

Nuances and challenges of medical malpractice in Brazil: victims and their perception

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Abstract

Medical malpractice refers to the circumstance of harming a person as the result of medical performance based on a reckless, negligent or inexperienced approach. In Brazil, while the number of such cases is increasing, discussion of the subject is almost absent. The present study sought to elucidate some of the challenges found in the situations of the victims of medical malpractice. The experience of the victims was accessed through a semi-structured interview. The confusion of individuals when they discovered they had become victims was noted, as well as a difficulty in accepting the status of victim. The effects of the malpractice led to transformations both in behavior and in attitudes, such as a lack of confidence in medical professionals. It is therefore necessary to create strategies to help and care for the mental health of victims of medical malpractice.

Keywords: Medical errors. Stress, psychological. Narration.

Resumo

Nuances e desafios do erro médico no Brasil: as vítimas e seus olhares

O erro médico refere-se a uma circunstância que atinge a pessoa em decorrência de atuação médica baseada em atitude imprudente, negligente ou imperita. No Brasil tem crescido o número de casos, mas a discussão a respeito da vítima é quase inexistente. Este trabalho buscou elucidar alguns dos desafios presentes na situação das vítimas de erro médico. Utilizando uma entrevista semiestruturada, foi possível conhecer as experiências das vítimas e perceber de que maneira enfrentaram os desafios impostos. Observou-se a perplexidade ao descobrir-se vítima, e a dificuldade em aceitar-se como tal. As mudanças impostas pelo erro acarretaram transformações comportamentais e de atitudes, como a falta de confiança nos profissionais médicos. Sofrimento e sentimentos negativos passam a fazer parte da vivência dessas pessoas. Dessa maneira, é necessário criar estratégias que permitam auxílio e cuidado da saúde mental das pessoas envolvidas com o erro médico.

Palavras-chave: Erros médicos. Estresse psicológico. Narrativa.

Resumen

Matices y desafíos del error médico en Brasil: las víctimas y sus miradas

El error médico se refiere a una circunstancia que afecta a una persona como resultado de una operación médica basada en actitudes imprudentes, negligentes o de impericia. En Brasil se ha incrementado el número de casos, pero la discusión en relación a la víctima es casi inexistente. Este estudio tuvo como objetivo dilucidar algunos de los desafíos presentes en la situación de las víctimas de errores médicos. A partir del empleo de una entrevista semi-estructurada, fue posible el acceso a las experiencias de las víctimas y se logró una aproximación a los modos en que enfrentaron los desafíos impuestos. Se observó la perplejidad de estas personas al percibirse como víctimas y la dificultad en aceptarse en tanto tales. Las transformaciones impuestas por el error dieron lugar a cambios en los comportamientos y las actitudes, por ejemplo, la falta de confianza en los profesionales de la medicina. El sufrimiento y los sentimientos negativos comenzaron a formar parte de las vivencias de estas personas. Por lo tanto, es necesario crear estrategias de acompañamiento y cuidado de la salud mental de las personas afectadas por errores médicos.

Palabras-clave: Errores médicos. Estrés psicológico. Narración.

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The evolution of medical sciences has made available a major technological framework to benefit humans^{1,2-7}. Brazil currently sees an abrupt increase in the search for clinical interventions, whose justifications range from those which are truly needed to others targeting aesthetical improvements⁸. In parallel, there is also an increase in the so-called adverse events, often referred to as medical malpractice²⁻⁶⁻⁷⁻⁹⁻¹³.

Medical malpractice can be conceptualized as *inadequate professional conduct which assumes the lack of observance to technique, able to produce damage to life or to threaten the lives of others due to lack of expertise, imprudence or negligence*¹⁴. Whereas the Código de Ética Médica (CEM – Code of Medical Ethics) does not provide a definition, article 1, chapter III emphasizes that physicians must not *cause harm to the patient as a result of their actions or omissions, which can be characterized as lack of expertise, imprudence or negligence*¹⁵. There are three ways to characterize medical malpractice:

- 1) Malpractice – ignorance, incompetence, lack of knowledge, inability and inexperience in the art of the profession. This may be understood as a situation in which physicians perform a procedure to which they are not used, which is equivalent to lack of technical and/or practical preparation resulting from the lack of knowledge.
- 2) Imprudence – oversight, performance of a certain action in a hasty or poorly-rationalized manner, resulting from agents neglecting to make assumptions which could or should have been made. It happens when medical conduct involves risks to patients and is not scientifically supported. An example would be a surgeon operating without either the proper diagnosis or adequate preparation of the patient;
- 3) Negligence – absence of the care required by patients, suggesting lack of action, passiveness or omission, which implies laxity or lack of diligence to determine culpability. Forgetting gauze, tongs and surgical sponges during surgeries exemplify this category³⁻⁶⁻¹⁹.

