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Medical malpractice, liability of healthcare professionals and patient protection in the democratic republic of Congo from 2015 to 2019

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Abstract

Introduction: The aim of the study was to determine the reasons for medical errors committed by health professionals in hospitals in the city of Kisangani, to demonstrate the legal instruments on which Congolese law relies to protect patients in the event of medical error, to identify the modes of reparation reserved for victims of medical error in the jurisdictions of the city of Kisangani and the Province of Tshopo, and to report on the progress of the study.

Methodology: The study took place in the city of Kisangani and was based on two methods. Firstly, the interrogative method, using interview techniques based on a pre-established questionnaire, which enabled us to collect information from health professionals, victims of misconduct and legal actors. Secondly, the documentary method, which enabled us to collect data from the Simama Functional Rehabilitation Centre in Kisangani on the files of victims of medical misconduct, and from the Kisangani High Court for cases that had been tried.

Results: Poor concentration (accumulation, etc.), overwork and lack of knowledge of the procedure to be performed are the most frequent causes of malpractice, accounting for 35.1%, 26.3 and 13.9% of cases respectively. Book II of the Penal Code and the law on the protection of children (tied at 100%) are the main laws protecting patients from medical malpractice, the law protecting people living with HIV (65.6%) and the Congolese Civil Code, Book III (56.3%). Lastly, the Constitution of the DR Congo of 18 February 2006 and the Decree of 19 March 1952 (tied at 31.3%) complete the legal arsenal of Congolese laws protecting patients.

Conclusion: In the DRC, the issue of medical errors represents a real challenge for society. The human, social and economic consequences are dramatically underestimated. In Kinshasa and elsewhere, people are dying as a result of errors made by medical staff.

Keywords: Medical malpractice; Liability; Healthcare professionals; Patient; Protection

1. Introduction

Patients' rights have been at the heart of debates in recent years. In the past, doctors had real "power" over patients. Today, they are becoming co-authors in the care process. Patients can check their diagnosis, and even the treatments prescribed for them [1].

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Contacts between doctors and their patients are frequent, but the rules governing them are often little known. Patient safety has become a growing concern for healthcare establishments due to the high frequency of medical errors and incidents associated with care (iatrogenic) [2].

Medical malpractice has been a topic of discussion since antiquity, as the occurrence of malpractice was already fully recognized by ancient societies. In Egypt and ancient Rome, for example, there were sanctions to condemn errant doctors, based on a code of ethics that defined the therapist's responsibility in precise terms [3].

With technological evolution and innovation in medical resources, medical science has developed and, consequently, cases of medical malpractice and error have also increased.

Healthcare staff (doctors or nurses) may be inclined to commit offences in the course of their work. These are mainly offences against the physical integrity or life of the patient. Thus, only the guilty party must eventually bear the punishment, as stipulated in article 17 paragraphs 8 of the constitution of 18 February 2006: "criminal responsibility is individual; no one may be prosecuted, arrested, detained or sentenced for the acts of others..." [4].

In principle, civil liability is laid down in Article 258 of the decree of 30 July 1888, establishing the Congolese Civil Code, Book III, as follows: "Any act whatsoever by man which causes damage to another person obliges the person through whose fault it occurred to make reparation for it" [5].

Certainty is not peculiar to our condition, thus, "*since errare humanum est* i.e. ''error is human''", all our activities are subject to the possibility of error, etc. [6].

The discovery here of the double faces of error: horrible because of its harmful consequences; but also attractive, because it reveals the hidden weaknesses of the system. We now need to take account of the second side, which requires it to be used for prevention purposes.

The information conveyed on medical malpractice and/or error indicates that in fact the number of victims is very high worldwide. Every year, according to figures from the World Health Organization, 20,000 medical errors occur in Belgian hospitals, resulting in at least 2,000 deaths. We must therefore not only recognize and identify the existence of these numerous malfunctions, but also put in place the appropriate corrective measures to prevent them [7].

In the Democratic Republic of Congo, the issue of medical malpractice is a real challenge for our society. The human, social and economic consequences are dramatically underestimated. Some people die as a result of mistakes and/or errors made by healthcare staff in health facilities in Kinshasa and elsewhere. Most of these medical errors go unpunished because some of the families affected do not complain [8].

The responsibility of the medical team is an obligation for a health professional or a health care establishment to answer for the damage caused during a medical act or care and to assume the civil, penal and disciplinary consequences.

Medical liability is a very broad concept that may directly concern either the doctor or nurse who performed the act, or the healthcare establishment in which the act was performed. It may be of different kinds: civil, criminal or disciplinary. The rules then differ according to the case [9].

Judges are increasingly confronted with conflictual relations between healthcare professionals (doctors, nurses, etc.) and their patients.

