

ERROR OR NEGLIGENCE IN MEDICINE: A LITERATURE REVIEW

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ABSTRACT

Medical professionals have a legal and professional responsibility to prevent harm to their patients. This means meeting each patient's standard of care for their medical condition. When a doctor makes a mistake in treating a patient, he or she may be responsible for a malpractice lawsuit by the victim. However, medicine is an uncertain field, and honest mistakes can and do happen. Everyone should know the difference between a medical error and a medical negligence. A medical professional who makes a mistake does not automatically make a medical mistake. In this review are presented literature data collected from a Medline search, regarding the medical error, fault and negligence in medical activity. The search of literature data was performed for studies published between 1994 and 2020, regarding the terms of medical fault, negligence, medical error, medical mistake and malpractice.

Key words: medical error, medical fault

Introduction

Consensus on a unified definition of what constitutes a medical error is lacking. A systematic review in 2010 showed 26 definitions. A relatively concise definition describes a medical error as "a failure in the treatment process that leads to or has the potential to lead to patient injury." (1)

The medical error defined as an adverse effect after an applied treatment is based on factors such as incompetence of medical staff, lack of education or experience, illegible handwriting, language barriers, inaccurate documentation, gross negligence and fatigue. There are also many different types of errors, from medication errors, misdiagnosis, incomplete treatments or overtreatment and surgical accidents. Medical errors are

also associated with extreme age, new procedures, the state of emergency and the severity of the medical condition being treated. (2)

A medical error is simply an error or a wrong step in the treatment of a patient's condition. Every known medical condition has a standard of care or a minimum level of treatment. If the medical professional meets this standard, but still makes an error due to unexpected or atypical factors in the case of the patient, we can speak of an error and not of medical negligence. (3)

Many medical conditions have common symptoms, and errors during the diagnostic and laboratory testing processes can lead to directions of treatments that harm the patient. Finally, the dividing line between medical error and medical

malpractice is a necessity in achieving quality health care.

Because medicine is a field with many elements that can influence obtaining a diagnosis and initiating a correct treatment, it is understandable that the number of medical errors, sometimes causing deaths, has increased greatly from one period to another. If in 1999 in the US were estimated 98,000 deaths due to medical errors, in 2010 there were 180000. The 2013 study suggested that the figures range from 210000 to 440000 deaths per year due to medical errors. (4)

The possible causes of medical errors are multiple. Frequently, establishing a correct diagnosis can be difficult either due to lack of doctor's attention (burn-out), lack of medical experience, lack of clinical and paraclinical examinations. The error in diagnosis is a common medical error. Improper diagnosis can lead to unnecessary or harmful treatment because the patient's true illness will not be treated immediately, prolonging the patient's suffering.

Another common mistake is taking the wrong medication. Prescribing the wrong dose or not following drug interactions can have harmful effects on the patient. Prescribers and caregivers should carefully consider a patient's medical history to track allergies and potentially harmful combinations of medications before administering medications. If they fail to do so or if the information is left out of a patient's table, the consequences can be very serious. In the USA, annually, between 500000-800000 such medication errors are registered, with or without serious consequences. (5)

Nosocomial infection is a risk encountered in any hospital unit or medical procedure. Most nosocomial infections are not serious and can be treated. However, some infections can become much more serious and even more lethal.

The CDC reports that every day, one in 25 patients in the hospital will receive a nosocomial infection, sometimes with fatal consequences. These infections include pneumonia, gastrointestinal diseases, urinary tract infections, primary bloodstream infections, and surgical site infections from inpatient surgery. Most nosocomial infections can be prevented or controlled if medical institutions implement appropriate procedures.

The technology used in therapy can sometimes be the cause of medical errors. Often, a medical error is not an error at all, but rather the result of an unsafe medical device. In this situation we can speak of an error of fact which is the consequence of an imperfection of medical science at that time or of a particular reactivity of the patient. This type of error occurs during the practice of the medical profession, even if the rules of professional conduct are observed. Anyone placed in the same working conditions can make a de facto error. It is considered that errors in fact are becoming more frequent due to technological advances.

A medical error as a mistake does not affect only one person, the costs of a certain medical error can actually have an impact on a large number of people and institutions. A 2008 study put the direct financial costs of medical errors at more than \$ 17 billion, and that figure does not include the indirect costs to patients, their families, and their employers. Taking into account the other costs of injuries,

illnesses and deaths due to medical errors, the price could total up to \$ 1 trillion per year.

