CULTURA & SAÚDE

ISSN 2595-7546
Vol. 3 · No. 2 · May 2003
São Paulo, Brasil

ARTICLE · CULTURA & SAÚDE

Imaginary Error

Distinguishing true medical error from the limits of medicine and mere grievance

Prof. Dr. Irany Novah Moraes

Received for publication in May 2003 · Section: Article · Language: English

ABSTRACT

The author examines the distinction between medical error and imaginary error, arguing that many occurrences imputed to error are nothing more than the natural evolution of the disease. On the occasion of the launch of his book Erro Medico e a Justica, he holds that the subject should be understood by physicians, jurists, and journalists, from the three perspectives of the patient, the physician, and the judge. He explains that the legal characterization of error requires harm, participation of the physician, and a causal nexus, in addition to negligence, malpractice, or recklessness. He then develops a typology of imaginary error, covering the limitations of medicine, iatrogenesis, accidents, complications, anomalies and anatomical variations, technical failures, and excusable error, illustrating them chiefly with examples from vascular surgery. He stresses that the medical contract is one of means and not of ends, and concludes that a clear grasp of this problem is essential to judge fairly the successes and failures of medicine.

KEYWORDS: *medical error; imaginary error; iatrogenesis; medical liability; contract of means; grievance*

***M** any an occurrence charged as medical error is nothing more than the natural evolution of the disease.*

It is with satisfaction that I begin the new year by placing in the windows of the country's finest bookstores the book **Erro Médico e a Justiça** (Medical Error and Justice). It is the 5th edition of a series, thus completing the trilogy on medical error, made up of: Erro médico, 1st edition, 1990; Erro médico, 2nd edition, 1991; Erro médico e a lei, 3rd edition, 1995; Erro médico e a lei, 4th edition, 1998; and now Erro médico e a justiça, 5th edition, 2003.

This publication highlights the significant work of RT – Editora Revista dos Tribunais, in the landscape of the country's legal culture, which masters the art of placing at the disposal of the entire interested community — and, more than that, in the hands of university students — and thus reaching today the professional of tomorrow, conscious that the future has arrived, and it is tomorrow, in the morning.

The subject at hand should be well studied by lawyers, whether for the defense or the prosecution, as well as by the public prosecutor, by judges and appellate judges, by journalists, and, of course, by the physician. A relevant role in minimizing the problem is that these three pillars — lawyer, physician, and journalist — be deeply engaged in the problem of medical error and have clear ideas of the matter, so as to find the truth of each occurrence.

The physician practices a high-risk profession, and destiny sets along their path traps that only competence and devotion to the work can disarm. Unusual dangers are always lying in wait! The success of the work does not depend on the physician alone, but also on multiple factors beyond their will. The failure of the outcomes sometimes attributed to them stems from the fact that the patient or their family projects onto the physician their inability to come to terms with the cruelty of destiny and the limitations of medicine. The wide dissemination of dissatisfaction with outcomes, whether or not pertinent to indiscriminate cases, carried out by the media, has generated confusion as to what really constitutes medical error. Worse still are the harms resulting from the shaking of the patient's confidence in the physician, which is fundamental in the healing process. As if that were not enough, the generalization spreads to the whole class and spares no one. Thus, everyone comes to doubt physicians and, more serious still, Brazilian medicine itself is put at stake.

It is well advised that everyone become thoroughly informed on the subject, so as to know how to discern the false from the true, without being carried away by emotion in interpreting the facts that are published and generally even trumpeted. To be well understood, it must be analyzed from three perspectives, namely: that of the patient, that of the physician, and that of the judge.

As to the first – the patient's view – the mere frustration of their expectations may lead them to suppose that the physician has erred. The second – the physician's view – in turn, struggling permanently against death, feels the limitations of medicine. The third – the judge's view – is extremely technical, for it is the function of justice to settle doubts about the conduct of individuals within society. The patient may complain to the Regional Council of Medicine or may resort to the ordinary courts, so that, should medical error be proven, they may seek redress for the harm.

