Leading the way

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Principles of safe transfer of care in O&G- some horror examples

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Trends in Medico-Legal claims/complaints

- **Notifications peaked at the time of the medico-legal crisis in 2001**
- **Since then civil claims have dropped to levels of a decade ago**
- **There is a matching rise in disciplinary matters**
- **Premiums have stabilised, insurance products are more flexible**
- **There is rationalisation of the industry**

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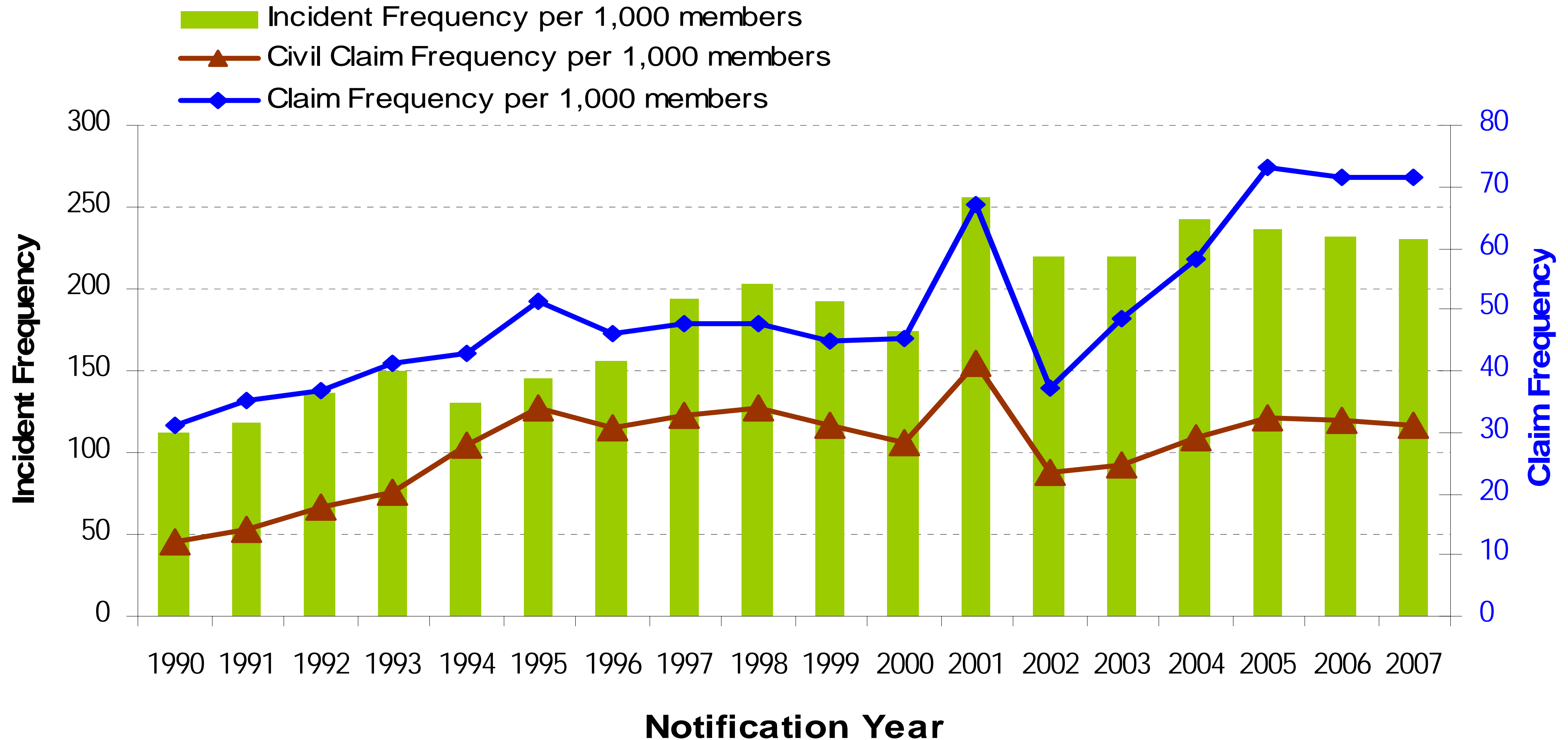
UNITED Incident & Claim Frequency per 1,000 Members