A study which collected data regarding researches on medical errors in national and international databases found that there is a large concentration of investigations on the theme in Europe and North America, indicating levels of occurrence of medical errors, with variation of 2.9 to 16.6 per 100 patients submitted to any type of medical intervention¹². In Brazil, from 2003 to 2012, the scientific production on the theme comprises 52

papers which use “medical error”, “adverse event” and “malpractice” as descriptors. It is worth stressing that this figure includes papers in areas related to medicine and medical error, for instance, errors regarding pharmaceutical dosages and nursing²⁰.

Even though the amount of records on malpractice is currently increasing, what truly happens to victims is unknown; Brazilian studies emphasize more the number of claims filed in regional medical councils (CRM, Portuguese acronym), as well as on the disciplinary measures applied, the profile of physicians involved in such claims, and even on some important “rules” to be used by physicians to avoid and prevent malpractice and thus avoid the unpleasantness of the whole situation^{2,13,14}. In other words, most of these studies neither approach aspects related to subjectivity nor issues regarding victims.

Between 2000 and 2004, the Conselho Regional de Medicina do Estado de São Paulo (Cremesp – Regional Medical Council in the State of São Paulo) assessed claims of medical errors involving physicians in São Paulo to the Judicial Power. Even considering the complexity of the Brazilian judicial system, 353 decisions were found at the civil level and 23 at the criminal level. Around 46% of these decisions were in favor of the patient, with mental distress claims being the most common kind of penalty applied to physicians reported; that is, the judicial system verified that the actions of these professionals inflicted pain or suffering on the victim²¹.

Nowadays, the occurrence of medical errors has been growing exponentially, especially due to actions by the media, which triggers strong pressure to assess culpability, as well as to find out the cause of the error⁶. Nevertheless, one may say that the cases that gain notoriety and reach the public represent a small portion of many others involving less harm to patients. Many physicians are not even reported or investigated by the competent legal authorities⁹. Although this investigative disposition may be considered as the first step to lessen patients’ pain and suffering, it relegates or even sets aside the experience of victims of medical errors.

Seeking to give voice to victims of disastrous situations resulting from these adverse events, this study discusses the need and importance of learning about medical errors in Brazil considering the narrative of the victims, and taking into account the practical dimension as well as the challenges imposed on their lives.

Method

This is a qualitative study with victims of medical errors in the states of São Paulo and Rio de Janeiro. It includes interviews carried out during a one-year period, between October, 2011 and October, 2012. Initially, the only criterion considered to select participants was the proof of a medical error provided by courts of general jurisdiction. However, such criterion could not be maintained due to the difficulty often imposed by lawyers or health institutions when it comes to contacting victims. Another difficulty found was in the very attitude of victims themselves, who more often than not did not want to participate in the study. The justifications for the refusal showed that victims believed their situation had already been widely exposed in the media, with no effective result. Thus, they considered it was not worth going through the whole exposure process one again: why would it be different with this study?

In face of this realization during the identification of interviewees, the selection criterion was altered and preferred cases for the study became those involving medical errors which had been acknowledged by the Brazilian judicial system, with no margin for doubt in cases of medical errors resulting from surgeries performed on a limb other than the one which should have been operated on. Thus, interviewee identification only considered the proof of the existence of the error by the judicial system rather than its gravity. As an element used to compare narratives, we included four participants who were still waiting for a legal ruling on the error, as their lawsuits were still being prosecuted.

Targeting analysis accuracy, the methodological strategy used to produce the narratives was an in-depth interview with a semi-structured script. This strategy was based on a trigger question: *"How did you experience the discovery of the medical error so far?"* Interviews were carried out individually and lasted at least 40 minutes and no more than two hours. In addition, participants were able to choose the venue where the interview would take place, which, in some cases, meant that their lack of mobility needed to be taken into account.

