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MEDICO-LEGAL RISK MANAGEMENT IN OBSTETRICS

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ABSTRACT

Since the middle of the last century, the concept of medico-legal risk has been developed considerably following the questioning of doctors on the legal issue and is now an integral part of medical practice, especially in gynecology-obstetrics. Statistics show that the number of civil, criminal or administrative proceedings increases every year even if the number of condamnations remains low. This important development is the result of a change of the relationship between the caregiver and the patient. Formerly, it was a moral contract based on mutual trust, the patient had a priori trust in his doctor while being aware of the limits of medicine. With the evolution of society, the patient conscious of his rights, believes in the omnipotence of science, no longer has a passive role in the act of care but becomes more and more demanding, accepting badly the medical accident whether it is faulty or not. In fact, patients no longer see themselves as patients but as care clients. We then realize that there is a real contract between the medical profession and the patients. The pressure on the management of medico-legal risk is exerted with particular intensity on gynecologists - obstetricians, sonographers, generalists and midwives who touch on a risk emblematic of modern societies: pregnancy, birth and maintaining a sufficient rate of procreation to renew society. For this particular risk, we almost find ourselves in the logic of the atom: society refuses to fail. What to do in practice? What contours for enhanced security that do not demotivate professionals, in particular for the mother-child pole?

KEYWORDS: Management, medico-legal risk, medical file, communication, information.

INTRODUCTION

The practice of medicine is indeed a difficult activity due to scientific progress, the proliferation of specialties, exploration and treatment techniques, the growing demand for medical care, the economic and financial constraints, which today make, medical activity is gaining in efficiency but at the same time creates responsibilities and generates risks. The risks taken being the price of its efficiency. When the medical risk results in a complication - proven or not - it potentially turns into a medico-legal risk, which will have to be done upstream to prevent the occurrence and / or downstream to manage the consequences as well as possible.

Obstetricians' interest in the forensic field has increased considerably and changes in surgical practice have been noted for fear of litigation. In addition, training in obstetrics and gynecology is the subject of medical malpractice and risk management education.[1] Recent data on obstetric and gynecological malpractice claims are lacking.

OBSTETRICS RISKS

Obstetrics is subject to the typology of “risks” that affect medical practice, but with the specifics of:

Permanent risk management: In fact, pregnancy and childbirth carry under normal conditions a risk, and start a pregnancy even under normal conditions; it is therefore to accept the occurrence of an unforeseeable or unpredictable event. In addition to the significant decrease in maternal and neonatal morbidity and mortality, there is the impression of a medically controlled birth leaving no room for the incident. Risk management is of particular relevance to maternity care because the consequences of error, such as maternal death or a handicapped baby are so catastrophic. Indeed, it is for this reason that many would argue that the labour ward is the area of highest risk within the entire health service. According to the NHS Litigation Authority (NHSLA) in 2015/16, although obstetrics took 3rd place in the ranking of the number of medico-legal claims received by speciality, it took 1st place when specialities are ranked according to the financial value of such claims, accounting for 42% of the total value of all claims received (Figures 1). The management of pregnancy and childbirth is therefore in a way the model of risk management and, moreover, the public health policy which is adopted for pregnant women can be oriented towards different loads both over time and / or from country to country.[2]