Medical malpractice (error of norm) occurs when a doctor does not meet the standard of care for a patient or commits an error that another professional with a similar qualification in the same conditions, would have observed and applied. These types of errors can be generated by commission (actions that are not necessary, but are taken by the healthcare professional) and by omission (when actions by the doctor are required, but they are not taken).

Clinical errors and malpractice claims are increasingly important aspects of medical practice. Acquiring a disabling disease due to medical intervention contributes to the cost of care, which increases the costs of the health system and society at large. The report of the Institute of Medicine (IOM) estimated the total cost of medical errors at \$ 17-29 billion per year (5). The report also estimated that there were an additional 7,000 deaths a year due to medical errors.

Studies to date have indicated that over 70% of errors that led to complaints of malpractice were considered preventable cases; half of the errors occurred in outpatients and most commonly involved antibiotics, antidepressants, cardiovascular agents, anticoagulants and corticosteroids. Other causes of complaint were lack of adequate informed consent (36%) and failure to diagnose or misdiagnose (22%) (6,7)

A large number of complaints are registered annually and in the case of surgical interventions (thyroid surgery (45%), oncological surgery (51%) (8,9), in bariatric surgery the frequency of intra and

postoperative complications ranged from 32% to 53% (10) and in OMF surgery up to 50%. The causes of malpractice complaints ranged from failure to sign informed consent, diagnostic errors or intraoperative errors.

Another important element in the occurrence of errors and mistakes in medicine is the poor communication between doctor and patient, medical institution and patient. In Japan, there is evidence that courts are beginning to consider the inadequate provision of information to patients as a breach of the duty to care. (11) But, perhaps more importantly, the doctor's explanations and communication with patients seem to influence the likelihood of allegations of malpractice (12, 13).

Certainly, not all clinical errors lead to complaints of malpractice and not all complaints of malpractice are the result of clinical errors. There are factors that influence patients' decision to file a complaint: (1) a poor relationship with providers or clinicians before the alleged injury, (2) televised advertising of law firms, (3) explicit recommendations from health care providers or professionals seek legal advice, (4) feeling uninformed and (5) financial concerns (14).

There are many strategies proposed to reduce the incidence of clinical errors. Government institutions in several countries support the establishment of leadership and research tools to increase the knowledge base on patient safety. They also advocated for a public system of public data reporting at the national level to help identify and learn from mistakes. In the UK, (15) the required changes should include unified reporting and analysis mechanisms when things go wrong, a

more open culture where errors or failures can be reported and discussed, and preventive mechanisms to reduce the risk of medical malpractice.

At a practical level, greater team training is needed to improve patient safety and improved patient safety as a result of such training (16).

The use of electronic prescribing technology and information technology has been extensively investigated as a method of reducing prescribing errors (17 - 19) and has proven to be effective [66 - 68]. The use of computer-based protocol reminders seems to reduce errors, regardless of the clinician's seniority, and is supported as a means of improving patient safety (20,21). There is growing evidence that systems that use information technology (IT), such as the computerized input of physician commands, automated dispensing cabinets, the administration of barcode-coded drugs, and are key components of strategies to prevent administration errors of medicines. It has also been reported that IT systems have the potential to save up to \$ 88 billion over 10 years in costs in the United States, with the increasing adoption of IT technology in the medical environment (22,23). Hospitals that have automatic notification and registration systems, order entry, and clinical decision support have fewer complications, lower mortality rates, and lower costs (24,25). Computer-assisted decision-making also seems helpful, as do diagnostic accuracy assurance systems using algorithms, checklists, instructions,

and guidelines (26). Some commentators argue that the desire to reduce medical errors by using a combination of incident reporting and emphasizing a systemic approach is unlikely to be useful, as clinicians' behaviors are based on personal identities that may be contrary to guidelines and / or protocols (27). In addition, professional independence, suspicion of managers and values of clinicians can be significant obstacles to a systemic approach to reducing clinical errors (28). In short, a systematic approach to the development of methods to prevent clinical errors is at the beginning.

Conclusions

The causes of medical errors are multiple: error in diagnosis, lack of medical experience, lack of clinical and paraclinical examinations, incomplete treatments or overtreatment, poor communication between doctor and patient, technology failure and surgical accidents. The important thing for us to realize about medical errors is that they can be prevented almost entirely. Some of these mistakes are made through negligence, others are caused by deficiencies in communication between medical professionals, and others are caused by overworked employees at facilities with insufficient staff or technology. There are certain things we can do to prevent medical errors in our lives, such as using IT systems that effectively help us to decrease the possible human error.

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