All medical professionals are subject to an obligation of means, not an obligation of end. They are not contractually obliged to cure you. This naturally raises problems of interpretation regarding the concept of fault and medical liability [10].

When medical care is not provided in accordance with the rules of the art, the patient may legitimately seek compensation for the harm suffered and, in order for the healthcare professional to be held civilly or criminally liable, there must be a fault relating to the medical acts of diagnosis, care and prevention [11].

Very often, however, victims were not compensated because they were unable to establish the existence of the doctor's fault. As a result, medical malpractice can be considered generically as a breach of the obligation incumbent on professionals to provide conscientious, attentive care that complies with the latest scientific findings. Medical liability,

on the other hand, requires a combination of fault on the part of the healthcare professional, harm to the patient and a causal link between the fault and the harm.

In France, Law no. 2002-303 of 4 March 2002 now regulates the matter, instituting a principle of legal medical liability [12].

Medical malpractice, unknown to the Congolese a few years ago, is now becoming a veritable social phenomenon. It is therefore time for the authorities to look into the issue and find appropriate solutions to protect patients.

Health professionals also need to be informed of their duties and rights in their dealings with patients. Throughout their work, they must honour their various oaths (depending on the guild: Hippocratic, Florence Nightingale, etc.) setting out the principles of medical ethics. They should at all times and in all places reflect on article 2 of the code of medical ethics: "Respect for life and the human person is the paramount duty of health professionals in all circumstances". The administrative and political authorities must promote and facilitate the dissemination of the message of medical law, which should be communicated in training structures, medical faculties, law faculties and institutions for training health workers. The aim should be to ensure that, in the next five or ten years, a good number of Congolese and health professionals are fully conversant with medical law.

Today, the victims of medical malpractice are very vulnerable, because only a few of them seek to denounce what they have suffered. There is another point that contributes to their vulnerability. The vast majority are people with a low level of education, which we believe is a decisive factor in preventing them from seeking legal redress.

Under article 259 of the Decree of 30 July 1888 on the Congolese Civil Code, Book III: "Everyone is liable for the damage he has caused, not only through his own actions, but also through his negligence or imprudence" [5]. This provision refers to a fault which, in law, is any act or behavior attributable to an individual which causes harm to another person.

If the patient succeeds in proving that the doctor committed an error that caused damage and the causal link is demonstrated, the patient is entitled to compensation.

The aim of the study was to determine the reasons for medical errors committed by health professionals in hospitals in the city of Kisangani, to demonstrate the legal instruments on which Congolese law relies to protect patients in the event of medical error, to identify the modes of reparation reserved for victims of medical error in the jurisdictions of the city of Kisangani and the Province of Tshopo, and to report on the progress of the study.

In view of the above, the study has the following objectives:

To identify the factors that encourages medical malpractice by health professionals in hospitals;

Demonstrate the ways and means by which Congolese law protects patients in the event of medical malpractice;

2. Material and method

2.1. Description of the Kisangani City

We carried out our research in the city of Kisangani, city of hope, Boyoma La Belle, a city in The Democratic Republic of Congo in Central Africa, The Capital City of Tshopo Province.

It has an altitude of 393 metres and a surface area of 1,910 km^2, according to the INS. The city of Kisangani has a population density of 229 inhabitants per km^2. Located 1,724 km by river to the north-west of the capital Kinshasa, Kisangani is at the point where the river Lualaba takes its name from the Congo. The city stretches from the River Congo to the River Tshopo. The city is located in the centre of Africa.

Administratively, the city of Kisangani is subdivided into six urban communes (Makiso, Tshopo, Mangobo, Kabondo, Kisangani, Lubunga) and the Lubuya Bera collectivity.

It is bounded to the east by the territory of Bafwasende; to the west by the territory of Isangi; to the north by the territory of Banalia; to the south through the Opala territory.

However, the most commonly used means of transport is the motorbike taxi in a city where only international organizations and a few private individuals own cars.

Kisangani has two airports. One is an international airport with a 3,800-metre runway at Bangboka, and the other is the former military and later civilian airfield at Simi-Simi.

2.2. Type of study

To achieve the study's objectives, we carried out an empirical, longitudinal study of an analytical, retrospective and quantitative nature, based on the legal-sociological method (or intellectual method used by legal professionals to study legal phenomena in a society and the related regulatory texts).

2.3. Study Population

The study populations were made up of: firstly, healthcare providers from 5 General Reference Hospitals (GRH) in the city of Kisangani; secondly, patients who had been victims of medical malpractice during the study period; thirdly, those involved in the justice system (judges, magistrates and lawyers). And finally, fourthly, files relating to disputes between patients and healthcare providers whose judgements were handed down at the High Court of Kisangani.