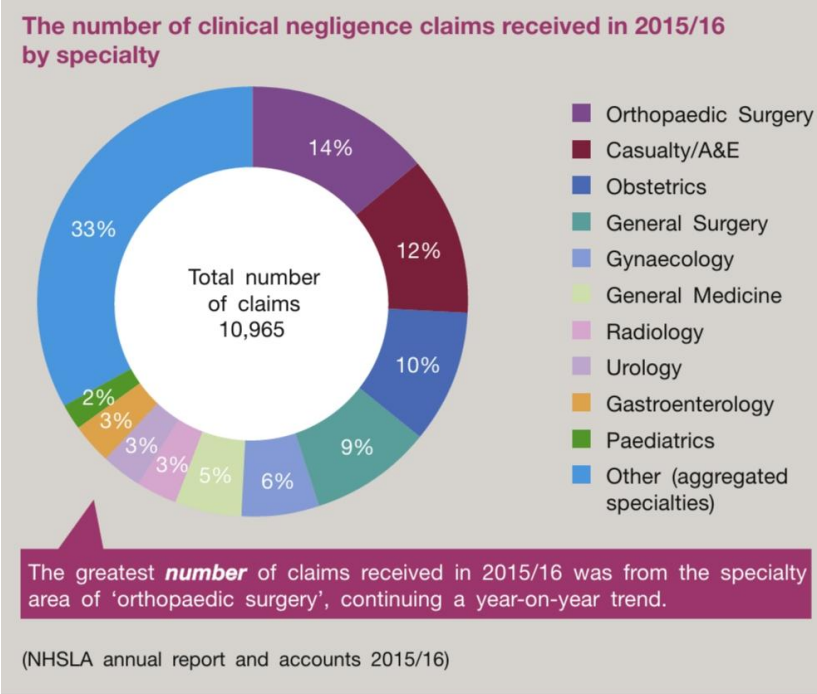


Figure 1

- **Difficult mastery of knowledge:** increasingly important and rapidly evolving: Obstetric gynecology is a specialty that is both medical, surgical and obstetric. Fetal medicine is in the process of building knowledge such as: ultrasound, imaging
- **Difficulty inherent in fertilization:** obstetrics must manage two lives therefore three risks: risk for the mother + risk for the fetus and / or the newborn + risk of conflict of interest mother-child.

Conflict of interest

- Choice between delivery by cesarean/ vaginal delivery in a patient at surgical risk because it is multi-operated while the risk for the fetus is greater by vaginal delivery.
- Indication of fetal extraction, the indication of which is disputed on the maternal level when extreme prematurity is at high risk of neonatal death or long-term sequelae.

Risk management inevitably raises the question of acceptable risk versus unacceptable risk and acceptability for whom: the mother, the child?

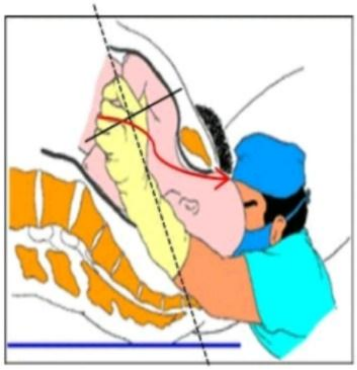
The complexity that generates or increases systemic errors: teamwork always associating the obstetrician, midwife and anesthesiologist, multidisciplinary work for maternal pathologies and antenatal diagnosis and network work (perinatal, city-hospital) necessary for the objective and transparent identification of responsibilities.

Risk management

The most encountered problems in obstetrics and generally lead to medico-legal proceedings are the best-known complications such as: shoulder dystocia, hemorrhage of deliverance and perinatal asphyxia and these are the three examples of management of risk that we will approach.

1. Shoulder dystocia (SD)

The frequency of shoulder dystocia is 1%, brachial plexus elongation (BPE) in SD is 6-35%.[3] The severity of this complication is the definitive risk of BPE: 6.7%, mortality linked to SD: 2 to 4 / 100,000 births.[3] Risk management lies in the diagnosis and removal of dystocia by the various maneuvers, starting with the execution of gestures without delay: 60 seconds for everything: large episiotomy and respect for the sequence of maneuvers "Belgian attitude": Attitude by Mac Robert (figure 2) and Suprapubic compression (and not uterine expression) then the Manouvre by Jacquemier (figure 3) in case of failure which must be done well.[3][4]



Le fœtus se présente avec le dos orienté à gauche, le bras gauche étant postérieur. L'opérateur introduit sa main gauche pour réaliser la manœuvre de JACQUEMIER

