

## REVIEW

doi: 10.5455/medarch.2022.76.377-382

MED ARCH. 2022 OCT; 76(5): 377-382

RECEIVED: OCT 04, 2022

ACCEPTED: NOV 01, 2022

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# The Impacts of Applications of Criminal Law on Medical Practice

Zaid Ibrahim Yousef Gharaibeh

## ABSTRACT

**Background:** Human health is the single most asset that any one person can and need to have it as qualitative as.. Despite this, however, there are occasions when things go wrong in practice and the patients wind up getting hurt while they are receiving treatment at the healthcare facility Obtaining and maintaining a good health are the goals of individuals and communities, which require having good medical systems. In rare cases, malpractice of medical systems may occur, a matter that affects patients and health providers. **Objective:** The main objectives of the present study were to review the literature for medical malpractice and how the application of criminal law impacts the medical practice.

**Methods:** This is descriptive review based on the related studies published in scientific literature and deposited in on-line indexed databases. **Results and Discussion:** Main findings of the study showed that medical errors are likely to increase overtime. Malpractice is likely to take place as if good intention to do the best. Activation of criminal law against medical malpractice may put stress on medical staff, and may be a triggering factor for improving services submitted to the patients. **Conclusion:** Activation of criminal law against medical errors places stress on medical community from one side, and may be a triggering factor for improving services from another side.

**Keywords:** Medical errors, criminal law, health, stress.

## 1. THE IMPORTANCE OF HEALTH

Our health is, without a doubt, the single most asset that any one person can have. This is true for most of us (1). Despite this, however, there are occasions when things go wrong in practice and the patients wind up getting hurt while they are receiving treatment at the healthcare facility (2). Traditionally, the protection of individuals within a society can be accomplished in a variety of ways, including through civil, criminal, and administrative procedures (3). In the Netherlands, over the course of time, procedures have been established to handle complaints, which has allowed for the handling of complaints regarding the performance of healthcare providers. These procedures allow for the complaints to be addressed. Changes that have been made to criminal law in recent years have resulted in a variety of repercussions for the medical care sector. Some examples of this include the appointment of medical prosecutors and the establishment of an expertise center on medical matters by the Public Prosecution Service.

In addition, there are suggestions made in legal literature that criminal law is applied in modern times in order to provide redress to patients (relatives) and as a "safety tool," which is to ensure security and to counteract risks within the healthcare sector. This is something that is being done in order to provide redress to patients (relatives) (4).

## 2. MEDICAL COMMUNITY AND JUDICIAL SYSTEM

This section investigates the function that various members of the medical community, primarily physicians, play in the judicial system. One might get the impression, within the framework of the English legal system, that medical professionals occupy an unusually privileged position. Nevertheless, doctors are particularly susceptible to the possibility of extremely severe civil and criminal liability, including the possibility of being charged with gross negligence manslaughter. This is one of the many risks that doctors face. In spite of the fact that one is less likely to identify doctors as members of the precariat than one might be inclined to do with care workers, medical professionals are also working under intense pressures as a result of austerity. This is because of the fact that austerity measures have been implemented. The individualizing effect of criminal liability deflects attention away from the economic setting and directs it instead toward medical errors and lapses in judgment (5).

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### 3. CRIMINAL LAW

When the criminal courts are presented with issues involving the behavior of medical practitioners, the general doctrines of criminal law are sometimes put under a significant amount of strain. This is because of the nature of the situation. Intention is typically defined in criminal law texts as either acting with the specific purpose of bringing about the prohibited result or acting with the awareness that the result is almost certainly going to follow, even if the actor's purpose is something other than bringing about the prohibited result. In other words, intent can be defined as either acting with the knowledge that the result is almost certainly going to follow, even if the actor's purpose is something other than bringing about the prohibited result. This section examines how English courts have dealt with claims that certain conduct can be justified on medical grounds, as well as how the criminal law ought to deal with claims of this nature, and it does so by examining how English courts have dealt with claims that certain conduct can be justified on medical grounds (6).

