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Review Article

Human Error and Management in Gynecological and Obstetric Cases

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Abstract

In this review we have collected information about errors that occur in gynecological and obstetric cases. Mistakes are an integral part of every sector, but our task should be to recognize and report mistakes. This will prevent problems that may appear later. Organizations promote health professionals in announcing their mistakes to the person's family but also to the person herself. Various error cases are described demonstrating the variety of errors that exist. In this way, health professionals and other people, possibly future patients, should understand that error is part of everyday life. Finally, health tips are suggested.

Keywords: Error; Obstetrics; Gynecological; False

Introduction

Mistakes are a common feature in healthcare. Mistakes of increased, moderate, or minor seriousness may occur which cause serious, moderate, or minor problems respectively. This most often happens due to negligence, stress, or semi-learning. Many unexpected problems are based on mistakes that occurred in the past and appeared later. This proves that usually many errors are not recorded. The reason may be either the concern of those responsible for sanctions, or the uncertainty about what really happened, or the ignorance of the use of the reporting system. The purpose of the reporting system is to transmit to the central authorities any errors that occur. This system should be used by each hospital, so that the health staff of the hospitals can be improved with the consequent improvement of the hospital itself [1].

The patient, on the other hand, wants to know about the errors that occurred during, for example, an operation or a treatment. He also wants to know the severity of the mistake and how it can be treated if it can be treated. This information will help solve the problem that has arisen, but it will be crucial for the quality of the services of the doctor and/or the hospital. However, professional organizations, such as the Institute for Health Improvement, have guidelines that support open communication with patients after errors.

From 2009 until today, the American College of Obstetricians and Gynecologists supports patient information by doctors about errors that occurred during monitoring or performing a delivery or during surgery. In this way, the safety of each patient will be maintained, as well as the management of the error that may be in danger.

More specifically, in gynecological and obstetric cases, errors often occur either individually in each category separately, or errors of misinterpretation of a gynecological case as obstetric and vice versa. But this way, because obstetric incidents are about 2 people and not one, any mistakes are more serious.

When an error has occurred, obstetricians-gynecologists may support its disclosure to parents, but they are concerned about the parents' reaction to the hearing and the risks that may arise. Despite this, trying to report the error and trying to improve the reporting method will bring the desired results later [2]. Because maternal morbidity and mortality remain persistent challenges for the U.S. health care system, efforts to improve patient's safety are critical. An important aspect of ensuring patient safety is the reduction of medical errors [3].

Mistakes that occur during the perioperative period can cause serious problems later and so health staff should recognize and reduce these mistakes. They are broadly divided into 2 types of errors: latent and active errors. Latent errors indicate inadequate organization while active ones must be dealt with individually [4].

Discussion

Error Cases

After searching with keywords: error, mistake, obstetrics, gynecology, health staff, we found 1800 articles from which we selected 11, as we believe that they aim at the topic of this article and were within the last 5 years. In a study of births in Norway, it was found that 65.2% of adverse reactions were reported by parents, while a much smaller proportion, 39.1% of cases were reported by hospitals. 48.3% of the cases recorded were related to serious errors in the provision of health care or to a system error and not to individual errors. Most errors were detected in small and medium clinics by the supervisory authority [1].

In a case of neonatal death which involved a child with a head injury and was therefore identified as suspected of child abuse, it was discovered that the characteristics of the injury could be attributed to violence. Autopsy revealed severe leptomeningeal congestion and bleeding. Also, the microscopic neuropathological examination showed hemorrhagic purulent leptomeningitis. However, after a more extensive study of the incident, they found that the baby, according to the birth archives, underwent a caesarean section with vacuum assist. The fractures that the baby had on his head were combined with this type of extraction. Thus, the examination of a wound after the birth of the infant is characterized as of major importance, as an omission of check of the newborn resulted in death [5].

In another neonatal event, in which the newborn was resuscitated in the operating room and then transferred to the ICU, an error had occurred during fetal lung maturation. Then the medical staff using a surfactant tried to cure it. The father's behavior, during the transfer of the newborn to the ICU and after the announcement of the error, was confused and irritating. In such cases, parents should be informed by a specialist, so that there is an appropriate way to report the error [2].