The study included 12 interviewees (5 men and 7 women), between 25 and 72 years of age. Participants had different professional and educational backgrounds, including some with incomplete high school education to others with complete higher education. The study showed that only four of them managed to continue working, while the others were unable to do so as a result of the error. The

number of participants followed a saturation-based sampling logic, which allows those conducting the study to stop interviews when the data begins to repeat itself, thus the number of patients may be higher or lower than the one initially proposed. It bears noticing that the argument here is justified by the interest in the in-depth knowledge about the feelings, emotions and thoughts of participants included in the sample, whose target was not generalizations²².

The 12 interviewees lived where the error occurred, being four in Rio de Janeiro and the rest in São Paulo. The collection began in São Paulo, and we did not intend to include cases which happened in Rio de Janeiro. However, given the difficulty we had to contact victims, we had to expand the scope of the collection. Rio de Janeiro was then chosen because it was easy to contact victims of medical error in the state, as there was a non-government organization (NGO) dealing specifically with medical errors in the state, which is something São Paulo lacked. This NGO facilitated the contact with victims of court-validated cases.

In Rio de Janeiro, contact with the victims was mediated by the NGO and, in São Paulo, by lawyers specialized in this type of case, both which guided the identification of final decisions of public lawsuits in courts of general jurisdiction. Unfortunately, the validation criteria used by regional medical councils in Brazil could not be used due to an ethical precept of the CEM, which mandates, in most cases, the maintenance of the anonymity of professionals investigated by class entities. Only one of the 12 cases studied was validated by Cremesp and seven others by courts of general jurisdiction.

Interviewees' names were altered to preserve their anonymity. The errors involving Márcia, Marília, Jorge, João and José occurred in the private health care system; all others happened in the public system (Table 1, attached). In order to facilitate the reader's understanding of the meaning of each line, besides the interviewee's name, the error of which they were victims has also been identified.

In the cases studied, no direct relation was found between the type of error and different forms or degrees of anger or acceptance. One can assume that the way victims deal with the error is more related to their own individual characteristics and less to the type of error. That being considered, we deemed it was not advisable to establish generalizations or comparisons. Each reaction was peculiar, which reinforces the idea that responses are influenced by personality and personal nature.

The interviews were recorded and their transcription, analysis and interpretation were grounded on assumptions and concepts stemming from the work of Walter Benjamin as well as from the analytics of the meaning²³, a path which can be used to understand reality, making it possible to reconstruct the experience. This method conceives the narrative as an artisanal means of communication in which experiences are the raw material that grant meaning and contextualize that which was experienced, as a record of the experience. Thus, to narrate would be to exchange experiences, taking into account to which extent something experienced can be elaborated. The narrative allows experiences to be told whereas new meanings to difficulties are found²⁴.

Results

The stories and cases in this study are the result of hours of narratives by the participants, who proved willing to talk about a difficult time in their lives. Many of them still find it traumatic to remember these circumstances, which were marked by suffering and profound sadness of having to go through a situation resulting from a medical error. Researchers sought to acknowledge the importance of the experience of each victim, valuing the art of narrating facts, which has been hindered by excessive explanation as well as by the lack of interest in the exchange of experiences.

This paper addresses the initial stages of experiencing medical errors in the lives of the victims. That is, it discusses the types of impact of the discovery and how the victims absorbed and faced the situation. The moment the error is discovered is depicted with indignation and some victims are still perplexed in face of the gravity of the event; they seem not to believe that it really happened and that they have no choice but to face the consequences of this error:

"I was floored. I did not know what to do. Why had that happened? I still ask myself, 'What happened for this to be happening to me?' I mean, it changes your whole life, right? At first, you end up depending on others for everything, from brushing your teeth to using the restroom. So, it's very hard, because you want to do things and you can't. You keep thinking: 'Gee, I was doing something to get better and now it's worse!' It's hard (...). When it [the surgery] happened to me, I was afraid of even walking through the hospital entrance. I got the shivers, and outburst in tears. This messes with our heads, we may go crazy over it (...). Until I can walk again, I'm like a child

learning to walk, it's even funny, right? [laughter]. The first steps are horrible. My self-esteem is very low. My mind is shaken." (Marina – surgery on the wrong limb).