We used the occasional non-probability sampling technique. Given the importance of this study, we drew a sample as follows: 137 healthcare providers, 27 victims of medical malpractice, 32 legal actors and 14 cases whose judgments had been handed down by the High Court of Kisangani, including 1 case currently being examined.

2.4. Data collection techniques

The study is based on two techniques. The interrogative technique, using questionnaires and interviews to collect information from healthcare professionals, victims of misconduct and legal actors. For healthcare providers and legal actors, we administered the questionnaire by direct contact with the respondents. We therefore drew a random sample for each of these groups. On the other hand, for the victims of misconduct, the technique of sampling by reasoned choice and snowballing facilitated data collection in the form of a structured interview with the victims of medical misconduct, i.e. on the basis of the addresses found on the various consultation forms at the Simama Functional Rehabilitation Centre, we reached the victims of medical misconduct.

The documentary technique made it possible to collect data at the Simama Functional Rehabilitation Centre in Kisangani, in relation to victims of medical malpractice, and at the High Court of Kisangani for cases that had gone to trial.

2.5. Data processing and analysis

The data collected were analyzed and encoded using Microsoft Office Excel and SPSS, version 20.1. The results obtained were presented in the form of frequency tables, and data analysis was made possible by calculating percentages. Finally, the results were interpreted using the legal-sociological method.

2.6. Ethical aspects

Participation in the study was voluntary. Consent was free and informed, but verbal only. Respondents were told that if they agreed to take part in the study, a questionnaire would be administered to them. Respondents who freely agreed to be recruited could withdraw from the study at any time without prejudice.

3. Results

3.1. Results of the provider survey

3.1.1. Level of education and assignment structure of surveyed providers

The table shows that 39 respondents, or 28.5%, were from the GRH/Makiso; 31 respondents, or 22.6%, worked at the GRH/Kabondo; 26 respondents, or 19%, were from the GRH/Mangobo. Of this population, 93 respondents, or 67.9% of cases, were university graduates, including: 18 doctors (13.1%), 32 registered nurses (23.4%) and 43 graduate nurses (31.4%). The General Reference Hospitals of the Kisangani city are reference medical institutions. In principle, these institutions should use more senior staff in their departments to minimize the risk of medical malpractice or error.

Table 1 Presentation of the subjects surveyed according to level of education and assignment structure

Assignment structure	Study level								Total	
	Qualified Nurse		Undergraduate Nurse		Graduate Nurse		Physician			
	f	%	*f*	%	*f*	%	*f*	%	*f*	%
GRH of Kabondo	7	5.1	5	3.6	14	10.2	5	3.6	31	22.6
GRH of Lubunga	10	7.3	1	0.8	4	2.9	3	2.2	18	13.1
GRH of Makiso	13	9.5	11	8.0	9	6.6	6	4.4	39	28.5
GRH of Mangobo	8	5.8	13	9.5	3	2.2	2	1.5	26	19.0
GRH of Tshopo	6	4.4	13	9.5	2	1.5	2	1.5	23	16.8
Total	44	32.1	43	31.4	32	23.4	18	13.1	137	100

3.1.2. Most frequent causes of medial mistakes or errors

Table 2 Classification of study subjects according to the most frequent causes of medical errors (*n = 137*)

Causes of medical malpractice	*f*	%
Poor concentration (multiple duties)	48	35.1
Work overload	36	26.3
Lack of knowledge about what to do	19	13.9
Fatigue	11	8.0
Complexity of techniques	11	8.0
Variety of products to be administered to the patient	8	5.8

It was shown that poor concentration (accumulation, etc.), overwork and lack of knowledge of the act to be performed were the most frequent causes of errors according to 48, 36 and 19 respondents, representing 35.1%, 26.3 and 13.9% of cases respectively.

3.1.3. Medical errors or mistakes most frequently committed by healthcare professionals

Table 3 Presentation of study subjects according to the errors most often committed by healthcare professionals

Errors most often committed by healthcare professionals		f	%
Technical faults	Post-injection abscess	137	100
	Limb paralysis after injection	137	100
	Oversight of treatment time	74	54.0
	Forget to tick the treatment administered	45	32.8
	No patient follow-up	41	29.9
Diagnostic errors		34	24.8
Failure to prescribe background treatment		18	13.1

After analyzing the data, the study showed that technical errors (paralysis or disability following health care and abscesses following an injection) accounted for 137 respondents, i.e. 100% of cases. In addition, 74 respondents (54%) forgot to take the time to administer care, and 45 (32.8%) forgot to tick the care administered. Finally, 41 respondents (29.9% of cases) did not follow up their patients. Diagnostic errors concerned 34 respondents, i.e. 24.8% of cases. The failure to prescribe background treatment concerned 18 subjects surveyed, i.e. 13.1% of cases. These are the errors most often made by professionals.

