

The Concept of Good Practice and Malpractice: History and Current Aspects

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Introduction

Can “perfect care” be obtained in the clinical setting? This is one of the most provocative questions that healthcare experts, lawyers, and judges debate more and more often today.

The reality of healthcare is that unfavorable outcomes can happen. Not all negative events leading to major injury or death are predictable, preventable or even treatable.

In light of this, clinicians must focus on identifying the most preventable incidents, prepare for these, and then aspire to and practice the best medical practice.

Specialists in obstetrics and gynecology practice in a litigious environment and often face pressure to obtain “perfect healthcare” (1, 2).

The concepts of medical “good practice and malpractice” have probably existed for a long time, but surely have evolved over the decades and now are strongly affected by many new factors. The Institute of Medicine (IOM) drew attention to the subject in its 1989 report *Medical Professional Liability and the Delivery of Obstetrical Care* (3, 4).

About thirty years after this paper, obstetrics still ranked first among specialties in clinical malpractice and its related negative outcomes.

Medical-scientific progress, so-called “evidence-based medicine”, training for healthcare professionals, changes in the doctor-patient relationship, and the increasing awareness of the patient on his/her state of health have contributed to broaden and codify further the concept of good and bad practice over the years.

Clinical malpractice can have medico-legal consequences, and it can negatively influence the socio-economic context.

Healthcare is strictly related, also in obstetrics, to conscious and/or unconscious “defensive medicine”. From a certain point of view, even defensive medicine represents a form of malpractice, because it pursues what is best for the clinician and not for the patient.

Clinicians have to keep in mind that there will always be room for improvement in daily practice, in order to obtain firstly good health outcomes and valorize the role of scientific progress and medical care.

Good medical care can be obtained by a multilevel integrated and well-coordinated practice, based on good general and academic culture, intensive and ongoing training, and clear communication.

Malpractice, instead, is an improper, unskilled and/or negligent management of a patient. However, good practice can be achieved through several key steps aimed at minimizing exposure to incidents and bad outcomes:

- standardization of care (guidelines - observing protocols)
- identifying high-risk patients
- training
- adequate communication (teamwork and healthcare members-patients)
- ensuring documentation is complete.

There are two major types of malpractice:

- Errors of omission resulting from an action not taken
- Errors of execution resulting from the wrong action taken.

Obstetrics is one of the most notable fields in which “good practice or malpractice” is a very topical concept and an ongoing problem for all healthcare members. Several obstetric practice areas (examples in Table 1.1), patient risk assessment, ongoing training (simulations, e-learning platforms, periodic meetings, and audits)

Table 1.1 Labor and delivery areas targeted for providing “good care”.**OBSTETRIC PRACTICE AREA**

- Threatened Preterm Birth and Preterm Delivery
- Oxytocin Administration
- Magnesium Sulfate Infusion
- Magnesium Sulfate for Neuroprophylaxis
- Management of Hypertensive Crisis
- Management of Post Partum Hemorrhage
- Management of the Second Stage of Labor
- Management of Shoulder Dystocia
- Vaginal Versus Abdominal Delivery – Vaginal Birth After Cesarean Section (VBAC)
- Operative Vaginal Delivery (OVD)

require standardization and improved communication skills. This chapter will briefly discuss which main aspects play a decisive role in making a medical-surgical procedure adequate or not. Table 1.2 sums up the most important “good practice” key points and common malpractices in labor and delivery. Moreover, in the following chapters, these aspects will be deepened for each specific topic.

Standardization of Care

There is increasing evidence in the obstetric literature that standardization of care improves clinical practice and patient outcomes. Written guidelines are becoming more prevalent in all fields of medicine, both to create better, more uniform practice and to avoid medical negligence.

The use of guidelines, protocols, and checklists to guide care, especially in select critical situations, represents a major focus of efforts to improve patient safety (5-7). Researchers have estimated that a greater number of near-miss, minor or moderate injuries could have been avoided by better adherence to available protocols (8). Guidelines should be developed by specialist organizations, both national and international, and should be supported by a high level of scientific evidence. They should provide effective and safe care and should involve some degree of flexibility, so that physicians can also use a degree of individual judgment in the management of their patients (9).