Recently, there have been cases in which doctors have been criminally convicted for criminally misdiagnosing a patient with constipation who then died of a diaphragmatic hernia. The patients in these cases had died as a result of the diaphragmatic hernia. These incidents took place only not too long ago. The possibility of criminal prosecution for medical professionals may have the unintended effect of reducing the number of available medical practitioners in the market. An online poll was taken by the Korea Medical Association's total membership of 79,022 medical professionals, who responded to the questionnaire. In order to process all 3,109 of the responses that were given, the analysis was carried out using the questionnaire system of the online survey that was conducted by Doctor's News. The findings suggest that medical professionals have developed a greater tendency to prescribe excessive treatments, avoidance treatments, and defensive treatments.

Additionally, it was found that the modern world necessitates the use of specialized organizations for the purpose of performing medical evaluations. In order to resolve medical disputes in an objective manner, it is necessary to improve credibility by securing the expertise of the Korea Medical Dispute Mediation and Arbitration Agency (Korea Medical Dispute Mediation and Arbitration Agency). The services of the organization can be retained in order to accomplish this goal. In addition, there is a need for specialized organizations to conduct medical evaluations and to train medical staff in order to increase their level of comprehension regarding medical disagreements. This demand has led to the creation of some of these specialized agencies. As a consequence of this, the probability of having a medical dispute can be decreased, and the resolutions to such disputes can have a higher degree of equity (7).

The vast majority of medical professionals will, during the course of their careers, be involved in at least one instance of medical malpractice. This is a common occurrence that frequently results in costly and contentious

medical disputes. The practice of engaging in defensive treatment is referred to as "defensive treatment" when a medical dispute results in an interruption of a physician's ability to focus on his or her area of expertise (8).

It is possible to file a lawsuit against a medical practitioner in the event that it is determined that the practitioner was at fault for an injury or death that was sustained by a patient as a result of treatment (9). A system characterized by low levels of insurance coverage, low levels of medical expenses, and low levels of personal income has resulted in an increase in the number of medical disputes, which has occurred at an alarmingly rapid rate. This system creates predicaments like the three-minute consultation, which in turn leads to the destruction of the entire system for the delivery of medical care (9).

Because of factors such as the specialization of medicines, the specificity of medical practices, and the reticence of medical practitioners, it can be difficult to recover the damages caused by medical disputes. When taken together, these factors make it extremely challenging to recoup these losses. In the event that there is a disagreement regarding the medical care that was provided, it is the patient's responsibility to provide evidence not only that the care that they received was below acceptable standards but also that the treatment that they received was in violation of the laws that were in effect at the time. In the event that the patient does not comply, the disagreement will be deemed to be invalid. However, because the conditions of patients can vary and serious illnesses can be made worse by natural causes, it is not easy for experts to demonstrate that a medical practitioner is responsible for the consequences of their medical practice. This is because serious illnesses can be made worse by natural causes. Because of this, it can take a very long time to arrive at an accurate diagnosis, which can result in the wrong treatment being administered (10, 11).

In addition, certain uncommon medical conditions, such as heavy metal poisoning or autoimmune disorder, can present with unusual symptoms. Nevertheless, the social and financial costs incurred by patients and medical practitioners in order to resolve disputes are rapidly increasing as a result of the growing number of medical disputes and the length of time required to reach a resolution (12). This is due to the growing number of disagreements in the medical field, which in turn, makes it more difficult to find a solution in a timely manner. In addition, there is the phenomenon of doctors who intentionally perform defensive treatments or overtreatments due to the risk of medical accidents and who avoid medical fields that experience a high frequency of accidents. These doctors are known as "defensive medicine" practitioners. These medical professionals are commonly referred to as practitioners of "defensive medicine." As a direct consequence of this, the Korea Medical Dispute Mediation and Arbitration Board was established with the purpose of resolving medical disputes in a timely, unbiased, and efficient manner. This resulted in a shift away from more authoritarian methods of conflict res-

olution toward more autonomous methods, such as the practice of mediating or arbitrating disputes between the parties involved with the assistance of specialists, such as medical professionals and legal specialists. One example of an autonomous method is the practice of mediating or arbitrating disputes between parties involved with the assistance of specialists. As a direct consequence of this, it became possible to resolve the contentious relationships between disputants in ways that were more constructive and to maintain relationships that were friendlier (13, 14).