3.1.4. Provider responsible for medical fault or error

Table 4 Distribution of study subjects according to providers involved in medical malpractice

Medical malpractice providers	**F**	**%**	**Fault committed**	**f**	**%**
Yes	73	53.3	Technical faults	65	47.4
			Diagnostic errors	31	22.6
			Non-prescription of background treatment concerned	9	6.6
No	64	46.7		-	-
Total	137	100		-	-

This analysis revealed that 73 subjects in the study, i.e. 53.3%, acknowledged having committed a medical fault or error in the exercise of their profession. Among the mistakes or errors committed, technical errors were revealed in the case of 65 respondents, i.e. 47.4% of cases. Diagnostic errors concerned 31 respondents, or 22.6% of cases. Non-prescription of background treatment concerned 9 subjects surveyed, i.e. 6.6% of cases. None of these providers had informed their patients of the incident. On the other hand, 64 subjects in the study, i.e. 46.7%, had never done so.

3.1.5. Attitude of the career who commits a fault

Table 5 Presentation of study subjects according to the attitude of the caregiver who commits a fault

Attitude of the carer who commits a fault	***f***	***%***
Lack of knowledge of the situation	109	79.6
Compassion with the victim	17	12.4
Contempt	9	6.6
Acceptance of the victim's care	5	3.6

The results of this analysis show that 109 subjects (79.6%) were unaware of the situation, while 17 respondents (12.4%) sympathized with the victims.

3.1.6. Consequences of medical malpractice

Table 6 Distribution of study subjects according to the consequences of medical malpractice (n=137)

Consequences of medical malpractice	***f***	***%***
Bodily injury (iatrogenic abscesses, paralysis, etc.)	102	74.5
Transmission of infections (nosocomial infections)	89	65
Legal proceedings	87	63.5
Prolongation of hospital stay	62	45.5
Death	51	37.2
Additional cost of care	48	35

Of these results, bodily injury and the transmission of infections are recognized by professionals as the consequences of medical malpractice, with 74.5% and 65% of cases respectively. This was followed by legal action in 63.5% of cases.

3.1.7. Providers' knowledge of the legal consequences of medical malpractice or error

Table 7 Presentation of study subjects according to providers' knowledge of the legal consequences of medical malpractice or error

Providers' knowledge of the legal consequences of misconduct	**f**	**%**	**Legal consequences**	**f**	**%**
Yes	123	89.8	Imprisonment	43	31.4
			Reparation and payment of damages.	29	21.2
			Fine	21	15.3
Undecided	14	10.2			
Total	137				

In view of the above, the majority of the 123 respondents (89.8%) were aware of the legal consequences of medical malpractice. In the case of medical malpractice or error, the consequences were imprisonment (31.4%), compensation and payment of damages (21.2%).

3.2. Results of the survey of victims of medical malpractice

3.2.1. Survey at the Simama Functional Rehabilitation Centre (patient files)

As we did not know who the real victims of medical malpractice or error were in the population of the city of Kisangani, we consulted the medical records of patients who had consulted the Simama Functional Rehabilitation Centre during the period covered by the study, i.e. from 2015 to 2019.

The study revealed the following information: the Simama Functional Rehabilitation Centre recorded:

Table 8 Victims of medical errors or malpractice at the Simama Functional Rehabilitation Centre

Year	**Number of consultations**	**Right leg paralysis**				**Left leg paralysis**				**Paralysis of 2 legs**				**Total**	
		Children		**Adults**		**Children**		**Adults**		**Children**		**Adults**			
		f	***%***	***f***	***%***	***f***	***%***	***f***	***%***	***f***	***%***	***f***	***%***	***f***	***%***
2015	868	29	12.2	3	1.26	17	7.1	1	0.4	2	0.8	0	0	52	21.8
2016	924	16	6.7	3	1.26	22	9.2	5	2.1	1	0.4	2	0.8	49	20.6
2017	1092	13	5.5	4	1.68	14	5.9	4	1.7	2	0.8	3	1.3	40	16.8
2018	1193	12	5	6	2.5	13	5.5	2	0.9	0	0	0	0	33	13.9
2019	1217	24	10	8	3.36	22	9.2	6	2.5	0	0	4	1.7	64	26.9
Total		94	39.5	24	10	88	37	18	7.6	5	2.1	9	3.8	238	100

In 2015, 52 victims of medical errors or malpractice out of a total of 868 consultations, representing 6% of which 48 were children (20.2%) and 4 adults (1.2%). In 2016, 49 victims of medical malpractice or error out of a total of 924 consultations represented 5.3%, including 39 children (16.4%) and 10 adults (4.2%). In 2017, 40 victims of medical malpractice of a total of 1,092 consultations, representing 3.7%, including 29 children (12.2%) and 11 adults (4.6%). In 2018, 33 victims of medical malpractice or error out of a total of 1,193 consultations, representing 2.8%, including 25 children (10.5%) and 8 adults (3.4%). In 2019, 64 victims of medical errors or malpractice out of a total of 1,217 consultations represented 5.3%, including 46 children (3.8%) and 20 adults (8.4%).

