In [1] by Femi Oyebode, the paper discusses the relationship between clinical errors and medical negligence as well as characteristics of lawsuits and events that are sources of lawsuits. The pattern of malpractice claims have been examined. Among the hospitalized worldwide, 3-16% sufer injury as a result of medical intervention, usually due to adverse drug effects. This frequency appears higher in intensive care units and emergency departments. The paper concludes that 1 in 7 adverse events in medicine result in malpractice claim and the factors that predict that a patient will resort to lawsuit depends on the poor relationship between clinician and the patient and the feeling that the patient was not kept informed. Methods for preventing clinical errors are still in their infancy. The most promising include new technologies such as electronic prescribing systems, diagnostic and clinical decision-making aids and error-resistant systems.

In [2] malpractice claims were studied and leading causes of surgical error and their ways to prevention was also researched. 444 closed malpractice claims were studied from 4 liability insurers, in which patients alleged a surgical error. Surgeon-reviewers examined the litigation file and medical record to determine whether an injury attributable to surgical error had occurred and, if so, what factors contributed. Reviewers identified surgical errors that resulted in patient injury in 258 of the 444 (58%) claims. Sixty-five percent of these cases involved significant or major injury; 23% involved death. In most cases (75%), errors occurred in intraoperative care; 25% in preoperative care; 35% in postoperative care. Thirty-one percent of the cases had errors occurring during multiple phases of care; in 62%, more than 1 clinician played a contributory role. Systems factors contributed to error in 82% of cases. The leading system factors were inexperience/lack of technical competence (41%) and communication breakdown (24%). All this data is pertaining to medical care at the US.

The study in [3] aimed to evaluate factors contributing to medical negligence relevant to craniofacial surgery. The methods employed were Retrospective analysis of verdict and settlement reports on the Westlaw legal database for outcome, awards, physician defendants, and other specific factors raised in malpractice litigation. Of 42 verdicts and settlement reports included, 52.4% were resolved with either an out-of-court settlement or plaintiff verdict, with aggregate payments totaling $50.1M (in 2013 dollars). Median settlements and jury-awarded damages were $988 000 and $555 000, respectively. Payments in pediatric cases ($1.2M) were significantly higher. Plastic surgeons, oral surgeons, and otolaryngologists were the most commonly named defendants. The most common alleged factors included intraoperative negligence (69.0%), permanent deficits (54.8%), requiring additional surgery (52.4%), missed/delayed diagnosis of a complication (42.9%), disfigurement/scarring (28.6%), postoperative negligence (28.6%), and inadequate informed consent (20.6% of surgical cases). Failure to diagnose a fracture (19.0%) and cleft-reparative procedures (14.3%) were the most frequently litigated entities.

In India, a study in Bilaspur was conducted [4], comprising of 123 doctors, 68 males and 55 females from varying departments to gauge the frequency of doctors having knowledge of medical law and consequences of negligence. A questionnaire was developed to assess the awareness of consumer protection art and whether they were following medico legal aspects. It showed that 79.2% of the doctors were aware about the code of medical ethics. Male doctors showed more knowledge compared to female doctors. Department wise general surgeons were slightly more aware than gynaecologists. Along lines of experience also the knowledge differed.

In [5] medical liability of a physician in training has been studied, whether the proper standard governing resident physician conduct should be that of a reasonably competent generalist physician, that of a specialty physician, or whether the standard should be some subjective determination that addresses the resident level of training. Westlaw™ and LexisNexis®, two major legal databases used by law professionals, were searched to identify existing case law and law review articles related to the standard of care that applies to physicians in training. Of 57 sources initially identified, 15 legal cases and 10 law review papers addressed the standard of care pertaining to physicians in training. Results have shown that the standard by which the professional conduct of a physician in training is measured has varied; most recent legal cases have applied a specialty physician standard. Relevant court rulings have tried to strike a balance between patient interests versus the societal need to train physicians. But conclusively it is the responsibility of the doctor who supervises the professional conduct of the resident.

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[3] Svider, P. F., Eloy, J. A., Folbe, A. J., Carron, M. A., Zuliani, G. F., & Shkoukani, M. A. (2015). Craniofacial surgery and adverse outcomes: an inquiry into medical negligence. *Annals of Otology, Rhinology & Laryngology*, *124*(7), 515-522.

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