The discovery of the error was almost always made by the victims themselves or by other physicians, in charge of later procedures. The vast majority of the professionals that erred did not take responsibility for the error in front of the patient or, when they did so, which was the case of two of the professionals, they did not fulfill the promise of dealing with the consequences and expenditures.

The attempt to fit phenomena in reference frameworks that give them meaning is part of the psychological structure of human beings. Frequently, in face of novelty, this attitude reveals the intent of identifying and establishing a relation of causality between the events, so as to put them in the list of what is known and understood. While this is limited to negative phenomena, the narratives showed that this was not different with medical error victims. Finding what caused the error to occur is a frequent characteristic of the narratives:

"Look, I've tried putting myself in the physician's shoes, but I failed. I don't know if he was distracted, if he took personal problems to work or if his workload is very heavy and he was tired, which hindered him during surgery. But, well, especially for a physician dealing with lives, problems must be kept outside the workplace. Now, was he tired? I don't know. You try to find an explanation, but you can't. I don't know what his problem was." (Marta – prosthetics inadequately set).

According to the participants, after the error is discovered, another challenge surfaces: finding a physician willing to repair the mistake of a colleague. This situation is very common for victims and almost all interviewees experienced that. José even reported that after the error was identified he was only able to find a physician willing to check the state of his eyes after seeing twelve professionals. The other victims also faced difficulties to find a trustworthy professional to minimize or, if possible, repair the error.

The feelings the victims begin to experience are unique and private, and are especially related to the way they conceive the error and accept their state. Generally, the vast majority has feelings of despair, anger and impotence:

"A lot of fear. And then anger. A lot of anger. It was hard to get rid of this... of this grudge. It was hard to

forgive Doctor D [physician 's name], who was the first physician. It was hard. I managed. I managed, but it wasn't easy. It wasn't easy, not to brag, but I don't think anyone can do it. There was a time, after I was like that, during rehab, that I had gone back to driving, I even stopped, I did this twice, I stopped the car in front of the hospital waiting for him to come out. Good thing he didn't show up, I was going to do something... something crazy. I waited for him: 'This guy will go by here, I will break both his knees'. That's how angry I was." (Jorge – prosthetics inadequately set).

All participants reported difficulties to recover their lives. Nonetheless, it was easier for some – such as for Marília (inadequate dermatological procedure) – than for others – such as for João, who became paraplegic. The gravity of João's case did not prevent him from going back to his daily activities; regardless of how hard it was to return, he succeeded: "I struggled with difficulties, but I managed it". This situation reinforces the idea that personality and personal characteristics may be more important in the way interviewees deal with the issue than the type of error itself.

However, even considering these individual differences, the analysis of the narratives shows that adaptations to the new lifestyle imposed affect practically all areas of interviewees' lives. Almost all patients reported changes that affected their professional performance, leading to difficulties and posing obstacles which resulted in lack of productivity and labor incapacity.

Many of the feelings expressed by the participants stem from the impact the medical error had on their lives. This situation led to inevitable transformations and changes not only to the routine, but also to the way they faced life. It was possible to notice that some victims became more careful and started to question medical procedures more, as well as everyday events in general. Others stated that this kind of experience makes one appreciate life and, consequently, leads to more appreciation and consideration for those close to them, such as their families.

"I no longer trust doctors blindly. I became extremely careful when it comes to rules and procedures. There's something else I changed too. As a teenager, I was often told to let things go. So much so that the physician erred and I was letting it go. Marília no longer lets things go. Marília questions everything in life. Marília is a go-getter. Marília is careful, I got more cautious. I changed a lot in that sense, not only for myself, but also for those dear to me." (Marília – inadequate dermatological procedure);

"So, this episode made me rethink a lot of things. First, I used to value work too much and the family too little. So, now I appreciate my family more than professional life" (José – wrong organ operation).