Looking at all these results, we have the impression that it was during 2019 that we recorded the highest number of victims of medical malpractice.

3.2.2. Survey of victims of medical malpractice

Using the addresses of patients treated at the Simama Functional Rehabilitation Centre, we were able to reach 53 victims, 27 of whom had given up their time to answer the interview using a pre-established questionnaire.

3.2.3. Victims' knowledge of medical malpractice

Table 9 Distribution of victims according to knowledge of medical malpractice

Victims' knowledge of a medical fault	*f*	*%*
Yes	*25*	*92.6*
Undecided	*2*	*7.4*
Total	*27*	*100*

This survey revealed that 25 victims out of 27 surveyed, i.e. 92.6%, were aware of the medical fault or error.

3.2.4. Consequences of medical malpractice

Table 10 Distribution of victims according to the consequences of medical malpractice

Consequences of medical malpractice according to victims	*f*	*%*
inability to use the affected limb or organ	*27*	*100*
additional cost of care	*27*	*100*
Death of the person or victim	*12*	*44.4*
Invalidation of the person	*5*	*18.5*

Analysis of the data showed that the inability to use the affected limb or organ and the additional cost of supplementary care were the consequences of medical errors or malpractice in 100% of cases. In addition, 12 respondents (44.4%) added death as a consequence of medical errors or malpractice.

3.2.5. Management of the consequences of medical malpractice or error

In this study, all 27 respondents, i.e. 100% of victims, reported that the consequences of fault or error were dealt with by the victim or the victim's family.

3.2.6. Victims' knowledge of the legal system

Table 11 Distribution of victims according to awareness of referral to the courts

Victims' knowledge of the referral to the courts	f	%	Justification	f	%
Yes	21	77.8	We didn't go to court because we didn't have the resources to deal with the legal process.	16	59.3
			We didn't go to court because the people of Kisangani are not in the habit of accusing health professionals for fear of open conflict.	11	40.7
			We didn't take our case to court because we didn't have a lawyer.	9	33.3
			No legal action was taken for a relationship with the perpetrator (the professional)	4	14.8
No	6	22.2	Have forgiven because it is an unintentional act.	6	22.2

			No legal action was taken for a relationship with the perpetrator (the professional)	4	14.8
Total	27	100			

The study showed that most of the 21 out of 27 respondents, or 77.8% of victims, knew that they could take legal action for compensation. Of these, 16 subjects, or 59.3%, did not have sufficient means to face the legal process. 11 victims (40.7%) mentioned the fact that the population of Kisangani does not have the culture of accusing health professionals for fear of open conflict. Also, 9 victims (33.3%) mentioned the lack of advice (lawyers). In addition, 6 of the victims surveyed (22.2%) had forgiven the offender because, in their opinion, the act was unintentional.

3.3. Results of the justice stakeholders survey

3.3.1. Identification of justice stakeholders surveyed

Table 12 Presentation of the actors of justice according to their function and seniority

Length of service (years)	***Function***						***Total***	
	Judge		***Magistrate***		***Lawyer***			
	f	***%***	***f***	***%***	***f***	***%***	***f***	***%***
1 - 5	0	0	0	0	12	37.5	12	37.5
6 - 10	1	3.1	4	12.5	4	12.5	9	28.1
11 - 15	2	6.3	2	6.3	7	21.8	11	34.4
Total	3	9.4	6	18.8	23	71.8	32	100

The following information was noted from the 32 legal professionals interviewed:

23 (71.9%) were lawyers; 6 (18.8%) were standing magistrates and 3 (9.4%) were sitting magistrates (judges), including one from the Court of Appeal (CA) and 2 from the High Court of Kisangani (HC). Of these actors, 12 respondents, or 37.5%, were juniors in the profession with 1 to 5 years' experience in justice matters. 11 respondents, or 34.4%, had 11 to 15 years' experience and 9 respondents, or 28.1%, had between 6 and 10 years' experience.