If the outcomes of medical practice can result in criminal punishment, then in the long run, this would lead to an increase in the burden that is placed on patients as well as an increase in the overall costs of medical care throughout the country. A medical review was performed as part of the civil dispute that was brought before the Mediation Arbitration Board prior to the three doctors being taken into custody. This review was done as part of the civil dispute that had been brought before the board. On the other hand, the Mediation Arbitration Board's medical review was carried out solely by a single licensed medical practitioner. This provided evidence that there was no element of subjectivity at play, and as a result, the reliability of this judgment appears to be in question. As a consequence of this, the objective of this study is to investigate the effect that a legal dispute in the medical field can have on clinical settings and to offer suggestions for the continued development of medical environments (15).

There are a few distinguishing characteristics of medical disagreements in Korea concerning the administration of pain relief, and these characteristics have been identified. It is essential that patients and pain physicians have access to information regarding medical disputes in the field of pain management in order to aid in the prevention of additional disputes and litigation. Patients as well as the medical professionals who treat their pain can benefit from this information. It is imperative to have guidelines and recommendations for the treatment of pain, in particular those that are centered on medico-legal cases (15).

According to the findings of Lim et al (16), the number of patient complaints increased significantly at a compound annual growth rate (CAGR) of 4.2% ( $p < 0.01$ ), whereas the number of medico-legal cases and ex-gratia payments for case settlements decreased at CAGRs of 4.8% ( $p = 0.05$ ) and 15.9% ( $p = 0.19$ ), respectively. The CAGR for the number of patient complaints was 4.2%. 88.6 percent of the 237 medico-legal cases that have been closed were resolved without the need for any kind of legal action to be taken. Among those cases, 78.1% were resolved without any ex-gratia payments or waivers being distributed to the parties involved. There were 11.4% of medico-legal cases that led to legal action, and 66.7% of those cases were settled without any ex-gratia payments or waivers being made. In total, there were 11.4% of medico-legal cases that resulted in legal action. The Patient Relations Service's (PRS) engagement of the complainants and facilitation of written replies were the

primary modes that were utilized in order to reach a resolution to the issue. There was not a single case that was brought in front of the judge. When the PRS was involved in a case, there was a significantly increased likelihood that the case would be resolved without the need for legal action ( $p = 0.009$ ). This was the case regardless of whether or not the PRS was involved. When compared to the cases in which legal action was taken, the median value of the settlements reached in these cases was noticeably lower. Because it addressed patients' core dissatisfactions and providers' perspectives, their hospital-based dispute resolution system was able to promote claims resolution before legal action was taken. This was the case even though legal action was not taken. This was attained by following a procedure that involved early engagement, open disclosure, and equitable negotiations. This early dispute resolution strategy served as a complement to system-level mediation and arbitration in the effort to reduce the amount of medico-legal litigation that was taking place. It also kept costs under control (16).

Recent years have seen a rise in the number of lawsuits alleging medical malpractice, which has the potential to have a sizeable effect, financially speaking, on healthcare systems (17). Historically, when faced with the possibility of a claim, service providers have responded by taking the position of "deny and defend," with the hope that this tactic will deter unscrupulous lawsuits and claims (18). There is a high incidence of claims that are not backed by any evidence that would indicate that they are incorrect (19). It was demonstrated by Studdert et al (19), who reported their findings in the NEJM, that more claims result from medical mal-occurrence (also known as poor outcomes), as opposed to medical malpractice. In point of fact, a considerable number of medical complaints and claims were associated with erroneous allegations (20), inadequate communications, severed relationships between providers and patients, and unfulfilled anticipations (21).

