



# NEGLIGENCE AS THE MAIN MEDICAL ERROR BY THE SURGICAL TEAM: AWARENESS SURGICAL AND PRAXIS.

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## Abstract:

**Objective:** Determine the factors influencing the negligence associated with mistakes in the patient in the different institutions providers of health care.

**Methodology:** For bibliographic documents locating several sources and documentary were used. Bibliographic search was conducted in February 2019 in Ebsco, Pubmed, using descriptors; scientific writing, review of database of the library of the University, critical reading. Obtained records ranged between 85 and 16 registers after the combination of the different key words. The articles were sought between the years 2003 to 2019.

There was also a search on the internet in the 'Academic Google' search engine with the same terms. We selected those documents which inform about the negligence, errors, surgical awareness.

**Conclusion:** Within the literature reviewed could be observed that there are different factors that can reach in the surgical equipment surgical negligence. Yet this may be one the causes of that patient can be affected physically and psychologically they may even die.

**Keywords:** Damages and perjuries, demand, negligence, errors, surgical conscience, adverse events, professional ethics.

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## 1. Introduction

Over time it has been possible to identify a number of definitions and concepts of quality of care in general, focusing on well-being and patient perspective (Aguirre-Gas, Zavala Villavicencio, Hernandez-Torres, Fajardo-Dolci & 2010) Also negligence and other errors are permanent motifs in

all surgical procedures due to its disastrous consequences and high morbidity and mortality and mortality that has been generated in the professional responsibility of the surgical staff (Torres, 2008).

Medical malpractice committed by a professional health commonly associated with physicians who perform acts not appropriate or not having the diligence required for these types of procedures, causing harm to patients( "Introduction Medical Malpractice" sf), Unlike the error that is a bad practice when having surgery, this error is independent of the damage that may occur in the patient's health. A serious error also a detrimental outcome that does not derive from the doctor's fault in the production of damage but all the individual or collective care medical equipment(Szánthó P, 2001). For a good procedure should take steps to avoid adverse events that bring damages as consequences in the lives of patients. It is important to recognize the concept of quality in medical procedures to determine errors malpractice and professional responsibility in order to resolve them and prevent them(Aguirre-Gas et al., 2010). To determine the factors that influence negligence associated to mistakes in patient care in different health institutions(Aguirre-Gas et al., 2010).

## 2. Methodology.

For locating several documents bibliographic and documentary sources were used. literature search was conducted in February 2019 in EBSCO, PubMed, using descriptors; scientific writing, reviewing database of university library, critical reading. Records obtained ranged between 85 and 16 records after combination of different keywords. Articles were sought between the years 2003 to 2019.

A search was also conducted online in the search engine 'Google scholar' with the same terms. those documents report on negligence, errors, surgical awareness were selected.

## 3. The concept of error, accordingly present and adverse events in the surgical team.

The error can be defined as the failure of a planned action to be completed and that was executed defectively (technical error); or the use of a wrong plan to achieve an objective (error of planning)(Prado, sf). Likewise, the fundamental difference between complication or adverse event and error are just that in the latter preventing through current medical knowledge could have avoided the adverse event. Therefore, it is essential to define patient safety as any act that seeks to avoid, prevent or minimize the adverse outcome, or stop the damage that occurs in the process of care

and resulting cost and measurable disability(Arenas-Marquez & Anaya-Prado, 2008).

Since the surgical patient management requires the involvement of a multidisciplinary and interdisciplinary team, usually the error is not the result of individual actions, rather it is the predictable consequence of a series of actions and factors include the process of diagnosis or treatment in a health system. Currently six factors as causes of complications and errors in surgery are recognized: 1- Organization; Situational 2-; 3- Task Force;Human 4-; 5- Routine, and; 6- patient. In the team, error prevention is critical, "communication", trust between team members and the ability they have to handle these unexpected events. A good surgeon makes up a good team that would ensure quality of care and thus reduce errors. Poor communication leads to serious physical consequences, health and moral for the patient(Arenas-Marquez & Anaya-Prado, 2008).