3.3.2. Judgments rendered

Table 13 Breakdown of legal actors according to judgments handed down (n= 32)

Judgments rendered	***f***	***%***
Criminal conviction (principal penal servitude) of the defendant	*10*	*31.3*
Payment of damages to the civil party	*10*	*31.3*
Payment of fines and legal costs	*7*	*21.9*
Acquittal of the accused	*2*	*6.3*

The study showed that the criminal conviction of the perpetrators (principal penal servitude) and the compensation of certain victims (payment of damages to the civil party) constitute the judgments handed down according to 50.0% and 43.7% respectively of the judicial officers surveyed.

3.3.3. Legislation protecting patients in this area

For this variable, Book II of the Penal Code and the Law on the Protection of Children (tied at 100%) are the main laws protecting patients in the event of medical malpractice. The law protecting people living with HIV (65.6%) and the decree of July 30, 1888, containing Book III of the Congolese Civil Code (56.3%). Lastly, the DR Congo Constitution of February 18, 2006 and the decree of March 19, 1952 (31.3% equally) complete the legal arsenal of Congolese laws protecting patients.

Table 14 Presentation of legal actors according to the laws that protect patients in matters of medical malpractice (n=32)

Laws protecting patients	***f***	***%***
Penal Code Book II	*32*	*100*
Law protecting children	*32*	*100*
Law on the protection of people living with HIV	*21*	*65.6*
Congolese Civil Code, Book III	*18*	*56.3*
Constitution of the Democratic Republic of Congo of 18 February 2006	*10*	*31.3*
Decree of 19 March 1952 as amended and supplemented to date.	*10*	*31.3*

3.4. Examination of medical files relating to medical malpractice or error at the Kisangani High Court

A few files relating to medical malpractice or error were found at the Tribunal de Grande Instance in Kisangani.

Table 15 Breakdown of offences committed and prosecuted by year

Fault committed /Year	**2015**		**2016**		**2017**		**2018**		**2019**		**Total**	
	f	**%**	**f**	**%**	**f**	**%**	**f**	**%**	**f**	**%**	**f**	**%**
Manslaughter	1	7.1	1	7.1	1	7.1	2	14.3	1	7.1	6	42.8
Criminal abortion	0	0	1	7.2	0	0	2	14.3	0	0	3	21.5
Illegal practice of the healing art	1	7.1	0	0	1	7.2	1	7.1	0	0	3	21.5
Revealing medical confidentiality	0	0	0	0	0	0	0	0	1	7.2	1	7.1
Voluntary administration of HIV/AIDS	0	0	0	0	0	0	0	0	1	7.2	1	7.1
Total	2	1.3	2	14.3	2	14.3	5	35.7	3	21.4	14	100

The observation made in this table shows that the offence of manslaughter (42.8%) is committed more by professionals in the city of Kisangani. It is followed by criminal abortion and illegal practice of the healing art (21.5%, tied figures).

3.4.1. Medical files having been judged at the High Court of Kisangani

Table 16 Presentation of medical cases tried at the Kisangani High Court

Year	**Judgment delivered**				**Cases in process**		**Total**	
	Conviction		**Acquittal**					
	f	***%***	***f***	***%***	***f***	***%***	***f***	***%***
2015	2	14.3	0	0	0	0	2	14.3
2016	2	14.3	0	0	0	0	2	14.3
2017	1	7.1	1	7.1	0	0	2	14.3
2018	3	21.4	1	7.1	1	7.1	5	35.7
2019	3	21.4	0	0	0	0	3	21.4
Total	11	78.6	2	14.3	1	7.1	14	100

A reading of the data contained in this table shows that fourteen (14) offences committed by professionals were reported during the period covered by the study. More offences were reported in 2018 and 2019, with 35.7% and 21.4%

of cases respectively. Of these offences, 11 offenders (78.6%) were convicted and 2 defendants (14.3%) were acquitted. Only one case (7.1%) was under investigation.

3.4.2. Payment of damages

Table 17 Presentation of medical records by payment of damages

Damages paid	f	%	Reason	Total	
				f	%
No	8	57.1	Failure to bring a civil action	5	35.8
			Acquittal	2	15.3
			Case pending (in progress)	1	7.1
Yes	6	42.9	Civil party constituted	6	42.9
Total	14	100		-	-

The research revealed the following results: 6 offenders, or 42.9%, were ordered to pay damages to victims. Whereas 8 defendants, or 57.1%, had not paid the compensation for: Failure to bring a civil action (5 cases, or 35.8%); Acquittal of the defendants (2 cases, i.e. 15.3%); Case pending (1 case, i.e. 7.1%).

4. Discussion

4.1. Most frequent causes of medical errors or mistakes

The study showed that poor concentration (accumulation, etc.), overwork and lack of knowledge about the procedure to be performed were the most frequent causes of errors according to 48, 36 and 19 respondents, representing 35.1%, 26.3 and 13.9% of cases respectively.