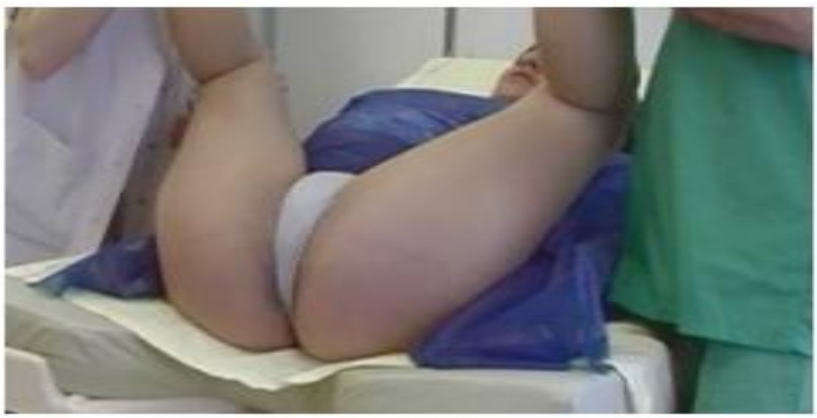


Figure 2 and 3

Prevention comes down to identifying risk factors and asking for a cesarean section.[3] However, to avoid BPE, 3695 unnecessary cesareans must be performed when the estimated fetal weight is> 4500g and 2345 unnecessary cesareans for an estimated fetal weight > 4000g and maternal cesarean / vaginal mortality multiplied by 6.2, relative risk of death in the event of cesarean by severe hemorrhage: 21.0 . Risk of serious maternal morbidity for cesareans between 20 and 40 per 1000. Thus for 3.2 BPE avoided a maternal death by complication of cesarean.[4]

2. The hemorrhage of deliverance

The main cause is wasted time with too late diagnosis. The bleeding from delivery can quickly worsen and blood loss can be equivalent to that caused by a wound in the femoral artery.[5]

Supervision of a woman who has just given birth must be extremely vigilant before and within 2 hours of deliverance.[5] Blood loss should be objectively assessed, not approximatively assessed, and the medical device to measure hemoglobin should be accessible in the birth room.[5][6]

In case of serious bleeding, the administration of globular concentrates must be implemented very quickly[6] (Figure 4). The hemorrhage of deliverance is an example of the possible traceability of "risk management" at each level of care, from the individual to the institutional responds a responsibility, a possible control and therefore a "correction".