A critical attitude and the search for rights and justice are characteristics that became more present in the victims. They justify it by saying that this happens because they feel betrayed, attacked by lies and false statements, so that they began to adopt an inquisitive attitude. The fear of having to undergo a new surgery or submit to another medical intervention is also recurring among interviewees. This feeling seems to be evidenced by the contrast between the situation experienced and the memory of the positive expectation they had toward the intervention before the error. Together with the fear of having another unsuccessful intervention is the fact that the cure is not likely to happen and that improvements are only their only possibility, reinforcing the fear and the lack of confidence in the work of another physician who may assist them:

"So, I am trying to find another physician, not here, because no one here will provide me with good care. But what about my fear of operating the other one? I'm afraid have surgery in the correct knee. I don't even know what to think. Until I can trust a physician, and then talk to him/her a lot, only then will I think about having it. Now, at this moment, if I were to go into surgery, I would run away from the hospital and no one would see me. I'm still in a lot of pain, but I'd rather be in pain than having to go through all of this again." (Mariana – blind as a result of cataracts surgery).

Some narratives also highlight the importance and the need to provide psychological care to victims, implying that they believe this service could help them overcome barriers imposed by the error and develop better conditions to face life. This hypothesis seems to be ratified by the narratives of those who received psychological care, which reinforced the importance of follow-up carried out by a psychologist. These interviewees pointed out their improvement when it comes to accepting their new condition and overcoming challenges posed by the consequences of the medical error.

Discussion

Many authors stress that, when human beings are overtaken by something unexpected, their initial reaction is surprise, and, sometimes, denial²⁵⁻²⁶.

However, by the end of this phase people understand the situation better and begin to consciously experience it, as we could observe among interviewees.

What is understood from the narratives about the moment when the error is identified is that the decision to seek to understand or define the cause of the error only creates more doubts and anxiety in the victims. The lack of information, dialog and support by the institution or professional appears in all narratives. This was repeatedly mentioned, showing how much it contributes to increase the psychological stress of victims of medical errors. The questions generated by this situation escalate to a point that even the presence of the physician in the operation room is questioned, as patients were sedated before even having a word with the professional or knowing whether the professional was present in the room.

A wide, anthropological view on suffering indicates that it can be characterized as an existential situation which, sooner or later, every human being does experience²⁷. If little can be done to avoid suffering, one can, at most, minimize the suffering inherent to existence. Considering this perspective, three steps can be defined to cope with suffering:

- 1) Accepting it as something that is present and that must be faced. It is the dramatic moment of existence. The possibility of adopting a positive or negative attitude in face of suffering gives one the freedom to grow and mature;
- 2) Suffering allows one to see the world through different eyes. In face of it, what was had been greatly important is renounced. Suffering distances people from desires that, until then, governed their existence. This may help them feel more independent;
- 3) To be meaningful, suffering itself cannot be taken as an end. In order to fight it, one must transcend fear²⁸.

The narratives also show that physicians have difficulties admitting their failures to patients. In addition to the entire emotional de-structuring to which victims are subject as a result of the error, this attitude only worsens their suffering, which intensifies with the lack of support, understanding, respect and ethics by the person in charge of the treatment¹⁷. When there is no mutual trust, which must govern the doctor-patient bond, the relationship may present typical forms of exercising authority, such as orders and threats, lecturing, exclusively technical and impersonal care, in addition to the tendency to ignore patients' problems,

among others. This study showed that the most constant attitude of professionals in cases of medical errors is to deny the patient's perceptions, even if this means ignoring clinical scenarios whose complications clearly indicate the error²⁵.

Medical errors can have a personal or structural influence. The personal influence happens when the responsibility lies solely on the physician. It is often grounded on physician's lack of training, lack of responsibility or other occasional reasons. Errors under this category are always the result of malpractice, imprudence or negligence. Structural errors occur mainly when medicine is practiced in precarious conditions and using obsolete equipment, which might happen due to governmental or administrative negligence in regard to health care²⁹.

An English study admitted that 16% of patients hospitalized are victims of some kind of medical error and that half of these errors are attributed either to mistakes regarding procedures that precede the surgery or to technological and equipment failures⁷. In France, medical errors are seen and studied rigorously and the legal system has already identified the most common errors considering their typology. One out of ten patients hospitalized is a victim of a medical error, but the French government has been developing a regulatory framework to protect them and reduce the number of errors. This framework stresses the need to avoid excessive workload for physicians³⁰.