For a clear separation between what is real and what is imaginary, it is worth recalling that the characterization of medical error is grounded in fault and its reparation in the *liability* of the physician for their acts. In this context, justice requires three premises, namely: 1. *the existence of harm* (death, mutilation, etc.); 2. *the participation of the physician*; and 3. *proof of a causal nexus* — that is, proof that the harm was produced by the said physician's conduct. Once these prerequisites are established, one or more of the following three conditions must be proven: negligence (carelessness, neglect, laziness); malpractice (incompetence); and recklessness (a procedure carried out anxiously, without caution).

No Professional Procedure Is Free of Risk

The human organism, whose functional balance is extremely complex, presents a high degree of vulnerability. To aggravate this situation, add the disease. Thus, any medical or nursing procedure aimed at relieving pain or even preserving health may, on occasion, lead the patient to death. Such an outcome can occur without anyone's fault; it is enough for the organism to react anomalously to the remedy. This fact stems from the secrets of life, not yet unraveled by man.

It may be said that there are risks inherent in the diseases as well as others inherent in the therapeutic methods themselves. Progress, through better knowledge of the essence of the healing processes, has greatly reduced the incidence of these problems, increasing the safety of treatment. However, on the other hand, this same progress is making possible more precise diagnoses and creating more delicate methods to treat ever older patients with ever more serious diseases, until then regarded as "beyond hope."

Evidently, not all patients are curable. Many suffer from serious diseases at advanced stages and with no prospect of recovery. There are situations in which the disease is so severe that its natural evolution is toward death.

Among those who suffer most are those with chronic and incurable disease. Chronicity suggests a long time of suffering, and incurability seals their fate. Elisabeth Kübler-Ross treats this theme with great depth.

Faced with the aforementioned situation, the patient usually reacts in one of three ways: 1 - accepts the facts with equanimity; 2 - alienates themselves from their problem; or 3 - rebels.

The first group comprises the great majority of patients. On confirmation of the disease, they pass through an initial phase of great sadness and then accept the facts with equanimity and resignation. These patients cooperate with the physician and the nursing staff, take the treatment seriously and, without complaint, gradually adjust to the new conditions of life. They seek to find their limits and pursue alternative activities. They usually show a great will to live and take satisfaction in the smallest progress and joy in every gain.

The second group is that of those who, not accepting the situation, pretend to ignore it. They behave as if they did not know what they have, nor its severity. They go so far as not even wanting to know the name of the very physician who treats them. When they know it, they forget it or pretend to forget. Indeed, they truly forget, for their memory erases the name it does not wish to retain; they do not speak of the subject and do not want to inform themselves about the disease in order to be able to help themselves.

The third group is that of those who, not reconciling themselves to the situation, rebel against it. In their hours of intimacy, each of them wonders: why me? Finding no answer, they revolt against everything and everyone. It is easy to understand the lack of a good psychic structure to face an incurable disease. The imbalance in this situation leads them to attack everyone, but particularly the physician and the hospital. The physician, because they are the one who says what the patient does not want to hear and prescribes what they do not want to do; and the hospital, because it is the place where what they would not wish to happen takes place.

There are certain cases of great severity for which there is some hope, provided that measures regarded as heroic, albeit at high risk, are taken. In these circumstances, it is impossible to say with certainty what the evolution of the case would be if the alternative procedure were adopted.

At this point, doubts sometimes arise as to the conduct adopted. *A posteriori*, with the unsatisfactory evolution of a procedure, it is easy to criticize and assert that another course of action would have been better.

I must recall, further, that a medical act involves several professionals of differing levels of qualification. All have their direct or indirect participation in that act. The

medical care team is large, and it involves the physician, nurse, midwife, social worker, nutritionist, pharmacist, dentist, nursing technician, nursing assistant, receptionist, administrator, and administrative staff, such as the doorkeeper, laundry personnel, maintenance and cleaning personnel. All have their share of contribution in each procedure and, consequently, their portion of responsibility.

Imaginary Error

The media disseminates indiscriminately, without properly characterizing it, every complaint as though it were medical error. It is natural that, faced with the death of a loved one — even in the failure of a treatment, or in the amputation of a gangrenous limb, whose natural evolution may lead the patient to death — there arises an emotional crisis in the patient or their family that disturbs the interpretation of the facts. This point must be clear to everyone. I will deal with cases in which the physician does everything to save the patient, yet it is not always possible. This is the limitation of medicine. The distressed family often seeks to lay the blame on the physician or even on the hospital.