General acceptance of the need for guidelines and

shared protocol care has been slower to develop and has been limited to the past few years. However, in recent times, a sensitivity to the importance of having common policies and speaking the same language seems to have grown.

Not only medical institutions but also governmental and legal agencies must work collaboratively to promote the best healthcare and to remove “the culture of blame” that often affects daily medical practice.

Identifying High-Risk Patients

Obstetrics and the entire team must pay attention to delayed diagnosis or elaborate misdiagnosis, by fully identifying notable and controllable risks related to adverse events.

A first important “good practice point” is to stratify every patient in low, moderate or high-risk groups, in order to shape adequate management (family history, obstetric history, previous surgeries). Hence the importance of avoiding superficiality and haste when taking care of a patient.

Training

Appropriate training is required before carrying out procedures or making decisions.

Simulation training is a critical component in obstetric training, as it allows trainees, both junior and senior, to practice a skill prior to performing a procedure on laboring women.

It is important that trainees become skilled in using de-

vices and instruments, as both have a place in modern obstetric care.

Not only the “initial training”, but also a “refresher training” is crucial in order to empower all team members to act in urgent or emergent scenarios.

Ongoing training is a central element to keep labor and delivery teams well-trained. Moreover, periodic meetings and audits seem to be helpful and can represent an important key element in the path of training and professional growth. In this regard, the analysis of adverse outcomes can help identify mistakes and critical areas for improvement.

Adequate Communication

Clear and transparent communication is another key element of practicing good medicine (10). In healthcare settings, communication operates on two levels that are strictly related to each other:

- Team communication
- Staff-patient communication.

Communication errors, in particular during hand-offs,

are critical contributing factors to many medical malpractice claims.

Good team communication and speaking the same language, especially in an urgent or emergent setting, is of vital importance. It makes it possible to manage critical events more effectively, avoids wasted time and saves the lives of patients.

Another marker of good clinical practice is the ability to speak clearly and inform the patient of what is being done, which also may involve obtaining his/her consent to perform a procedure (verbal and/or written consent).

Ensuring Documentation is Complete

Incomplete clinical documentation and the absence of written and/or verbal consent to perform a procedure often negatively affect the integrity of medical practice.

Well-kept documentation provides a way for both healthcare professionals and patients to clearly understand if and why clinical events have gone wrong.

Table 1.2 “Good practice key points and more common malpractices” in labor and delivery setting.

GOOD PRACTICE

- Careful assessment of the clinical situation (full evaluation of pre-requisites, potential contraindications and risks-benefits balance).
- Guidelines, observing protocols (with a degree of flexibility).
- Have a valid indication for performing any procedure.
- Keep in mind the potential failure factors for a procedure and think about possible alternative.
- Clear communication with the patient, obtaining of a verbal consent (also written, if needed) and careful registration of the events.
- Choice of techniques, instruments, and devices as well as clinical situation and obstetric experience/preference consent.
- Whoever conducts the delivery, high-quality training is crucial: knowledge, experience and skills needed to manage different situations and potential complications that may arise.
- Personnel with infant resuscitation skills should be alerted and be available if needed.
- Care in the post-natal period is important to minimize the risk of adverse outcomes in the short- and long-term period.

MALPRACTICE

- Improper management of labor stages (failure to monitor maternal and fetal status).
- Delay in recognition and treatment of presumed fetal distress.
- Lack of knowledge of pelvic anatomy, fetal head position or other warning signs.
- Procedure performed in the absence of maternal and/or fetal indication (practitioner convenience, call schedule, defensive medicine).
- Misdiagnosed relative and absolute contraindications to performing a procedure.
- No contingency plan/protocol to follow.
- Insufficient skill, lack of training and inconsistent practices/supervision to manage clinical situations.
- Communication breakdown among team.
- Informed consent not obtained prior to doing a procedure.
- Incomplete clinical documentation.

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