A study carried out in the state of Minas Gerais sought to understand the perception of medical and law students regarding the level of interest and information on medical errors, as well as the need to discuss the theme in undergraduate courses. The authors identified that, for over half the participants – 185 medical students and 119 law students – the most important reason to be interested in the theme is the fact that it is a currently affair³¹. The students believed that media influence on the population and the increase in the number of medical schools trigger medical errors and, for this reason, considered it necessary to learn about and discuss the matter. The study also indicated the occurrence of errors could be avoided if health care professionals practiced a more humanized, dignified kind of patient care, strengthening the doctor-patient relationship, grounded on respect, patience and tolerance³¹.

The increase in the number of cases of medical errors in Brazil has led to an unexpected situation: the consolidation of defensive medicine, in which professionals try to protect themselves by exaggerating when ordering more sophisticated subsidiary

exams, withdrawing from high-risk procedures and often refusing patients in serious conditions with more potential for complications and sequelae. This way to practice medicine suggests that physicians adopt conducts considering a possible future need for defense and, thus, being protected in case a patient becomes a potential enemy willing to sue them⁵⁻³²⁻³³.

The medical community in Brazil relied on almost 433 thousand certified professionals in 2015, a ratio of 2.11 physicians per 1,000 inhabitants, with irregular distribution of professionals throughout the country. The highest concentration is in the Southeastern region, with 55.3% of physicians in the country³⁴. The Brazilian population has continuously been proving more rigorous when it comes to medical procedures, demanding first-world health care. However, services are not always equipped to meet such demands and the level of training provided in some courses leaves a lot to be desired, which allows the increase of adverse events that hinder the image of the profession³.

Even though the exclusive focus on technical improvement can be explained as a result of the need to find a solution for the increase of demand, both in regard to amount of care provided and to quality demands. This convergence has led to the dehumanization of medicine and its adoption does not favor physicians, patients or the society, as it could be expected. Technical competence is essential in good practice, and the desire for it is so strong that it undermines another fundamental aspect of the profession: ethical and human competence. The humanitarian bond must be the main aspect of the doctor-patient relationship, even considering that the best and best-applied techniques must guide the treatment and the healing process³⁵.

Medical training should have two basic applications: provide the student with essential scientific and technical knowledge to exercise their future profession; facilitate the gain of maturity of the adult and balanced personality, able to understand the complex biopsychosocial structure of patients¹⁶. Based on what can be implied from what was said by interviewees, neither of these essential aspects was perfectly contemplated in the professional training of those that inflicted their errors on their patients.

It was not possible to establish the direct relationship between how medical errors are perceived and variables of genre or typology. On the other hand, significant differences were observed in regard to the victim's economic status and level of

education. These differences were identified based on post-error medical treatment. These variables seem to have influenced even the acceptance of the problem. The study showed that the victims with higher education – Márcia, Marília and João – obtained better access to post-error treatment. Márcia (surgery on the wrong limb) sought a physician in a university in São Paulo, Marília was treated in the United States (USA) to address the consequences of the wrong dermatological procedure and João relied on a private physiotherapist to work on the problem resulting from inadequate application of anesthetics.

These victims are the most financially sound ones, which favored the access to good physicians and treatments. It is important to notice that the definition of treatment used regards procedures aimed at minimizing damages, including victims' psychological follow-up which may help them in the acceptance process. Differently, the medical error which happened to the interviewees with no higher education or less financially sound – Mariana, Jairo, Marina and Maria – happened in the public health care system and these patients had no choice but to rely on this very system for post-error treatment. Cataracts surgery which caused blindness; forgetting surgical material inside the patient's body; surgery on the wrong limb; need for surgery ignored by the physician – these are the errors which occurred to each of them (respectively), who did not receive the due attention of the public health care system or the psychological support they could not afford:

“A while ago, as soon as it [the error] happened, I told my mother I would like some type of psychological support. But I didn't get it because it's hard to get it here, even when it's necessary [referring to public health care]. It's hard. Now, imagine how hard it would be to get a psychologist? I think this problem doesn't happen just here, it's a problem generated by the SUS (the Brazilian Federal Health Care System) all over the country. But I think they should be a bit more sensitive to the fact that people suffering due to medical errors end up putting their lives on hold for a while and need support” (Marina – surgery on the wrong limb).