Inability to Come to Terms

The patient's inability to come to terms with the results they expected from medicine is, without doubt, the result of a series of factors. Some can be singled out, but as a whole they intertwine and, in truth, all find in each patient's emotional response the factor that magnifies their problem.

Dissemination without strict criteria has harmful consequences for the physician and for the institutions, but the greater harm is still to the patient. The first negative effect it produces is the fear it instills in the population toward every necessary procedure of health care. The second harm is the patient's disbelief in the efficacy of treatments. The third, in my view the most serious, is the shaking of the physician–patient relationship, through the undermining of the patient's confidence in their physician. Everyone knows that a good part of the efficiency of a treatment lies in the tranquility that the physician's word produces in the patient and their family, thanks to that confidence.

Even good news — of significant progress, of partial successes in advanced research and of very refined technology — when disseminated in a scandalous and bombastic manner, is pernicious, for it gives the impression, to the less informed, that something still in the experimental phase is an accomplished fact in current use. But the harm of this practice lies in developing a high degree of expectation for solutions to problems that, apparently, are minor.

All sensationalist news should be met with a degree of reserve. Some of it, with a certain bad faith, carries intrinsically the germ of distrust.

Many an occurrence charged as medical error is nothing more than the natural evolution of the disease. Other cases are due to unavoidable accidents, some of them even foreseeable. Complications, occurring also in the evolution of diseases and modifying their natural course, may cause sequelae or even lead the patient to death. Many facts attributed to medical error are, in truth, not so and may be classed as an inability to come to terms. What most generates this attitude is the paradox between enormous progress set against the great limitations of medicine, and always with emotional involvement. Consider, for example, the fact that in external mutilation the patient feels greatly harmed. Their defect is hard to hide or even disguise. All this problem leads to an irremediable inability to come to terms. In these circumstances, in the psychologically weaker individuals, there appears the revolt against their destiny and the spirit of vengeance or of demand. They project onto the physician their anguish. Thus arise the impulses to impute to the physician the fault that is not theirs, and to call error the limitation of medicine in not being able to treat everything successfully.

Iatrogenic Disease

Iatrogenesis is a compound word; it comes from the Greek: *iatrós* (physician) + *genos* (origin) + *ia*. Thus, it is an expression used to indicate what is caused by the physician but, by extension, by all members of the health service who participate directly or indirectly in the medical procedure. It refers not only to what occurred by what the physician did, but also to what they failed to do and should have done. It is fitting to make clear that any **mutilating surgery** is also understood as iatrogenic.

Some examples of iatrogenic diseases may facilitate a better understanding of the question. I will borrow them from vascular surgery which, by its very nature, is extremely far-reaching, since the vessels, whether blood or lymphatic, concern the whole human economy. Under such conditions, operations of the other specialties can easily generate iatrogenic lesions whose solutions fall within the competence of the vascular surgeon. The specialty itself also calls for many a heroic and extremely iatrogenic solution; thus, certain vascular problems whose treatment in itself entails a permanent lesion. Such is the case of gangrene, for whose treatment amputation is indicated. This, by its nature, creates other very serious problems for the patient, by causing great functional limitation.

I recall that all arteries and veins may be injured during a surgical act of any specialty, as a surgical accident, and the consequence will depend on the nature and degree of the lesion and on the organ affected.

Anomaly is a congenital malformation or deformity characterized by an irregularity of the organism, a condition that makes the individual different from others. It is indicative of a deviation from the normal. In the more advanced degrees one speaks of deformity and, progressively, of malformation or monstrosity; it differs from *variation* in that the latter does not cause the functional alterations that occur in the former eventuality. These concepts must be clearly understood, since responses different from the usual are to be expected in patients bearing congenital problems. I emphasize the fact that there are problems that are compensated and that do not permit a diagnosis but that decompensate when others are treated.

Accident

Experience has shown that, in most cases, the questions center on the difficulty of understanding what an accident in medicine is. Thus, let us see: an *accident* is an occurrence that is unexpected but foreseeable. It may be a traumatic fact or a morbid phenomenon that occurs in a healthy or sick individual. A surgical accident is, for example, an undesired severing of an artery during the operative act.

