating theatre or because they think that their intervention/surgery cannot harm the patient and thus it is equal to a non interventional treatment. If medical interventions were limited to the needed ones only, then medical errors should firstly be seen as unforeseen events.

Not only did the NCC MERP produce the nation’s first comprehensive taxonomy for studying medication errors, it also established the following definition of a medication error: A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems including: prescribing; order communication; product labeling, packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.

Medication Error Severity

One of the most important steps in analyzing medication error data is understanding its severity. NCC MERP developed an Index for Categorizing Medication Errors for determining the outcome or effect of the medication error on the patient. The Index contains four major subscales; these include potential for error, actual error that did not reach the patient, actual error that reached the patient but did not result in harm, and actual error that reached the patient and resulted in harm.