Often in publications reporting on morbidity and operative mortality. Surprisingly, these reports are always within the ranges reported in the world literature. Additionally, the results of surgical morbidity related errors are usually reported by a penalty by medical personnel. Thus the opportunity to improve professional performance by taking as its starting point the critical analysis of mistakes is limited(Arenas-Marquez & Anaya-Prado, 2008).

## 4. Etiology of error: Negligence generates the error?

Since the nineteenth century there is evidence of interest in mortality caused by negligence that fails, clearly identifying the lack of knowledge and skills, and poor diagnosis and surgical judgment and causes of errors. Currently poor organization, lack of teamwork, and factors related to physician and patient are recognized( "Introduction Medical Malpractice" sf).

Errors in the operating room can have catastrophic consequences for patients, relatives, staff of the surgical team and the institution as a whole. Compresses forgotten, operations in the wrong place, blood transfusions and organ transplants bad typified can be the result of poor interpersonal dynamics, where failure "communication" and collaboration in the surgical team members(Institute of Medicine (US) Committee on Quality of Health Care in America, 2000). Given these events, also generated by checklist, localization of anatomy, correct the mistake in patients, medical history and lack surgical guide

verification. While these are certain errors resulting from negligence of the surgical staff, he could do cause of death, and this would bring consequences for both the personnel in the operating room and patient. Also being patient. Precisely the Commission on Accreditation of Health Institutions in the US(Doyle et al, 2013;. "Sentinel Event | Joint Commission 'sf). He identified the flaws in the "communication" as the root cause of operations in the wrong place and other adverse events(Makary et al, 2006; "Sentinel Event | Joint Commission," Sf.).

Moreover, surgery patients are involved in up to 45% of adverse events. There are estimates that the percentage of surgical events that may occur while a patient is in surgery vary from 35 to 66%(Flin, Yule, McKenzie, Paterson-Brown, & Maran, 2006). In view of this literature, and errors percent increase from 2003 to 2008 have changed in magnitude, while the literature says that errors represent the eighth leading cause of death. Of particular interest is the General Surgery, where you can document legal responsibility for more than 80% of cases(Flin et al., 2006).

The error is common and can cause damage. However, to isolate the factors that underlie specific types of errors has proven to be a formidable task. The types of errors that occur vary widely due to the extreme complexity and heterogeneity of the tasks involved in care. Also a persistent error is poorly understood but leave sponges or instruments in patients undergoing surgery. Such accidents can result in major injuries. In a report on 24 cases of foreign bodies retained after intra-abdominal surgery, complications observed included bowel perforation, sepsis and in two dead patients(Gonzalez-Ojeda et al., 1999). As a result currently these types of situations occur that impact worldwide. If a count is incorrect, ie, they do not take into account all materials, you must perform an X-ray or a manual scan. In case series published, some incidents appear to be the result of a breach of these rules(Kaiser, Friedman, Spurling, Slowick, & Kaiser, 1996).

However, these errors persist. Although not determined the incidence, estimates suggest that such errors occur in 1 of every 1,000 to 1,500 intra-abdominal operations(Rappaport & Haynes, 1990). Of the above tests statistical reports reveal that a total of approximately 234 million surgeries are performed worldwide each year, of which 7 million disabling complications and death occur in 1 million(Rappaport & Haynes, 1990). It has been shown that the application of the checklist has been

able to significantly reduce morbidity and mortality rates(Rappaport & Haynes, 1990).

## 5. As seen in the past, surgical error: A step to surgical conscience?

Probably there are errors in surgery since the man himself dared to violate the integrity of the human body seeking to resolve a health problem. Awareness about surgical error is also nothing new. Ernest A. Codman (1908) investigated the causes of unexpected deaths in the operating room and dared to present a classification of errors in surgery(Weiser et al., 2008):

- ✓ Surgical errors were due to the lack of technical knowledge or skills.
- ✓ Those who were due to lack of surgical judgment.
- ✓ Generated by lack of care or equipment for such affection, to negligence.
- ✓ Those caused by lack of skill in diagnosis.