It is important to note that, in this matter, a distinction must be made between *accident* and *complication*, two concepts relevant to the problem of the limits of medical liability. It is a fortuitous intercurrence, more unexpected than unforeseeable, that may occur in the diagnostic process as in the therapeutic one.

At this point, one may recall the cases resulting from anesthetic, radiological, and surgical accidents. In medicine, as in traffic, one does not expect the accident to occur, but one admits that it may. There are operations that place at high risk certain structures which, once injured, may trigger sequelae, some of them disfiguring or producing dysfunctions. Thus, tumors of the parotid gland may involve the facial nerve and, however much care the skilled surgeon takes, it may be injured. If it is a matter of simple manipulation, the sequela may be temporary; however, greater trauma may cause permanent sequelae, resulting in facial asymmetry due to contralateral retraction.

The following cases also constitute accidents. In an operation in a delicate site, even with all the surgeon's skill and care, the fragility of the tissue may lead it to tear and render that act unfeasible. A suture in an extremely friable artery, made in accordance with the most correct technique, with the greatest skill, if the stitches tear, also renders that act unfeasible. Another example is the involvement of a vessel by a malignant tumor that one wishes to remove: the adhesion between the two is such that, in order to remove the tumor, the surgeon injures the artery.

Some of these cases allow an immediate repair of the intercurrence. Such facts occur more frequently than one might imagine, but the high skill of the surgeon overcomes the difficulty, and the operation is labeled a *difficult operation*.

Accidental lesions of the recurrent nerve may occur in thyroidectomies, with permanent disturbance of speech. One must consider the patient's profession and imagine the disruption it causes them, in the case of a singer or even a teacher. In neck surgeries one may also recall accidental lesions of the phrenic nerve, with consequent lowering of the diaphragmatic hemicupola and possible respiratory disturbances.

It is understandable that modernity is bringing at every moment new diagnostic and therapeutic opportunities and that these also carry with them further chances of complications. These, being still little known, become less foreseeable, which in no way diminishes the probability of occurrence. To exemplify this fact and thus make it better understood, it is enough to recall the new process of treating hemangiomas by embolization. It is a technique conceived in 1980 which, owing to its recent use in practice, means that few specialists have great experience, which does not allow one to have large statistics for estimating in numbers the expected accidents or the complications. The organism's response may be greater than desired, sometimes by a simple arterial spasm, triggering ischemia of the adjacent areas as well, which may cause undesirable sequelae, rendering the final result precarious. It is difficult for the patient to understand the failure of this process as an accident, tending, generally, to regard it as a medical error.

These examples were referred to here to recall that such lesions are caused by the physician on the basis of a choice made between risks and benefits. The patient, in special situations before a diagnosis, must know that there are noble structures that, at times, however much caution is exercised, identifying them and setting them aside with great care, still do not withstand the slightest trauma of a most delicate retractor. Clearly knowing such risks, it falls to the patient to choose between the risks of not being treated, allowing the disease to progress in its natural evolution, and the mutilation or possible, but unexpected, dysfunction that may result from the treatment. In cases where mutilation is the treatment, the situation is already a different one.

Complications

This is the appearance of a new morbid condition in the course of a disease, whether or not due to the same cause. It is very frequent for a chronic disease, which in its natural evolution has bouts of acute exacerbation, to present them precisely during treatment. They would occur in any case, with or without treatment; only, by misfor-

tune, they arose in the course of the treatment. This can be exemplified by a patient with atherosclerosis who, during the treatment of a gangrene, dies of myocardial infarction on the day of hospital discharge. The disease existed; it was systemic. He overcame the amputation, but a coronary artery occluded. It is fitting to cite here, too, evisceration, a complication that occurs in malnourished patients in the postoperative period of abdominal surgery. The suture tears and the viscera become exposed. Remember that the malnourished person is not only the one who goes hungry, but also the one who eats badly or follows diets without proper guidance. Other examples, perhaps even more drastic than these, may be recalled to illustrate in essence this aspect of the problem. Recall the case of radiotherapy after cancer surgery and, after it, chemotherapy which, in order to kill the cancer cells, attacks the patient deeply, with many sequelae, greatly harming the patient's quality of life.

