Medico-legal aspects in Urogynaecology

Medicolegal is something that involves both medical and legal aspects, mainly:
Medical jurisprudence, a branch of medicine
Medical law, a branch of law
Medico-Legal Case: can be defined as a case of injury or ailment, etc., in which investigations by the law-enforcing agencies are essential to fix the responsibility regarding the causation of the said injury or ailment. In simple language it is a medical case with legal implications for the attending doctor where the attending doctor, after eliciting history and examining the patient, thinks that some investigation by law enforcement agencies is essential. Or a legal case requiring medical expertise when brought by the police for examination.
"Any case of Injury or ailment where some criminality is involved is called a Medico-Legal Case (MLC)".

A definition not being accepted in many parts of the world

Future in urogynaecology...

• **dramatic changes in obstetrics**
  (pelvic floor changes during pregnancy and with delivery, coloproctological aspects, risk of caesarean, pelvic floor rehabilitation, obstetric fistulae in the third world and after repeated caesareans, ...)
Future in urogynaecology...

• symptoms of urogenital aging leaving the taboo area
• demographic changes will increase number of pelvic floor disorders

- the demographic change will increase the number of patients with pelvic floor disorders with micturition problems and prolapse

<table>
<thead>
<tr>
<th>Year</th>
<th>&gt; 65 yrs.</th>
<th>65-74 yrs.</th>
<th>75 yrs.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900</td>
<td>1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1992</td>
<td>6.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2050</td>
<td>20%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Future in urogynaecology...

• minimal invasive/alloplastic surgical procedures increasing (with little knowledge of long-term results and complications)

Future in urogynaecology...

• increase in urogenital tract lesions with endoscopic surgery
With such a low incidence it is amazing that 194 ureteral lesions in 10 years have been settled in our arbitration board in Hannover!

in gynaecology 27 – 31 % were medical blunder in ureteral lesions 45 %!
endoscopic procedures are performed on out-patient basis or extremely short stay in hospital – then asymptomatic!
classical necrosis of bowel, ureter or bladder appears after 8-12 days, thus not registered in many countries!
We need more honesty!

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Recent graduate, % (n = 126)</th>
<th>Program director, % (n = 132)</th>
<th>P value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pelvic organ sling</td>
<td>13</td>
<td>28</td>
<td>.005</td>
</tr>
<tr>
<td>Retropubic midurethral sling</td>
<td>30</td>
<td>63</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Transobturator midurethral sling</td>
<td>13</td>
<td>29</td>
<td>.003</td>
</tr>
<tr>
<td>Greutropexy*</td>
<td>33</td>
<td>62</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Intraoperative cystoscopy*</td>
<td>72</td>
<td>88</td>
<td>.001</td>
</tr>
<tr>
<td>Cystotomy repair</td>
<td>53</td>
<td>79</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Vaginal uterine repair</td>
<td>26</td>
<td>31</td>
<td>.126</td>
</tr>
<tr>
<td>Uterine ligament suspension</td>
<td>24</td>
<td>34</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Colpocleisis</td>
<td>26</td>
<td>34</td>
<td>.42</td>
</tr>
<tr>
<td>Abdominal paravaginal repair</td>
<td>33</td>
<td>40</td>
<td>.22</td>
</tr>
<tr>
<td>Posterior colporrhaphy</td>
<td>77</td>
<td>90</td>
<td>.006</td>
</tr>
<tr>
<td>Anterior colporrhaphy*</td>
<td>79</td>
<td>89</td>
<td>.025</td>
</tr>
<tr>
<td>Rectovaginal fistula repair</td>
<td>17</td>
<td>21</td>
<td>.907</td>
</tr>
<tr>
<td>Anal sphincteroplasty</td>
<td>19</td>
<td>32</td>
<td>.027</td>
</tr>
<tr>
<td>Single-channel cystoscopy*</td>
<td>38</td>
<td>57</td>
<td>.003</td>
</tr>
<tr>
<td>Multi-channel proctodynamics</td>
<td>17</td>
<td>19</td>
<td>.781</td>
</tr>
<tr>
<td>Peavy filling</td>
<td>79</td>
<td>89</td>
<td>.025</td>
</tr>
</tbody>
</table>

*P value for which the AAGS resident education objectives recommend the highest level of competence, "does.

Table 1. Recent trainees' and program directors' perceptions of residents' abilities to independently perform procedures after graduation.

Int Urogynecol J (2013) 24:1241–1242
DOI 10.1007/s00192-013-2114-y

EDITORIAL

Nothing lasts forever? Long-term outcomes of stress urinary incontinence surgery

Peter L. Dwyer

DOI 10.1087/s00399-009-0531-1

ORIGINAL ARTICLES

Short-term morbidity following vaginal prolapse surgery: what the surgeon does not see

Maya Basu · Jonathan R. A. Duckett
Where we come from – where do we go?

What should we teach our residents and fellows:
- anatomy and surgical skills
- understand the pathomechanisms
- decision making and choice of treatment
- understand alternatives
- understand the steps for securing informed consent
- current situation and views
- interest for research

We need teachers/mentors

- a teacher – a mentor knows that education is not just the “imparting of facts”
- a sponsor – a mentor introduces the student to the “new world” where he needs a guide to get started
- an advisor – he provides a sounding board and is a good listener. Mentoring involves personal bonding and a long-term commitment
- an agent – occasionally he can remove obstacles

W.A. Andersen 2007
we need teachers/mentors

a role model – values are best transmitted by deeds, not by words
a coach – a good coach knows when to offer encouragement, when to push, and when to take a break
a confidant – it is more an affair of the heart than of the head, and its two-way relationship is based on trust

W.A. Andersen 2007

our goal for the future...

• overcome discrepancies in the countries
• help to set standards
• identify areas that need improvement
• monitoring
• keep up with fast changing situation
• make the best use of technical tools

Chiara Benedetto – Past-President of EBCOG
our goal for the future...

- keep up with increased patient’s expectations
- reaching technical skills before working at the patient
- balance between innovations and efficiency
- facilitating professional migration
- trainees fellowship
- training the trainers

Chiara Benedetto – Past-President of EBCOG

same problem with slings and meshes...

The ensuing mesh kits that came on the market were attractive due to the simplicity involved in the placing of these, and—to put it bluntly—incompetent surgeons found themselves suddenly looking rather competent!
The major limitation when deciding on a surgical procedure, may be the lack or loss of anatomical and surgical skills and for many medical and paramedical reasons, the lack of experience.
Violation of the law can happen...

- contributory negligence
- wrong indication
- lack of organisation
- lack of investigation
- deficient informed consent
- wrong technique
- wrong management
- management of complications
- therapeutic safety advisory

Our program

Willy Davila, Cleveland Clinic Florida, U.S.A.
Medico-legal situation in the U.S.A., lessons to be learnt

Peter Dwyer, Melbourne University, Australia
Lesions of the urogenital tract in gynaecologic and urogynaecologic surgery

Don Ostergard, Long Beach, California, U.S.A.
Future place of alloplastic materials

Karl Tamussino, University of Graz, Austria
Quality control by registries?

Mohan Chandra, Dharan, Nepal
Situation in the “third world” and lessons to be learnt