In this controversial it proposed that surgical societies should require surgeons to track the results of their own cases, in order to know your statistics and skills. Surprisingly this proposal, Codman was ejected from all surgical societies. No doubt his work should be recognized pioneer in promoting the highest standards in quality surgery(Weiser et al., 2008).

The complex is that in the XXI century, it is not usual recording and analysis of surgical errors. Less is still a priority for government agencies and individual hospitals, apply professional standards and support derived privileges error analysis. Taking into account this fact, to this date still going on that no priority which involves an analysis of errors, because from there you can interrupt an error or malpractice( "Introduction Medical Malpractice" sf). All these reasons should be directed cWhen care is provided, all acts therein include should be focused on providing quality, however, under this may be situations in which the quality and therefore the care impacts of negatively because of errors, incidents, errors or adverse events like today it is called the injury resulting from the intervention of health services( "Introduction Medical Malpractice" sf).

## 6. Common Errors: Current Affairs

They are living in a world where professional surgical team often makes mistakes, and that is why so can cause serious problems to the body during a

surgical procedure, and can sometimes be as patient death ( "(PDF) Errors in surgery. Strategies to improve surgical safety 'sf).

- ✓ Lack of surgical verification.
- ✓ Clinic history
- ✓ Check list
- ✓ Operations in the wrong place.
- ✓ Lack of communication.
- ✓ Location of anatomy
- ✓ Correct the mistake in patients
- ✓ Strange objects

**Table 1. These errors are derived in accordance with all revised literatures, which were analyzed and used frequently.**

Which causes errors committed	Features
Lack of surgical verification.	Contribute to ensure compliance with the basic safety standards in surgical procedures which improve the safety of surgical patients
Clinic history	It is the relationship of life events a person of extreme intimacy data are recorded, you must have permissibility This is because the same legal standard supports medical history as an essential document.
Check list	He is credited as a tool for patient safety, certifies good practice, prevention of adverse events in the surgical area not only reduces morbidity and mortality of patients but reduces the legal risk professionals (second victims) tool of legal certainty
Operations in the wrong place	He is credited by the lack of review of the medical history of the patient
Location of anatomy	To operate the site is one of the most serious cases because there the state of health of the patient will be determined, for that reason should have trained personnel and technical knowledge for prevention.
Lack of communication.	The atmosphere is the most effective place for coexistence of the surgical team, which is why communication should be accurate, effective and clear.
Correct the mistake in patients	He is credited with being due to negligence due to lack of review of the medical history of the patient. Therefore, you should consider surgical consciousness.
Strange objects	Refers to an oversight by the surgical team, napkin, clamps, needles, cases are usually left after finishing closing the abdominal wall.

### 7. Communication process in decision-making of the surgical team: individual error or system failure.

With support form decision studying teamwork in operating rooms is a complex task, because, to begin with, the nontechnical skills that need to be considered are diverse, among many others, communication, leadership, cooperation and coordination(Polk, 2005). Moreover, as do well to note the authors, health professionals interacting in operating rooms (surgeons, nurses, anesthesiologists and implementers) have work styles and representations of the concept of 'team' different and the task of integrating these aspects although it is difficult, it is crucial to promote adequate safety culture(Polk, 2005).

Tiven leadership, communication, lack of surgical awareness and decision-making in the surgical team, gives good performance results that lead to quality health care in the patient. Therefore, teamwork is an integral component of a culture of good communication in the operating room patient safety(Arenas-Marquez & Anaya-Prado, 2008).

### 8. Alternative to assess communication effectiveness in the surgical team.

With regard to evaluating the effectiveness in communicating the teams facilitate the timely resolution of problems which has been trying negligence, error, and potential interventions in surgical care. The observed studies making this individual awareness play an important role from the perspective of the operation of surgical teams, but a complementary approach is to examine the underlying attitudes that are influencing these behaviors of members for that purpose miscommunication(Cassinello Plaza, 2015).

Therefore, one of the most efficient ways to collect that information processes is through surveys attitude of teamwork and communication to be sure the problem to solve, which allows the reduction of these kinds of errors in the statements previous(Cassinello Plaza, 2015).