Complications Difficult for the Layperson to Understand - The natural evolution of some diseases may present intercurrences that are difficult to understand. Thus, let us see what occurs, not rarely, in pediatrics. Children with an acute diarrheal clinical picture may present, in the course of their evolution, ischemia of an arm or a leg, due to septicemia with septic embolism occluding small arteries, leading to ischemia and even to gangrene of the extremity.

This fact causes such an impact on the family that the inability to come to terms may trigger judicial complaints seeking indemnities as reparation for an *imaginary* medical error.

The family, in reconstructing the facts to formulate the complaint, recalls minor intercurrences plausibly occurring in the course of the treatment of serious cases. Thus appears the arm that swelled when the IV was applied or when it was restrained on the crib railing. These facts cause much bewilderment for the mother and family, chiefly because they occur with a loved one, at a moment of great distress.

The pediatrician, as well as the vascular surgeon, who care for the patient and have theoretical knowledge of medicine, understand what is occurring, how and why. However, other occurrences of the family's responsibility should be stressed. The mother who did not want to or could not breastfeed, the weaning that was premature, and the artificial feeding that was not followed correctly. Premature weaning and inadequate artificial feeding tend to be predisposing factors in acute diarrheal disease.

Judicial complaints in similar cases fail at their very foundation, for medical error cannot be characterized: there is no causal nexus between the physician's procedures and the appearance of the harm to the patient.

Deliberate Error to Prevent a Greater Harm

Serious situations occur in hospitals when an acute picture of hemorrhagic shock is verified in which blood transfusion is immediately imperative and the Blood Bank has the blood, but owing to a lack of adequate time the results of the serological tests to rule out Syphilis, AIDS, Chagas Disease, and Hepatitis B have not been completed. The hospital has compatible blood, but does not know whether the blood carries those dreaded diseases; however, if the patient does not receive the transfusion, they die.

Thus an imminent danger to life is configured, and the solution is the transfusion. The physician must administer the blood and save the patient from shock, for the greater harm outweighs the other which, moreover, is doubtful, since the tests may be negative.

The physician may follow one of two courses of conduct: 1 - not administer the blood so as not to run the risk of its being contaminated; and 2 - administer the blood, running the risk of also transfusing disease. In the first alternative, if the patient dies, the physician may be accused of failure to render assistance and, in the second, if the blood is contaminated, they may be accused of negligence or recklessness.

Faced with these conflicting solutions, the physician must administer the blood and save the patient, but to protect themselves from later problems, in case the patient should come to have any disease resulting from that transfusion, they should communicate their conduct in writing to the judge.

The family should closely follow the difficulty and sign the document, attesting that they are in full agreement with the physician's conduct and assuming responsibility for the decision. Such a procedure absolves the physician of any fault. The document of the family's authorization for this procedure is not sufficient to prevent the physician from later becoming the victim of future complaints on the part of that same family who, at that moment, agreed with the solution presented.

Problems of this nature occur with greater probability in interior cities, where the exchange or mutual aid between blood banks is more difficult. In the capitals, the way to reach the judge is through the on-duty police chief.

Technical Failures

This type of error requires, for better understanding, that an analogy be made with those of the professions in the field of the exact sciences, in which the technical failure is peculiar to the machine. Since the physician renders services, and these are independent of the machine, the failure in their procedure depends, on the one hand, on competence, feasibility, and individual dedication and, on the other hand, on the response of the patient. The former, those depending exclusively on the physician, are

called technical. Strictly speaking, they should be called *failures of the technician*. This problem, posed in this way, highlights the additional portion of responsibility attributed to the physician, by the fact of their working with a very peculiar *apparatus* built by **nature** — the human body. Thus one understands why, inadvertently, such failures are imputed to the physician. They, in truth, depend on the response of the *apparatus* with which the physician is working, precisely when this apparatus is not well and presents *defects* produced by causes, often, poorly known.

These so-called technical failures were thus characterized with progress, and it may be said that they are restricted to the physician of the scientific age. If today medicine is a science with a touch of art, in the study of medical error it must be regarded, first of all, as rigorously scientific. Here the error must be quantified and thus can be defined. Yet the fact that it can be measured does not permit one to forget that the biological is absolutely inexact, since many secrets of life are still unknown.