As such, one can argue that there is an intimate connection between medical error and the victims' economic situation, especially with regards to the alleviation of consequences and to the possibilities related to access to health care services. On the other hand, in spite of having obtained different treatments due to their economic and educational level, the subjective feelings of interviewees in face

of the different kinds of error which victimized them were not significantly different. All of them felt indignant, fearful, mistreated, deluded and distrustful.

Thus, regardless of the gravity and intensity of the error, it is noticed that feelings and subjective sensations were similar and equivalent. There were no relevant differences, all interviewees suffered a lot as a result of the error. Dependence, impotence, difficulty accepting the error and inability to work were consequences experienced by all victims in a higher or lower degree and extent. Even those who managed to return to work did so with a lot of difficulty, as the “stigma” of the error remains in their lives to these days and they do not foresee great ease in overcoming it.

Another significant data is that the error was validated by the CRM (Regional Medical Council) only in the case of one of the interviewees. The others, by their initiative or by that of their lawyers, chose not to bring the suit to this level, bringing it directly to the courts of general jurisdiction. It is important to remember that, the initial criterion to include a case in this study was the proof of a medical error, regardless of the entity ruling on the matter. Therefore, the aim was not to learn why the victim brought suit to a given instance and not to another. Nevertheless, what can be understood from the narratives is that almost all interviewees chose courts of general jurisdiction, aiming at financial compensation to cover expenditures with treatments.

The feelings brought on by the victims express the psychological distress everyone experiences when they find out they are the victims of a medical error. The narratives show that, from the moment they became victims, their lives are transformed, ruled by another logic, based on the losses which affect not only their everyday lives and routine, but the lives of those close to them.

Final considerations

A previously presented study made with medical and law students showed that medical students already showed concerns related to dealing with lawsuits resulting from medical errors in their future professional lives. It is essential that we consider this information as reference, considering that the students interviewed state that it is of paramount importance to improve the approach to legislation related to the profession and to medical ethics³¹. The medical sector is already alarmed by the growing number of ethical and legal lawsuits as well as

apprehensive when it comes to the consequences of the punishments, which might inhibit and threaten the scientific process, making medicine a timid, routine-like science³.

In regard to the reference made by the studies mentioned to the condition of patients²⁻⁶⁻¹³, one can clearly notice that the medical community is feeling threatened by citizen empowerment as well as by the “strengthening” of social participation, factors which have contributed to raise people’s awareness of their rights. According to the authors of these studies, such aspect led patients to become more inquisitive and demanding. For patients, it is important to understand the relation of “power” intrinsic to the doctor-patient bond, as it allows patients to resort to legal action when they realize they were harmed by errors stemming from the medical treatment.

Some institutions developed special bodies to verify patients’ situation. In 1999, the USA created the Agency for Healthcare Research and Quality, whose purpose is to investigate the quality of medical care and ensure patients’ security. In 2002, the Global Alliance for Patient Safety was formulated during the 55th World Health Assembly, showing a greater concern on the part of medical service providers with financial compensation for malpractice requiring the payment of damages. In France, also in 2002, the National Office for Reparation of Medical Accidents (Oniam) was created by initiative of the Health minister. The purpose of Oniam is to work for victims of harm resulting from medical services as well as from the quality of the health care system³².

Services supporting individuals going through distressful situations or serious trauma are essential for victims of medical errors to face life in a less negative way, as this support offers hearing and attention. Psychology can represent one of these forms of support, being the most sought path by some victims. Psychologists may encourage victims to seek their potentialities and self-awareness and, thus, see the importance of becoming able to act to improve their lives, even under adverse circumstances²⁶⁻³⁶. When talking about support and aid in cases of medical error, one must necessarily consider victims’ families and physicians, as they may need support due to their involvement in this difficult, sensitive situation. After all, they also feel emotionally shaken with the event and with the effects of medical errors.

However, studies on the topic reveal that both physicians and medical students are extremely reluctant to accept that they need help, especially in emotional matters. When emotionally distressed

physicians are the focus of psychological care, they tend to deny and hide their emotional difficulties. These studies show that they actually deny their suffering to their friends, family and even to themselves. They hide their problems because this threatens their right to practice their profession, as well as their income. They frequently tend to self-diagnose and self-medicate and, when they seek help, they do so informally, with friends and co-workers³⁷⁻³⁸.