Errors have also been observed in the administration of drugs in the operating room. In cases of anesthesia, errors occur with medications and doses. Fewer errors were observed in hospitals with electronic recording system and barcode use in syringes. Information is stored in the system such as when someone is allergic to a substance and if a drug with this substance was to be administered, since the patient's data has been stored in the system, it will mean an indication that will not allow the administration of this substance. The cost of installing the system can be quite high and difficult to install by all hospitals and clinics, but this way will minimize errors and subsequent problems that may be caused [4].

There are many times when mistakes occur when there are synonyms in the medical record. Thus, a medication that must be administered to a patient is administered to his namesake. It is even more serious if you mistakenly give medication to an infant who should not be taking these medications [3]. In one gynecological case, a 43-year-old woman had constant vaginal discharge of watery, odorless, and colorless fluid for 8 months. The Pap test was normal, as was her menstruation. The first diagnosis was urinary incontinence. In a second opinion he received and while the symptoms worsened, the ultrasound revealed hydrometra and papillary endometrial lesions. The hysteroscopy and biopsy taken showed endometrial adenocarcinoma. This unusual form of cancer, which was initially misdiagnosed as urinary incontinence, was diagnosed by ultrasound which was not performed in the first case. The most common symptom is bleeding in the postmenopausal period, but any other particular symptom that occurs in a woman should not be ignored. Early transvaginal ultrasound examination and endometrial sampling under hysteroscopy are recommended in any suspected case of cancer [6].

The most common errors, in a study, were the delay of bleeding transfer to the operating room and the reduced to zero familiarity with the administration of prostaglandin for uterine atony. The following are the wrong techniques of cardiopulmonary resuscitation and dystocia. This is followed by the delayed administration of blood products and finally the inappropriate avoidance of episiotomy in a case of shoulder dystocia and the extraction of the hip [7].

In an obstetric case of a 25-year-old, woman was 33 weeks pregnant. She was complaining of severe abdominal pain when the fetus was shaking. The diagnosis was peritonitis. An emergency laparotomy was performed, and a live baby was found with placental implantation in the eye and small intestine. This case signals to doctors that abdominal pregnancy remains a differential diagnosis for painful fetal movements [8].

It is also worth noting that mistakes made in pandemics of the past such as that of HIV should not be repeated, because in that pandemic one the ban on breastfeeding eventually led to

many more infant deaths than expected. For a better effect on the health of infants in the midst of a COVID-19 pandemic, skin-to-skin contact and breast-feeding should be promoted [9]. It is also worth mentioning that although the errors in radiology are less and less as the years go by, there is research related to obstetric ultrasound. It presents errors that occur at the study level but also at the individual level. These two can overlap or be combined. In any case, these mistakes must be eliminated [10].

Conclusion

Summing up, from the investigation of the incidents that we did, we conclude that mistakes happened and continue to happen until today. Errors are observed which are usually due to ignorance of the error logging systems. Dealing with mistakes, unfortunately, is based on hiding and not recording more of these incidents due to fear. However, promoting awareness of any errors that have occurred is very intense by organizations and committees.

After all, there is no one who is infallible and this should be understood by both the patient and the medical staff, so that the best possible discussion in case of error happens. Also, health professionals should understand that reporting errors is part of their job and their dignity. If, however, the patient does not accept the doctor's apology in case of error, it is normal due to his irritability and non-acceptance of the incident. In this case, too, the doctor did the right thing, even if he did not have the specific treatment [11]. At least in this way he allowed himself to feel better and to forgive him for his mistake.

We suggest all medical staff speak openly to their superiors but also to the patient in which the mistake was made about it. Also, the error reporting system and electronic drug barcode systems to be installed in every hospital and clinic. Healthcare professionals should examine the patient in more detail but also work more carefully, as well as faster, to avoid mistakes. Finally, mistakes of the past that happened become a lesson so that they do not happen again.

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Conflicts of Interest

No conflicts of interest.

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