According to the findings of research, an effective method for conflict resolution places an emphasis on identifying the interests of the parties involved and avoids rights-based methods such as litigation and arbitration (22). In some healthcare systems, models for alternative dispute resolution (ADR) have been developed and implemented. These models accord greater autonomy and confidentiality to resolve concerns through the facilitated exchange of information and clarifications (23). They place an emphasis on early engagement and open disclosure with less adversity and legalese. These in-hospital mechanisms have proven to be effective in preventing litigation, lowering costs, and increasing a sense of satisfaction and redress among those involved in the dispute (24).

#### 4. HISTORY OF MEDICAL ERRORS

Errors in medical practice have a long and illustrious history that dates all the way back to antiquity, and concerns over who is responsible for those errors have also a long and illustrious history. Mesopotamia had already

developed the Hammurabi Code by the time period that lasted from 1792 BC to 1750 BC (25). This code addressed the blunders that were made by medical professionals while they were engaged in the practice of their profession. The British legal scholar Sir William Blackstone is credited with making one of the earliest reports of errors in medical practice. His work is known as the “Blackstone Report.” The compilation of legal thoughts that he published the following year, in 1765, under the title *Commentaries on the Laws of England* was given that name. When he makes this reference, he is referring to *mala praxis*, which he defines as “neglect or unskillful management of a physician or surgeon.” When he makes this reference, he is referring to this. The word “malpractice” in its current sense was derived from this term in the first place (25).

According to the information presented in the prior sentence, “the first recorded medical malpractice lawsuit in the United States takes place in Connecticut where a patient died of a surgical complication in the year 1794.” This event marks the beginning of the modern era of medical malpractice lawsuits in the United States. Because the patient’s fracture didn’t heal properly, one of the patients threatened the doctor with a lawsuit. According to the information that was provided by Sandor (26) “in 1871 the Medical and Surgical Report recounted an audacious solution to a malpractice charge.” The surgeon made a proposal to correct the defect and investigate other potential solutions to the issue. In order for the surgeon to successfully perform the operation, he had to immobilize the patient because the patient refused to cooperate. After that, the patient made the decision to drop all charges against the healthcare provider. According to De Ville (27), “it might be characterized as an early case of defensive medicine.”

The problem first manifested itself in the 19th century as a consequence of litigators who pursued cases in an overly aggressive manner; the majority of the cases involved errors in the treatment of injuries such as fractures, dislocations, and amputations (25).

In the first half of the 20th century, there was no let-up in the number of lawsuits filed over alleged medical mistakes. This trend continued throughout the entire century. The majority of them claimed that the errors were the result of the actions taken by the doctor; more specifically, they claimed that the doctor made an error, which is also referred to as an error of commission, “such as causing injuries due to too much radiation (during radiographs examination), complications of surgical treatment, and diagnostic failures.” (26). In medical practice, there was a shift away from errors of action and toward errors of omission beginning in the 1950s and continuing onward. This shift continued until the present day. The medical practitioner did not carry out the procedure that ought to have been carried out for that particular circumstance. For example, the total number of lawsuits filed in the United States alleging failure to diagnose cancer increased by fifty percent between the early 1970s and the late 1980s. These lawsuits were filed in the United States (27). According to Berlin (25),

“a 1991 study disclosed that 75% of all adverse events due to negligence committed in New York hospitals in the late 1980s involved diagnostic mishaps, which were typically the result of a physician’s failure to do something.” This information was gleaned from a study that was conducted in 1991. In the meantime, “malpractice claims dramatically increased between the 1960s and 1980s, reaching 15 claims out of 100 physicians in any given year, with a doubling in payouts.”(28).