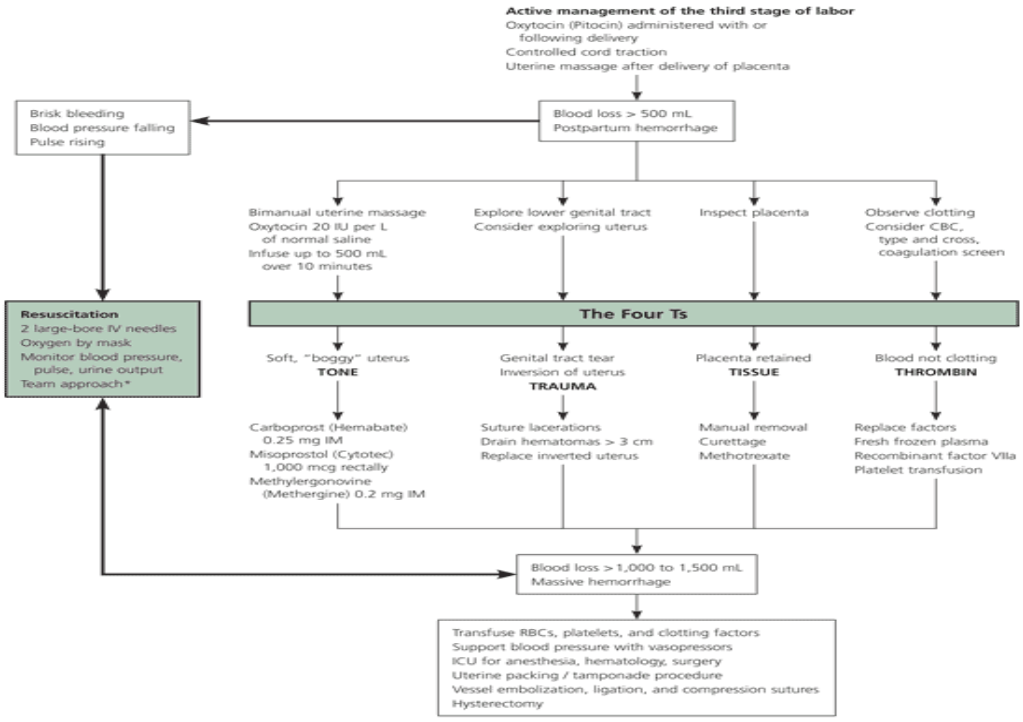


Figure 4.

The different levels of identification, care, anticipation, organization:

- At the Individual level: review the quality and competence of the operator (quality of training, compliance with protocols).
- At the Service level: daily control to the staff concerning the malfunctions, the report, the declaration, the development and the simulations.
- At the Regional level: dissemination of the protocols and control of the organization - blood transfer, transfer protocols as well as the quality circle.

3. Neonatal asphyxia

Perinatal asphyxia is one of the main causes of complaints about obstetrics and pediatrics.[2] On the obstetric level, the relationship is imprecise between per-partum asphyxia and cerebral palsy (Figure 5).[7]

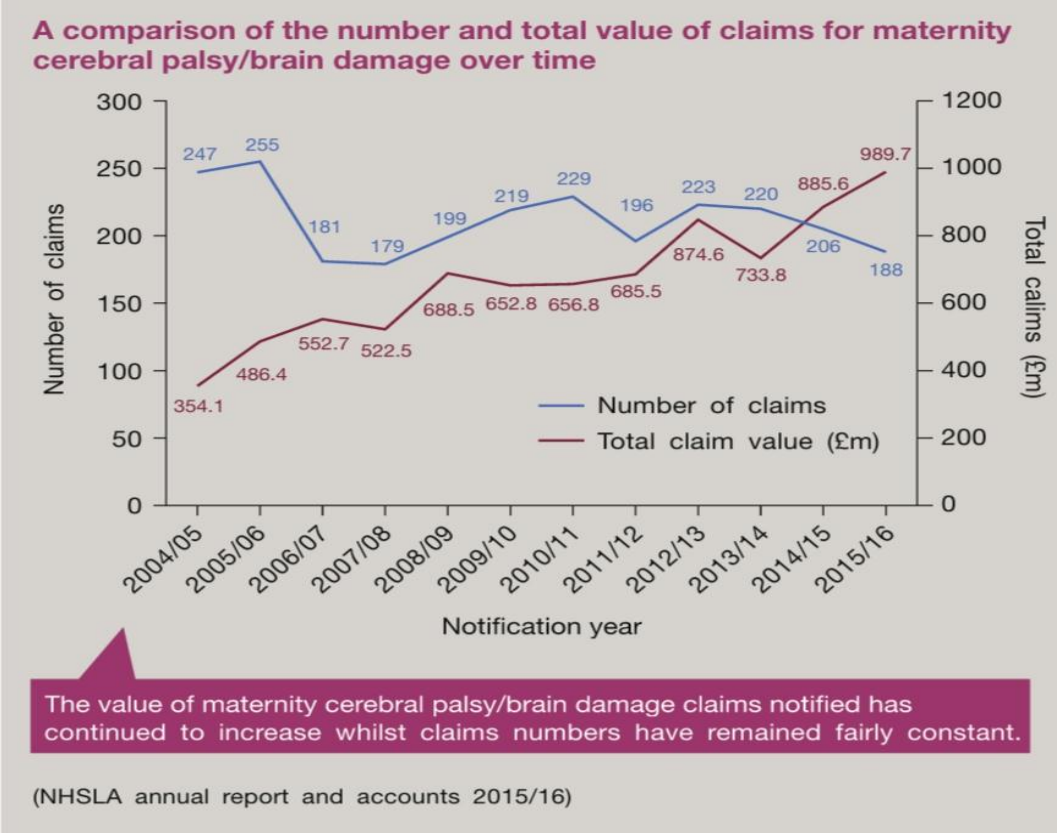


Figure 5.