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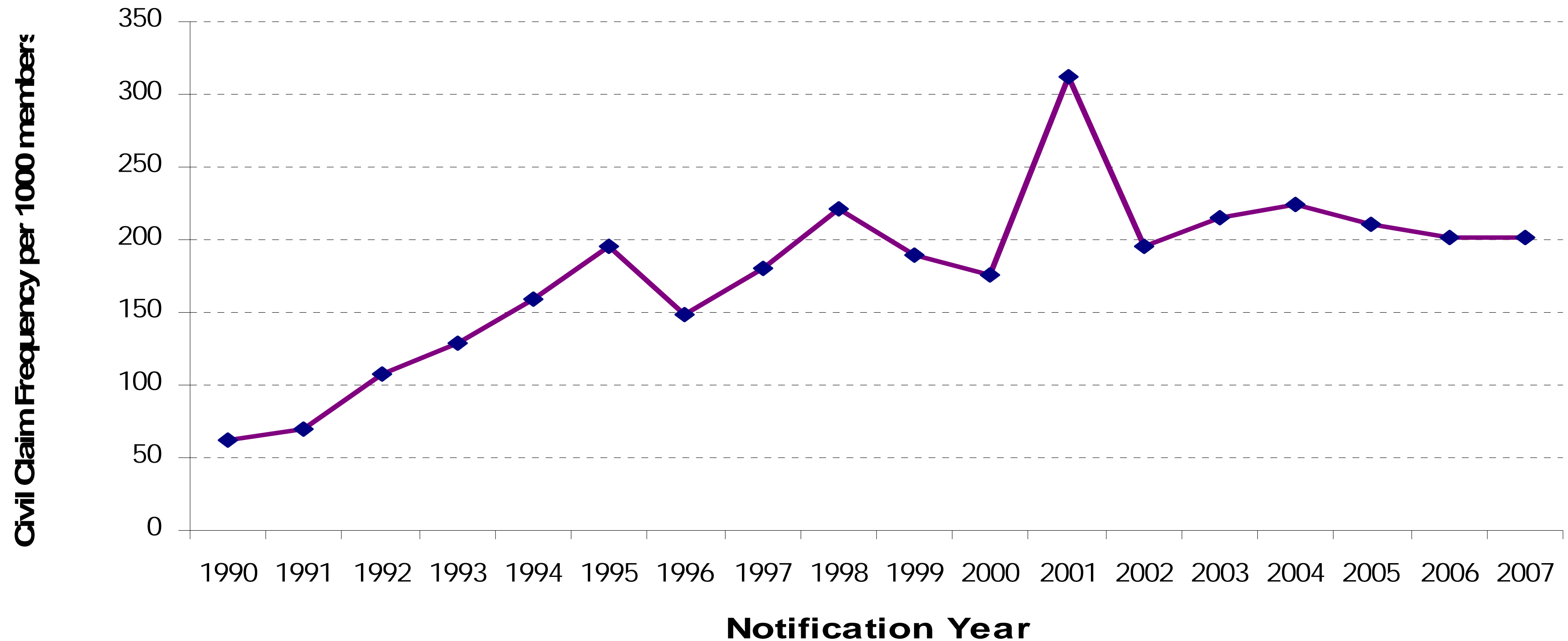
UNITED Obstetricians & Gynaecologists Civil Claims Frequency per 1,000 Members



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UNITED's Claims Experience - O&G 1990-2007

- O&G account for: 2% membership

  10% claim number

  21% claim costs

  20% premium paid
- O&G account for 20 times more $ 1M plus claims than other members
- Since 2002
  - 87 claims over $1million finalised total cost $212.9million
  - O&G account for: 25 claims (29%)

    total cost $82.3million (39%)