### 10. Surgical awareness to improve safety in the surgical patient.

Surgical consciousness is one of the keys to minimizing negligence that this in turn generates an error, either by execution or the wrong by the surgical team plan. Such is the case of surgical verification, this in turn refers to the moral principles which govern them, in any case, for surgical equipment is a major challenge in health systems, which is based on improving the quality of care; the only effective way to achieve this is by

establishing safety measures led with responsibility. Aimed at protecting the patient. The following is proposed (Torres, 2008).

- ✓ Create safety culture (checklist, verification guide)
- ✓ Cultivate the culture of humility (communication)
- ✓ Create a culture of teamwork
- ✓ Develop a culture of open and direct communication. This section basically is to lose the fear / fear of recognition error.
- ✓ Strategies to reduce errors during surgery.
- ✓ Create a culture of voluntary error reporting

### 11. Patient safety principle.

The Institute of Medicine of the United States published their study To mistakes human (To err is human), in which surgery mistaken as one of the major mistakes made in health institutions place is included, and states that the figures more high error with serious consequences occur in intensive care units, operating rooms such as (general surgery, plastic surgery, gynecology) and ER (Patino, sf).

Every year, thousands of people suffer injuries due to surgical errors caused by negligence as mentioned that in turn generate errors. It is for this reason that, since October 2004, the World Health Organization (WHO) developed a strategy of "World Alliance for Patient Safety," which promotes awareness and political commitment to improve security attention, so, in its Second Global Challenge for Patient safety they took the safety of surgical practices. They promoted the use of the checklist or "Check List", which is currently used in various health institutions in many parts of the world ("WHO | Safe Surgery Saves Lives" sf).

This list was developed as an efficient, simple, and practical method applicable to any surgical procedure to improve safety in surgical patients

### 12. Ethical and legal aspect present in the surgical team: Liability

Each time a patient receives in the surgery department is the responsibility of all members of the surgical team. It is important to take the proper precautions and care to the patient, thus avoiding injury, damage or injury, avoid provoking a disciplinary process of being justified is a high lack of court ethics and in turn if they are sufficient merit, reach a higher instance judge and classify law

as ordinary negligence, incompetence or other (Flin et al., 2006).

It is important to clarify the basic concept of negligence, which is defined as "failure to exercise due care, or care that a prudent person would exercise under the same circumstances" (Flin et al., 2006). Within the health structure, as a company, each actor has its own functions, duties and responsibilities. This implies that everyone should perform the functions assigned and are considered, broken and measures management guidelines, now required by health agencies, targeting patient safety and with the aim of reducing human error (Flin et al., 2006).

- Ethics: philosophy explains that ethics is a science that studies human actions as they relate to the purposes that determine their righteousness. Ethics always tries to determine an ideal behavior in humans, based on the natural law of life ("Editorial Reus | Liability of medical and liability of the health authorities, Domingo Bello Janeiro | 978-84-290-1552-2 | online Buy Editorial Reus' sf).
- Adverse Event: is an injury or unintentional damage to the patient by care intervention, not the underlying condition ("Editorial Reus | Liability of medical and liability of the health authorities, Domingo Bello Janeiro | 978-84-290-1552-2 | online Buy Editorial Reus' sf).
- Neglect: evil is an act done by a person in the area of health that deviates from accepted standards in the medical community and causes injury to the patient. Performing acts is not appropriate or not having the diligence required for the particular case ("Editorial Reus | Liability of medical and liability of the health authorities, Domingo Bello Janeiro | 978-84-290-1552-2 | online Buy Editorial Reus' sf).
- Responsibility: responsibility is a very broad concept that relates to assume the consequences of those acts we do consciously and intentionally ("Editorial Reus | Liability of medical and liability of the health authorities, Domingo Bello Janeiro | 978-84-290-1552-2 | online Buy Editorial Reus' sf).