For Bismuth, M Dan [13], emergencies appear to be the primary cause of errors (12 out of 31 cases, or 38.7%). The pressure that prevails in this area of medical practice may explain this top ranking. Errors also occur to a significant extent in internal medicine, with 7 cases (22.6%).

Diagnosis is the foundation of medicine and patient care, which is probably why diagnostic errors are the most common type of medical error leading to medical malpractice lawsuits. Thus, common causes of medical error or malpractice include incorrect diagnosis, prescribing errors, dose calculation errors, poor drug distribution practices, drug and drug device problems, incorrect drug administration, failure to communicate and lack of patient education [15].

In the United States, Alain Fuchsberg reports that medical errors are a major cause of patient injury and death. Knowing the causes and frequency of these errors helps patients, doctors and even insurers to prevent them or mitigate their effects.

But even with the most rigorous systems and standards in place, medical errors will continue to occur. Gaps in knowledge, skills, communication and information can lead to adverse medical events [16].

Common medication errors include incorrect dosing, poor quality of medication and adverse drug reactions. These errors can kill or injure patients [17].

Laura Cerland [18], in her 2014 Master's degree on medical error, reported that several factors can be at the root of medical errors or mistakes. These may be human factors including: (lack of inadequate knowledge about patient safety, lack of skills which can lead to medication dispensing errors, staff shortages which can prevent a patient from being followed up); patient-related problems: (patients brought in as emergencies); lack of knowledge (healthcare professionals need to be aware of developments in healthcare research, current drug names and accepted medical standards); technical failures (which can occur when the equipment and instruments used to administer or monitor a patient's medication break down) ; racial bias (which can lead doctors to jump to conclusions about the patient, resulting in medical errors and misdiagnoses); poor hygiene (which can lead to nosocomial infections); inadequate information flow (when patient records are mixed up, poor communication and medical errors can occur).

According to Bhasale and al. [18] the individual factors that predispose healthcare professionals to medical errors are: limited memory capacity (the amount of information that many healthcare professionals are required to know today far exceeds their memory capacity. The human brain is only capable of retaining a limited amount of information). Fatigue (fatigue affects memory. It is a known factor in errors involving healthcare professionals), stress, hunger and illness (when healthcare professionals feel stressed, ill or hungry, they don't work as well). Language (communication errors caused by linguistic and cultural factors can occur between patients and healthcare professionals in many interactions in the absence of an interpreter or a common language). Dangerous behavior (e.g. a novice healthcare professional performing an unsupervised procedure on a patient) and "harmful" working conditions (work overload) have been associated with medical errors or malpractice.

Mistakes or errors are inherent to human life and can occur in any field. Every day, men, women and children fall victim to medical errors in healthcare facilities. For several years now, we have been witnessing a growing number of cases of medical error in health establishments and hospitals, a situation that is at the heart of every debate in the Democratic Republic of Congo.

Making a correct diagnosis is an extremely complex and error-prone task for any doctor, but even more so in the context of emergency medicine. Poor concentration (accumulation, etc.), work overload, emergencies and a lack of sufficient knowledge of the procedures to be carried out are all factors that can lead to medical errors or mistakes.

To avoid these errors, we believe it is essential to understand their causes and thus be able to take appropriate measures to prevent them. The majority of errors occur during the reflective phase of the diagnostic process, caused by cognitive biases and also influenced by systemic causes (communication, teamwork, etc.).

Doctors are responsible for patient education. They also need to communicate with pharmacies about timely refills. The flow of information will become one of the most common causes of adverse events as the industry becomes more dependent on computers (new information and communication technologies, NICT).

4.2. Laws protecting patients in this area

For this variable, Book II of the Penal Code and the law on the protection of children (tied at 100%) are the main laws protecting patients from medical malpractice, the law protecting people living with HIV (65.6%) and the decree of July 30, 1888, containing Book III of the Congolese Civil Code (56.3%). Finally, the constitution of the Democratic Republic of Congo of February 18, 2006 and the decree of March 19, 1952 (31.3%) complete the legal arsenal of Congolese laws protecting patients.

We can read in the Explanatory Memorandum to Law No. 18/035 of December 13, 2018 laying down the fundamental principles relating to the organization of public health that the right to health is guaranteed by the Constitution of the Democratic Republic of Congo [14] which, in Article 18, stipulates that all sick people have the right to the care that their state of health requires, with respect for their dignity and, as far as possible, in their usual living environment. Patients at the end of their lives have the right to appropriate care, relief and comfort. To this end, they receive support from their relatives [4].