    9 of 87 claims exceeded $5million and all O&G
- Note: 250,000 births per annum

  600 children with cerebral palsy per annum

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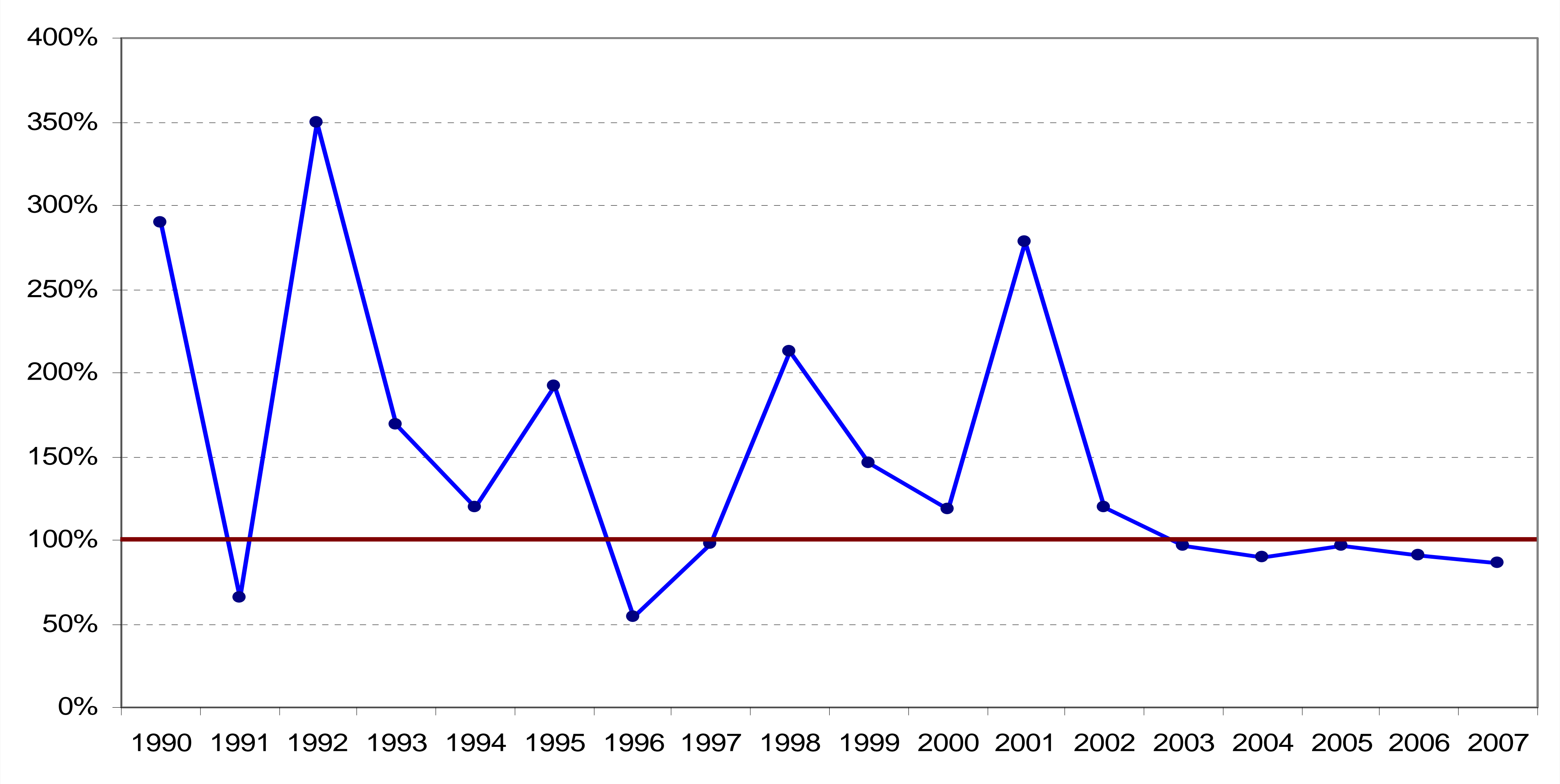
Obstetricians & Gynaecologists Loss Ratio (Claim cost / Premium)



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Medico-Legal Motherhood statements

- **Claims and complaints are made on the basis of poor communication skills leading to a poor therapeutic relationship ***
- **The knowledge and skill of those sued is better than those not sued***
- **Those not sued have a higher rate of adverse events than those sued***
- **What is best for the patient is usually best medico-legally**
- **The content of a handover process is more important than the technique**

*"Obstetrician's Prior Malpractice Experience and Patient's Satisfaction with care." Hickson et al, JAMA, Vol 272(20)1583-1587.

Transfer of Patient Care

- Transfer of care is linked to a number of hot issues
  - Safe working hours
  - Documentation
  - Privacy
  - The increasing complexity of medicine
  - The role of IT.
- There is a duty on the part of the transferring doctor to impart sufficient information to enable continued safe care
- There is a duty on the part of the receiving doctor to ensure that he/she has sufficient information to continue care safely
- Sins may be of
  - Omission
  - Commission