### 13. Legal process: surgical field.

Knowing the legal responsibility of the surgical team protects the integrity of their workforce,

allowing you to take what is right, what to do and know how to act when an action occurs. In any surgical procedure several professionals who make up the surgical team are present, all with the same goal (18). Significantly, against an adverse event, become blamed all members of the surgical team, according to Colombian law, they are only required to meet the people or person that led to the error, in accordance with Article 77 and 83 of Law 23 of 1981 updated on January 26, 2019(Marin, sf).

In any event, legal, personnel is part of the surgical team before the law responds individually, for it is taken into account autonomy, the degree of knowledge, expertise and professional experience. Legal aspects that shelter surgical acts should be well known by the actors of the group and should be strengthened, supported and sustained by professional ethics.

Health professionals knowledgeable of the standards system and sometimes subservient to them are shown, but ignore those that regulate fundamental aspects of its work and take precedence over other rules, which are specific to each country. For example, in Colombia the Constitution of 1991 (art. 4), which in addition to mention the right to health, also establishes the right to freedom and self-determination (arts. 16 and 28) and Law 23 1981 on medical ethics, which is not repealed in any respect by Law 100 of 1993 which regulate the specific issue of ethics prevails in these matters(Marin, sf).

#### 14. What is a medical error?

Misconception, false judgment, misguided action. Difference between a measured or calculated value and the actual value, in good faith mistake(Aguirre-Gas et al., 2010).

The most frequently cited definition is that of the Institute of Medicine: "Failure of a planned action to be completed as intended (runtime error) or using the wrong to reach a goal (error of planning) plan"( "Dictionary of the Spanish Language (2001) 'sf). The most frequently cited definition is that of the Institute of Medicine: "Failure of a planned action to be completed as intended (runtime error) or using the wrong to reach a goal (error of planning) plan"( "Dictionary of the Spanish Language (2001) 'sf). The definition of "decision or diagnostic or therapeutic procedure that, given the time and circumstances of the occurrence can be considered wrong by qualified and experienced peers" seems clearer. This definition excludes the consequences and the natural course of the disease

and excludes decisions made under extreme circumstances such as an urgent care clinic with great pressure(Murphy, Stee, McEvoy, & Oshiro, 2007).

The declaration of rights and duties of patients, is not originally considered that the patient has the right to be informed of the errors in the course of care of the surgical team ( "Law 1751 of 2015 Enacting Law on Health | FECOER 'sf). While current accreditation standards of the Ministry of Health concerning registration and assessment of adverse events and errors committed during surgery( "Medical error: a discussion of the medical construction of error and suggestions for Reforms of medical education to decrease errors - Lester - 2001 - Medical Education - Wiley Online Library" sf).

#### 15. Dilema presented in the surgical team.

Ratios and clinically competent doctors make mistakes that recognize, regret, with which they learn and live. Be explicit with the patient about errors represents a paradigm shift for physicians. Although most physicians recognize a hypothetical mistake, a minority of them is willing to provide details to his patient about this; especially if there is little apparent effect of a trivial error(Rosen, Adams, Derse, Grossman, & Wolfe, 2012), These reactions are presented as "wrong conduct clinical malpractice, by commission or omission, as a result of the decision to apply an incorrect standard". The dilemma fear of lawsuits, the threat to their prestige, feel embarrassed or not knowing how to effectively inform patients can influence the silence of doctors about their mistakes. Anxiety as "rebound reaction": What will happen ?, What will I lose ?, What will they say those who know me ?, Where will take to pay off my defense lawyer?(Gallagher, Studdert, & Levinson, 2007).

#### 16. Malpractice stems from the negative actions: negligence, incompetence, recklessness.

Given the high risk of making a mistake that exists in medical practice, malpractice is defined as the derivative professional liability for the inappropriate exercise of medical practice this in turn involves the surgical team( "Editorial Reus | Liability of medical and liability of the health authorities, Domingo Bello Janeiro | 978-84-290-1552-2 | online Buy Editorial Reus' sf).

- Malpractice can cause harm to the patient and responsibility for medical equipment.