Excusable Error or Professional Error

If the error can only be estimated by the result, the physician should be answerable only for what depends exclusively on them and not on the response of the patient's organism. On this point there is a wisdom in our justice, which establishes the physician/patient contract as one of means and not of ends. In this way, it safeguards the physician from liability for what did not go well because of the patient, whether by what the patient did not do as prescribed, or by the fact that their organism did not react as might have been expected.

It seems strange to distinguish medical error from professional error; however, such a distinction has been made chiefly by judges. They usually characterize professional error as that which results from a failure not imputable to the physician and which depends on the natural limitations of medicine, which do not always permit a diagnosis of absolute certainty, and may confound professional conduct and lead the physician to act erroneously. Also falling within this class are the cases in which everything was done correctly, but in which the patient omitted information or even concealed it, and, further, when the patient did not cooperate with their part in the diagnostic or treatment process.

Faced with the related situations, the error exists, is intrinsic to the deficiencies of the profession and of the human nature of the patient, and occurs in the exercise of the profession, but the fault cannot be attributed to the physician. Such errors are also called excusable.

The opportunity for medical error to occur exists throughout the entire course of the physician/patient relationship, from the first contact to the last, whether through discharge, abandonment of treatment, or death. Every technical procedure carries within it, even when correctly performed, a possibility of an adverse response.

Note that, on the patient's part, all interpretation of the facts will depend on how the physician presents them. Hence the importance of the patient placing absolute confidence in the physician. This will depend on the physician's reputation, acquired through the frequency of successes in the serious cases of the population they attend, and will predominate over *competence*, which the professional can only demonstrate to their peers, whether in academic or scientific life, or in the medical societies, or in relations with colleagues.

Medical Service Is a Contract of Means

It is worth recalling, further, that the physician/patient relationship is governed by an implicit contract for the provision of services. Although it is not in writing, the mere fact of the patient seeking out the physician and the physician attending to them is sufficient for such a contract to be established. However, it is invested with certain particularities. It is a contract of means, by which the physician undertakes to *care for the patient* and not, necessarily, to *cure them*. The physician must, by this contract, provide the patient with the best that medicine can offer, considering the occasion, place, and circumstances.

The individual rights of patients must be respected, without, however, forgetting the reciprocal ones — that is, the patients' obligations to follow the prescriptions rigorously, to seek to help themselves, to endeavor to understand their own problem, and to change physicians if they have no confidence.

The nature of the special contract of means is the watershed between medical error and imaginary error. Thus, to make clear where each of them may be classed, the elaboration of a typology of each resolves the matter didactically.

Typology

I will set out, objectively, the critical points of the two themes to which this article is devoted.

MEDICAL ERROR:

1 - Causing intentional harm – *malicious error (crime)*

2 - Divulging the patient's data – *breach of medical confidentiality*

3 - Causing harm unintentionally – *negligent error*

4 - Not doing what one should – *negligence*

5 - Doing what one should not – *recklessness*

6 - Doing it wrongly – *malpractice*

IMAGINARY ERROR:

1 - Limitation of medicine – *inability to come to terms*

2 - Mutilation (elective or emergency) – *iatrogenesis*

3 - Accident along the course of the procedure – *professional risk*

4 - Complication – *unexpected intercurrence*

5 - Anatomical anomalies – *paradoxical responses*

6 - Anatomical variations – *responses differing from the conventional*

7 - Technical failures – *lack of response from the organism*

8 - Excusable error or professional error – protected by the contract of means

Conclusion

The theme of this article shows, in a clear and convincing manner, how important it is for the physician, the jurist, the journalist, and the citizen in general to have clear ideas of this problem in order to make their own judgment of the successes and failures that modern medicine can afford.

From what has been set out, it is evident that everyone should have their own opinion on the subject. The scientific study of medical error, in view of its legal aspects, permits an understanding of the problem in its essence, providing material for reflections that lead to the truth of the facts.

Everyone — patients, families, physicians, jurists, journalists, clergy, legislators — in their own way, should give their share of contribution to help minimize the problem. This is my contribution.

No one can forget that the greater our knowledge, the greater will be the awareness of our ignorance.