Computerized monitoring of fetal heart rate (RCF) during labor, compared to intermittent auscultation, led to more cesareans and instrumental extractions, but neonatal mortality and cerebral palsy rate were unchanged.[8]

The prevention of medico-legal risk in the case of neonatal distress is not limited to the management of the pediatric and obstetrical file. It also requires compliance with certain communication rules. The medical information must take place in a suitable place and the practitioner must observe a caring attitude and concerned with the good understanding of the messages delivered. Risk management must become a medical culture, imposing systematic analyzes of mortality and risk-bearing events in care services and perinatal health networks. Improving the quality of care also requires writing and respecting algorithms for dealing with the most urgent situations in neonatology.

Crisis Management

The doctor has insufficient knowledge (and information) of medical law but also of his obligations. Risk management and the development of a risk management culture is a

necessary development. To develop a risk management culture, deviating from the norm should be considered separately from the responsibility of the individual.

To develop a reflection on risk prevention, 2 postulates

- The occurrence of an adverse event is not the result of bad luck and could have been avoided.
- The occurrence of an adverse event is not only due to the fact that healthcare professionals make mistakes, it is also and above all due to the institution's difficulty in organizing care.

This requires that the identification of all "problems" be promoted as a pledge of quality and progress by a declaration and above all by a "crisis cell", each time such an event occurs, which must allow for constructive reflection, and which must take the form of a protocol modification and its dissemination.

Establish or maintain communication to limit the medico-legal risk by establishing permanent contact, explain, ensure and provide simple, clear, fair, intelligible and approximate information so as to allow the patient to make a decision in all knowing the facts and becoming an actor in their own care. The lack of information represents the main cause, direct or indirect, of the lawsuits brought against the doctors who can be condemned to repair the resulting damage. It is then better to raise an error or an incident which will not have follow-up and which one could have hidden than not to give explanations in good time on an error which could cause damage.

Inform doctors and other services and prepare possible forensic consequences. Gather all the elements of the file and organize a summary meeting without forgetting to report the incident or adverse event.

Concept of acceptable risk

Acceptability has little correlation with the intensity of the risk. A risk is more acceptable when it is chosen and not Undergone.

The level of requirement is higher and higher, the obligation of means is gradually transforming into an obligation of result. In addition, insofar as the obligation of means is justified by the random nature of the effects of the acts carried out, as soon as the hazard disappears, the obligation is again of result.

The acceptability of technical risk refers to the idea of a risk calculated on the basis of a risk / benefit ratio. The acceptability of the risk must be enlightened by information on the frequent and serious risks normally foreseeable.

CONCLUSION

Obstetrics has seen many changes over the past twenty years. The increase in medico-legal risk is not the most encouraging development; it is certain that this aspect becomes cumbersome to bear and that it is largely responsible for the disaffection, which currently strikes the specialty. For the brave who still find a lot of charm in practicing obstetrics, it is advisable to adopt a prudent practice according to these new data, by emphasizing the prior information of patients both in the obstetric field and in the area of prenatal diagnosis.

It is necessary to identify the risks, to make a good medical and paramedical organization, to anticipate, to value the team work, the concertation, the respect of the protocols by keeping a traceability, vigilance and will.

Conflicts of interest

The authors do not declare any conflict of interest.

Contributions of the Authors

All the authors contributed to the writing of the manuscript. The authors have read and approved the final version of the manuscript.

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