The analysis of these studies shows that, in spite of high psychiatric morbidity among physicians and medical students, few of them truly seek help. Bias toward emotional problems seems to be – effectively – a barrier which has always fed this hurdle. Avoiding to seek appropriate help is also associated to the fact that a mental health problem may be seen as weakness, with repercussions on the progression of a successful career³⁸⁻³⁹.

In order to address this issue, some medical schools have been investing in initiatives that offer support to their students, considering the emotional turmoil experienced and its implications in the professional practice²⁵. This is the case of the USP Medical School. Aiming to promote the wellbeing of its students and prioritize actions targeting more attentive care to the quality of life of future physicians, the university created the Student Psychological Support Group (Grapal), the Tutoring Program (Programa Tutores), in addition to curriculum integration of subjects related to medical humanities⁴⁰⁻⁴².

Finally, the possibility to work with oral records and experiences of 12 victims of medical errors showed the complexity of representations,

meanings and attitudes of these individuals in regard to social actions. At the same time, the analytics of the meaning proved to be a path to better understand this reality which is so unknown to the Brazilian scientific community, especially scholars in the field of health care and similar institutions.

The main and most difficult issue in this paper is that this study is not limited to case studies, that is, it was not focused on comparing the cases to possibly better deal with its goals. The issue proposed was to identify the experiences of Brazilian medical error victims and highlight, to the scientific community, that their suffering creates new demands for studies, revealing adverse situations which need to be better studied and tackled. As inevitable as it may be, this study did not intend to differentiate the intensity and gravity of errors, but to shed light on some of the challenges related to being a victim of these errors, specifically at the moment when such errors are identified and the behavioral transformations that surface afterwards.

Still, there are many challenges and limitations regarding the approach to medical errors, involving lawsuits brought to courts of general jurisdiction and to medical councils. This study does not intend to generate conflicts of interest or any kind of problems between professionals and patients. Its purpose is rather to stress to the scientific community the physical and mental distress faced by victims of medical errors, which is increasingly common in Brazil, in an attempt to point out health care measures to minimize the pain and suffering of all those involved in a medical error.

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Participation of the authors

Vitor Silva Mendonça took part in the outlining of the study, as well as in data collection and analysis and in the writing of the paper. Eda Marconi Custódio advised on the research and revision of the paper.

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Appendix

Table 1. Description and status of medical error cases between October 2011 and October 2012.

Victim	Description of the medical error	Status/instance of the lawsuit
Mariana	Cataracts surgery resulting in blindness	Proven/Court of RJ
Marcela	Absence of a responsible physician during labor	Proven/Court of RJ
Márcia	Surgery in the wrong limb	Proven/Court of RJ
Marília	Inadequate dermatological procedure	Proven/Court of SP and Cremesp
Jorge	Prosthetics inadequately set	Proven/Court of SP
João	Anesthetic applied in the wrong place	Proven/Court of RJ
José	Surgery in the wrong organ	Proven/Court of SP
Jairo	Surgical material forgotten inside patient's body	Proven/Court of SP
Marina	Surgery in the wrong limb	Pending decision/ Court of SP
Marta	Prosthetics inadequately set	Pending decision/ Court of SP
Maria	Need for surgery ignored by physician	Pending decision/ Court of SP
Jeremias	Prescription of medication to which patient was allergic	Pending decision/ Court of SP

Interview script

Interviewee characterization:

- 1) Age
- 2) Gender
- 3) Educational level
- 4) Profession/occupation (ask about past occupation in case interviewee is retired)
- 5) Income-based economic class (considering the interviewee's own opinion)
- 6) Marital status

Trigger question:

- 1) Tell how your experience of finding out about the medical error been so far.

Aspects to be tackled during the interview:

- 1) Expectations before the medical procedure.
- 2) How the error was first identified?
- 3) Reaction of the professional after the error was identified.
- 4) Has any type of help or support been offered? By whom?
- 5) Does the error interfere in your life? If yes, how?
- 6) Can you see the importance of psychology for victims of medical error?