Article 1 of Law no. 08/011 of July 14, 2008 on the protection of the rights of people living with HIV/AIDS and those affected stipulates that, in accordance with Article 123 point 16 of the Constitution, the purpose of this Law is to determine the fundamental principles relating to the protection of the rights of people living with HIV/AIDS and those affected. It aims to Combat the spread of the HIV/AIDS pandemic; Combat any form of stigmatization or discrimination against people living with HIV/AIDS and those affected; Guarantee and protect the rights of people living with HIV/AIDS and those affected; Provide support and education for people living with HIV/AIDS, those affected and other vulnerable groups; and Reaffirm the fundamental rights and freedoms of these categories of people [20].

The French law of July 27, 1999 created universal health cover, which guarantees that all French people and those in the overseas departments will be covered by a health insurance scheme, and gives people on the lowest incomes the right to supplementary protection and exemption from advance payment of expenses [20], whereas the general social security scheme in the DRC does not provide its members with health care in the event of non-occupational accidents and illnesses.

Tamburini [22], in her writings on the major laws relating to health in 2021, has shown that health is a constantly evolving field, which has given rise to several "major laws" over the last twenty years or so. It selected the most important of these and found that the Kouchner Law of March 4, 2002 on patients' rights and the quality of the

healthcare system is the best, laying down the principles of genuine healthcare democracy. Promulgated by the President of the French Republic, Jacques Chirac, it strengthens patients' rights in terms of direct access to medical records, the right to information and informed consent, freedom of choice of practitioner and establishment, designation of a trusted support person, rebalancing patient-doctor relations, and the right to compensation in the event of fault. Over the last few decades, a number of legislative reforms have changed the doctor-patient relationship, making patients more involved in their care and formalizing their rights.

The Democratic Republic of Congo has signed up to the Universal Declaration of Human Rights, which promotes fundamental rights and individual freedoms. In several of our country's successive constitutions, there has always been a mechanism to guarantee the right to health, with a view to enabling the population to fully enjoy this right. This human right only exists on paper. However, the right to health implies an obligation on the part of all those involved in the health sector. This accountability is really a right for citizens and a duty for governments. A right remains a right when it is followed by a mechanism for claiming it, which is why it is important to analyze the concept of the "right to health", to see to what extent the Congolese people can enjoy their prerogatives in terms of health.

"Health is priceless" simply means that health is the principle and death is the exception. Hence, to enjoy your health to the full, you have to do everything possible to preserve it in the event of illness, otherwise death will follow. Health requires a great deal of resources to meet the associated costs, including Para clinical and clinical examinations, hospitalization, surgery, the purchase of medicines and the vagaries of care.

The Congolese population is exposed to many healthcare risks, which have a number of causes, notably linked to the state of mind and knowledge of healthcare professionals, healthcare materials, and working conditions of practitioners, incorrect diagnosis, and prescription errors and so on.

The various constitutions that have succeeded one another, apart from the fundamental law, have had to incorporate provisions relating to the right to health, among which it clearly appears as a subjective right of all Congolese people. The Constitution of the DR Congo of February 18, 2006, especially article 47, states: "The right to health and food security is guaranteed.

We believe that all these texts remain dead letters in the Democratic Republic of Congo, which has no specific law to protect victims of medical malpractice. This is the case in the French Republic, with its law of March 4, 2002 known as the "Kouchner law" on patients' rights and the quality of the healthcare system. The Democratic Republic of Congo is content with the old laws of its colony. In our view, health insurance is a factor in economic and social progress, as it enables the provision of sufficient quality healthcare. In the DRC, the vast majority of the population has no form of social security or health insurance. Few people have 1 regular job that pays a salary. The informal sector predominates, with irregular and unstable incomes.

5. Conclusion

In the Democratic Republic of Congo, there are no laws to protect patients from medical malpractice or error. Some laws that do exist remain dead letters. Some patients who are victims of medical malpractice or error have limited financial means to initiate legal proceedings, which are generally very lengthy, in order to obtain compensation (reparation) for the harm caused and/or criminal or administrative sanctions against the healthcare provider at fault, depending on the case.

Furthermore, in order to avoid these medical errors or mistakes, we believe that it is essential for the healthcare provider to understand the causes and thus be able to take appropriate measures to prevent them. The majority of errors occur during the administration of care or during the diagnostic process, caused by cognitive biases, also influenced by systemic causes (communication, teamwork, etc.).

Compliance with ethical standards

Disclosure of conflict of interest

The authors declare that there is no conflict of interest in the design and execution of this study.

Statement of informed consent

Informed consent was obtained from all individual participants included in the study.

Authors' contributions

This work was carried out in collaboration among all authors read and approved the final manuscript.

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