- Neglect: is a judgment that is presented by a bad practice, do what you should, do less; in other words, knowing what must be done, not done, or conversely, that knowing what should not be done carelessly done.
- The ineptitude: the lack of basic and essential technical knowledge must include. Inability.
- Imprudence is the opposite of prudence. It is facing a risk without taking precautions to avoid it, proceeding with unnecessary haste, without stopping to think about the disadvantages that will result from such act or omission

### 17. Professional Responsibility: know the basics.

- He notes that the surgical team has other responsibilities arising from the exercise of the profession are(Miranda, sf). Table 2.

**Table 2. Types of legal responsibility**

Responsibility	Description	Surgical equipment
administrative responsibility	Occurs when the health professional infringe one of the principles established in the General Health Law, its Regulations and other provisions arising from the Act	That is whether or not caused damage to the patient's health
Liability	The existence of damage, which can be financial or moral	That damage is caused willfully or negligently proceeding
Criminal responsibility	occurs when a person, in violation of the rules that describe criminal conduct, committed as fraudulent or negligent any illicit provided by such systems	Guilt must be committed in actions relating to professional work.

### 18. Effect of malpractice by which mistakes.

The types of responsibilities that may be incurred by health professionals through any of its kind under the modalities of incompetence, negligence or recklessness that saw lines above are summarized in bad practice, which is defined as a violation of basic medical principles or failure to observe the signs of Lex Artis "state of the art medical or malpractice"(Indice.pdf, sf).

In the story, the lex artis implies the obligation of the health professional to provide the patient with the care needed to achieve the desired end, through

their science knowledge and expertise. Act cautiously in order to avoid being responsible for the integrity of the patient. In that sense, Bañuelos Delgado explains that the health professional may only be responsible for his actions when it is shown that it incurred guilt for having been negligent in his care(Indice.pdf, sf).

In Colombia there are few statistics to meet demands caused by malpractice, this in turn also becomes relevant in Mexico that few that reveal the actual figures on the number of medical lawsuits that are initiated in different courts (prosecution, criminal courts, civil, administrative, labor), regardless of the non-legal as CNDH (National Commission on Human Rights), CONAMED (National Medical Arbitration Commission) the National Medical Arbitration Commission, is the institution in Mexico that best takes and publishes updated statistics that provide insight into some of the most important data that motivate health service users to complain and sue institutions(REVISTA\_OCT-DIC\_2011\_supl.pdf, sf).

Depending on the above, a review of major medical specialties is made, describing the number of complaints concluded by issuing award (sentence prefer arbitration court); to present incidence of malpractice in each specialty, which is attributed to the surgical team. According to the result of documentary analysis, as to test the figures are reported malpractice by specialty for the period 2011-2015 (REVISTA\_OCT-DIC\_2011\_supl.pdf, sf).

Table of Complaints concluded by issuing an award by specialty as a result of documentary analysis period 2011-2015 was shown that general surgery with 14 cases, 7 cases gynecology, orthopedics followed by 11 cases are most acts done bad practice. Therefore, they are most evident trends have surgical practice. Without taking into account the first half of 2015, between 2011 and 2014.(REVISTA\_OCT-DIC\_2011\_supl.pdf, sf).

### 19. Medical negligence. Characteristics of its consequences in criminal proceedings.

In our country, in accordance with the provisions of the Penal Code, any act or omission socially dangerous, planned and sanctioned by law, it constitutes a crime( "Judicial Weekly of the Federation - Tesis 2006245" sf)

- In some cases, medical malpractice can result in the settings of various offenses,

depending on the circumstances of the particular case.

- Some of the offenses in which doctors may incur by acting negligently are: professional liability, injury and murder.
- Its purpose is to impose some penalty staff surgical team that acted criminally.
- Criminal proceedings the victim is entitled to compensation for the damage, it must be repaired by the criminally responsible physician and not by the public entity for which he works.

### Final thoughts

We suggest that health professionals should have surgical consciousness, as is the tendency to avoid mistakes and ensure the welfare of the patient.

Through the literature review, it was noted that there are different factors that involve committing negligence causing errors, which the surgical team is responsible as a first step causing patients serious physical, mental consequences can even lead to death, that can decrease If surgical awareness measures are adopted.

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