# Preface

Medical errors exist and can provoke discussion and debate about quality and patient safety issues of health care provision, with multiple and complex social and economic implications. The starting point for bringing them to the forefront of public attention was the reports of Institute of Medicine titled "To Err is Human: Building a Safer Health System" and "Crossing the Quality Chasm: A New Health System for the 21st Century". On the report of Quality Interagency Coordination Task Force (n.d.), a medical error was determined 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". Researches worldwide revealed that the number of patients who have experienced a medical error in healthcare is worryingly high, while a significant proportion of harm refers to medical errors reasonably preventable. Under the burden of serious economic and social implications of physical harms and the finding that the root causes are mainly systemic in the overall health system, it is essential to take strategically designed actions to reduce medical errors, involving the health care professionals and patients, using Information Technology for detecting, reporting and analyzing the medical errors.

This book explores the impact of medical errors on patient safety, healthcare quality and on fiscal consolidation and cost containment on healthcare systems and looks to initiate a debate among health decision makers, health professionals and patients about accurate reporting of medical errors for empowering the culture of patient safety and healthcare quality. Additionally, chapters address the hidden weaknesses, failures and malpractices existing in healthcare systems globally, the variety of medical errors' measurement methods, and the different aspects of incident reporting systems implementation. This book aims to be an essential reference source, building on the available literature in the field of the detection and analysis of the various implications of medical errors while providing for further research opportunities in this dynamic field.

Health decision makers, health managers, health professionals, patients, medical malpractice lawyers, academicians, researchers, advanced-level students, healthcare information technology developers, and government officials will find this book useful in furthering their research exposure to pertinent topics in the various implications of medical errors.

It is hoped that this book will provide the resources necessary for health decision makers and health professionals to adopt a culture of openness and implement a systematic review of medical errors in order to improve the quality of care and patients' safety in the healthcare system, worldwide as well as to achieve the health care cost containment.

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## REFERENCES

Quality Interagency Coordination Task Force. (n.d.). Retrieved from https://archive.ahrq.gov/quic/