There is still room for debate regarding the precise definition of what constitutes a medical error at this point. The meaning of the phrase “the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim” has been described by a number of authors, all of whom reach the same conclusion. One definition of a medical error is as described above (29). The term “medical error” refers to inappropriate behavior on the part of a healthcare provider that results in harm to a patient. This behavior can be caused by negligence, recklessness, or malpractice. In Brazil, the term “medical error” refers to inappropriate behavior on the part of a healthcare provider that results in harm to a patient. It is a symptom of the maturation of the “error concept,” which takes into account all aspects of behavior that have the potential to harm the patient. This is an indication that the “error concept” has progressed over time. In a nutshell, the accusations of negligent behavior leveled against doctors have undergone a sea change over the course of the past few decades: whereas in the past, patients were the ones to sue doctors for doing something wrong, more recently, doctors have been the ones to be sued for failing to do something correctly. In other words, patients used to be the ones to sue doctors for doing something wrong, but now it is doctors who are being sued for failing to do something correctly. As a direct consequence of this, “contingency plans often arise within a clinician when faced with thoughts of shame, or embarrassment,” according to the author, in response to an accusation of wrongdoing made by patients or family members, errors in medical treatment, or other lapses in judgment (28, 29).

In addition, there has been a trend toward overdiagnosing patients and performing unnecessary operations on patients, both of which have the potential to cause patients harm. In addition, there has been a trend toward performing unnecessary operations on patients (30). Patients experience mental calmness as a result of this approach to providing the highest level of care. On the other hand, the potential for monetary gain may be the driving force behind it. Worse still, medical students and residents can observe this practice (such as so-called defensive medicine) while they are being trained, which contributes to the perpetuation of the problem. Defensive medicine is just one example. As a consequence of this, the purpose of this narrative review is to investigate and describe the connection between medical mistakes, medical negligence, and defensive medicine, as well as to suggest a few practices and mentalities that can be utilized to steer clear of both the errors and the practice of defensive medicine. In addition, the purpose of



this review is to investigate and describe the connection between medical mistakes, medical negligence, and defensive medicine (30).

## 5. MEDICAL RESPONSIBILITY

The attitude of the legal system in each nation toward the possibility of medical mistakes and the acceptance of medical responsibility is a significant factor in determining how and where D.M. is practiced. For instance, in Brazil, it is imperative that the subjectivity of medical responsibility be made clear; patients should be cared for by their doctors, but they should not be cured. In addition, the success of the treatment is contingent not only on the competence of the attending physician but also on a number of other individual and societal factors. As a result, in order to validate the existence of an error in medical practice, it is essential to define the nature of the fault that may or may not have been committed by the professional. And guilt, in turn, is demonstrated by inappropriate medical behavior based on negligence, recklessness, or malpractice. The judge will base his decision on the expert's analysis of the evidence after the judge has requested an expert examination to determine whether or not there was an error. But as far as the authors are aware, the medical responsibility in the United States and other countries is objective; there is a compromise with a cure and with a good result - independent of any factor that is not normal to the doctor-patient relationship. In addition, their legal system "is based on the premise of trial advocacy, which relies on the adversarial arrangement of opposing parties, a judge, and potentially a jury." "The adversarial arrangement of opposing parties, a judge, and potentially a jury." The jury is responsible for determining the facts, while the judge is responsible for deciding all legal issues (31). In addition, under Brazilian Criminal Law, a doctor may be held liable for bodily injury under Article 129 of the Penal Code and for murder under Article 121 of the same code if the patient dies while under their care. In both instances, it will be investigated to determine whether or not the doctor has committed a "non-observance of the professional technical rule." Should this be the case, the punishment will be increased. It is essential to note that "non-observance of professional technical rule" refers to the fact that the physician did not adhere to the procedures and guidelines that were recommended for each individual patient's circumstance.

Obviously, the procedures and protocols are based on the most compelling scientific evidence that is currently available (32-35).

## 6. CONCLUSION

The trend of having medical errors or malpractice is being increasingly observed over the time due to increasing demands for medical services. Malpractice is likely to take place as if good intention to do the best. Activation of criminal law against medical malpractice may put stress on medical staff, and may be a triggering factor for improving services submitted to the patients.

- **Authors contribution:** The author of this article is responsible for full written text and cited comments from the used references, including, also, its final proofreading.
- **Conflict of interest:** None declared.
- **Financial support and sponsorship:** Nil.

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