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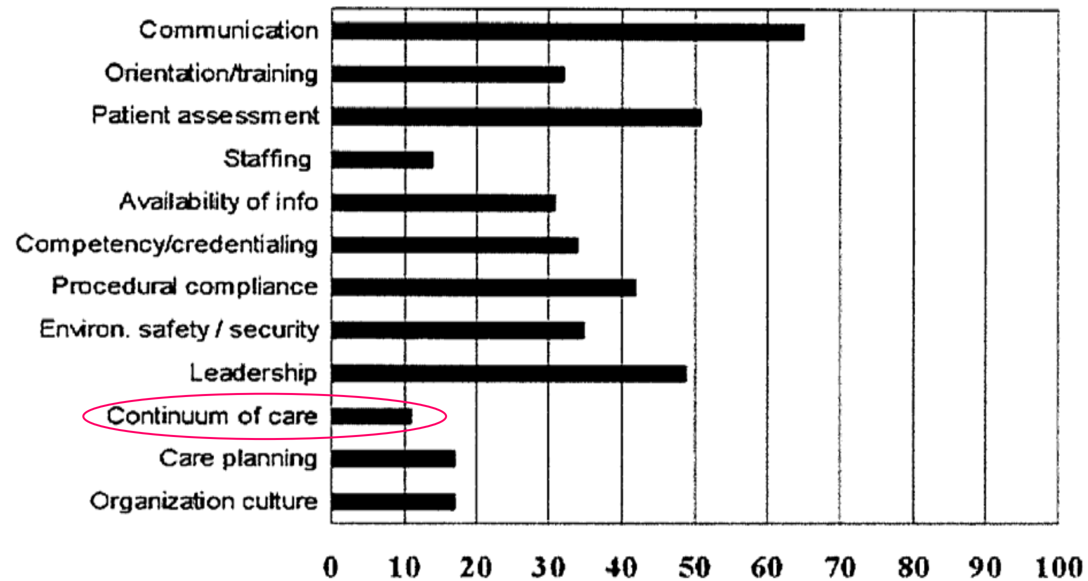

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Dr F, Dr A and Mrs K

- Mrs K consulted Dr F for her second pregnancy, the first was an emergency CS at 34 weeks because of pre-eclampsia. A low vertical incision was made in the uterus for delivery. The baby had icthyosis.
- Dr F referred Mrs K to Dr A because he was no longer practicing obstetrics. The letter mentioned a CS at 34 weeks but gave no other details of the operation.
- Mrs K went into premature labour at 34 weeks. Dr A was rung and ordered a repeat CS when a theatre could be made ready.
- Before the appointed hour foetal distress developed and an emergency CS was done.
- At operation a ruptured uterus was found, the uterus was saved and the baby lived. T/L was performed.

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Case Two- Drs B and F and Mrs P

- Mrs P, aged 48, G4,P4,(CS X 4), presents to Dr B with menorrhagia and pain. Dr B discussed treatment options of D&C and endometrial ablation. His working diagnosis is adenomyosis.
- Three years later Mrs P presented again, with worse symptoms, and Dr B did a D&C/Hysteroscopy, planning to follow it up with endometrial ablation. However, the curettings showed atypical hyperplasia and hysterectomy was recommended. Mrs P decided to have her ovaries removed at the same time.

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Drs B and F and Mrs P

- **The abdominal hysterectomy and BSO was uneventful and DR B left a drain in the pelvis and another below the rectus sheath. Dr B encountered some scarring at the bladder base from the C.S. operations. S.C Heparin was started.**
- **Dr B reviewed Mrs P on the first post-op morning and noted a satisfactory urine output. The pelvic drain had 350 ml of blood in the bag. He ordered removal of the IDC.**
- **The histopathology showed atypical hyperplasia and adenomyosis.**

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Drs B and F and Mrs P

- **Dr B left town leaving care to the on-call O&G as per a long standing arrangement.**
- **Nine hours after the catheter was removed Mrs P was in agony and reported that "My bladder feels as if it is about to burst". She and her husband asked for a catheter to be passed but this was refused, due to "the risk of infection", despite Dr B's standing orders mandating an immediate IDC and then contact to himself in cases of symptomatic retention.**
- **The nursing staff could not contact Dr B or his locum.**

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Drs B and F and Mrs P

- **After heavy sedation Mrs P had a moment of great abdominal pain and then she felt some relief. Meanwhile Dr B was contacted and ordered an immediate IDC. 1600 ml of heavily blood stained urine was drained and 350 ml blood drained into the Redivac drain.**
- **On the following morning Dr F saw Mrs B and noted heavily blood stained urine and 950ml in the pelvic Redivac drain. The abdomen was soft. Apyrexial. He ordered an HB (=89,Hct 25)(WCC 10.6) He stopped the s.c. Heparin.**

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Drs B and F and Mrs P

- **Dr F saw Mrs P on the third post-op day. She was "stable". She had drained 1500 ml through the drain to the pelvis. The urine was blood stained and she had a good output. Repeat HB was 76. Dr F ordered transfusion of 3 units of packed cells.**
- **Dr B saw Mrs P on the 4th post-op day. The urine was still blood stained. She was apyrexial and vital signs were normal. She was passing flatus and there was no nausea or vomiting. The pelvic drain had produced 1090ml.**

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Drs B and F and Mrs P

- **Dr B saw Mrs P on the 5th post-op day. She was making "slow progress", the urine was "rose" and the drain output down to 350 ml. The IDC was removed. She was able to void but with "shooting pains". Later that day she had some vomiting and the abdomen became very distended.**

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Drs B and F and Mrs P

- **Next morning Dr B found her to have normal bowel sounds and she had had a small bowel movement. He diagnosed an ileus and ordered drip and suck treatment. Mrs P was incontinent of urine and Dr B ordered reinsertion of the IDC. An MSU showed an E Coli UTI. Her pulse was 125 and temperature normal. The urine remained blood stained.**
- **Mrs P's ileus and UTI slowly settled over the next two days (Now day 8). Her temp rose to 37.9c. Her urine remained blood stained. Dr B ordered an U/S of the abdomen.**

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Drs B and F and Mrs P

- The US showed “moderate free fluid and fluid filled bowel loops”.
- Mrs P continued to settle slowly with removal of the N/G tube and the IDC. She went home on day 15.
- One day later Mrs P was admitted to another hospital with sepsis and an acute abdomen. Laparotomy showed gross peritoneal sepsis, a point of previous rupture of the bladder in the fundus, adherent, necrotic small bowel and a large amount of free fluid. A segment of small bowel was resected.

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Drs B and F and Mrs P

- Mrs P spent four days in ICU and had further transfusions. She was discharged 13 days later.
- Four weeks later Mrs P was admitted again with a DVT and symptomatic P.E. She spent two days in hospital and was placed on Warfarin for six months.
- Three months later Mrs P was readmitted with a small bowel obstruction but this settled with conservative management.

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Drs B and F and Mrs P

- **Dr B continued to care for Mrs P who asked him to supply an expert opinion in her civil claim made against the hospital.**
- **The case was settled for a very reasonable amount due to some unusual features in the way the claim was run by the lawyers for the plaintiff.**
- **United was responsible for 2/3rd and the hospital the remainder.**

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Dr R and the Mounty

- Mr X, a visitor from Canada and a Mounted Policeman, visited Australia for a conference
- He presented with an acute abdomen and at laparotomy was found to have a single band with necrotic small bowel involved. This was resected.
- Dr R left on holiday and Dr M took over.
- Recovery was unexpectedly slow with a wound infection, abdominal distension and pain.
- Eventually a CT was ordered. This revealed an ileus and note was made of stainless steel suture material in the rectus sheath.

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Dr R and the Mounty

- **Mr X eventually was well enough to fly back to Canada, however, a few days later he presented to his GP with ongoing wound infection.**
- **He was referred to a Surgeon who explored the wound and removed a large surgical sponge from the retro-pubic space.**
- **He has ongoing adhesive disease.**

Other agendas- Drs R and E and Mrs S

- Mrs S was cared for by her G.P. Obstetrician Dr R through her second pregnancy.
- At 38 weeks she presented to Dr R with reduced movements. He asked Dr E to perform a ultrasound after 24 hours of a foetal movement diary.
- The U/S showed a 4Kg baby with normal liquour. A CTG was described as “fairly un-reactive”. A repeat 4 hours later was the same. Dr E advised delivery.
- Dr R decided to induce labour with ARM and Syntocinon.

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Other agendas- Drs R and E and Mrs S

- **Labour progressed fairly quickly and Dr R went in at full dilatation. He found a slow foetal heart and decided to deliver with forceps while he called Dr E for help.**
- **He failed to deliver the baby and DR E proceeded to a CS.**
- **The baby had low apgars and was slow to resuscitate. It developed seizures and has gone on to suffer cerebral palsy.**
- **Drs E and Dr R have a history of differences of opinions about their roles in the joint management of pregnancies.**

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In summary

- Accidents occur
- Information may not be included, may be misleading and therefore may not be given appropriate importance
- Additional information may not be sought
- System issues are ever present
- In medical care other agendas are often dangerous for the patient
- The content is probably more important than the method of handover.

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Thank You