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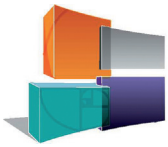

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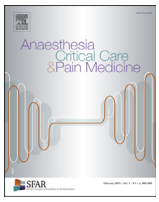

Review

The liability of the anaesthesiologist in ambulatory surgery

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ABSTRACT

With the development of ambulatory surgery, there may be questions about the legal risk of this procedure. Indeed, the discharge of the patient from the hospital on the same day as the medical treatment raises the problem of monitoring and supervising potential complications, with a substantial delay in medical care, and the anaesthesiologists can be confronted with new areas of liability. This article specifies the French statutory and legal framework of the ambulatory surgery, and shows how the responsibility of the anaesthesiologist can be involved during patient care at all steps. The analysis of judicial precedent shows that the legal risk for the anaesthesiologist also exists in outpatient surgery. Surgery and anaesthesia are medical procedures involving a relatively high risk of damage for the patient. The damage can be attributed to malpractice from one or several health care professionals or to a medical complication (abnormal damage not related to malpractice and independent of past medical history of the patient). In the light of the ongoing and significant development in ambulatory surgery, there may be questions about the legal risk of this procedure. Indeed, the discharge of the patient from the hospital on the same day as the medical treatment raises the problem of monitoring and supervising potential complications, with a substantial delay in medical care. If the patient suffers any damage, the surgeon, the anaesthesiologist and in some cases, the hospital will have to answer in courts: the surgeon for the surgical procedure, the anaesthesiologist for the medical care and the hospital as the liable institution. After having specified the statutory framework of ambulatory surgery, we will see how the responsibility of the anaesthesiologist can be involved during patient care at all steps.

1. The rules of medical liability

1.1. Civil liability (or administrative)

Medical practice is likely to cause various legal responsibilities for the health care professional. The specific activity of ambulatory surgery does not change the applied liability regulations.

In case of a damaging event that happened to the patient, the responsibility of the practitioner and/or of the hospital may be involved in order to compensate the patient. The regulation related to the liability of health care professionals and facilities is governed by article L. 1142-1 of the French public health code (CSP), resulting from the act of 4 March 2002 [1]: "Health care professionals [...] as well as any health care facility [...] are held liable for the harmful consequences of the acts of prevention, diagnosis or care particularly in cases of malpractice". This malpractice may be improper care, negligence or a deviation from the standard of care. Two cases must be distinguished: if the practitioner works as an employee in a hospital, the hospital will be held liable in courts: the administrative courts if the hospital is public funded, the civil courts if it is private funded. If the practitioner exercises as an independent contractor, he will be the one held liable in civil courts. In order to be granted any compensation for malpractice, there must be in most cases an injury to the patient, a medical error from a health care professional or facility and a causal link between the injury and the error. It is the compulsory insurance of the hospital or the practitioner's, which is financially responsible for compensation. If

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Table 1
The patient's clinical pathway in ambulatory surgery.

Preoperative assessment
Ambulatory validation
Risk/benefit ratio assessment
Anticipating side effects
Preparing the discharge after surgery
Peroperative stage
No specificity for ambulatory surgery
Discharge from PACU
Medical assessment
Signing the discharge slip
Postoperative follow-up protocol
Checking the discharge prescriptions
Patient's follow-up
The day-after phone call
Remote surgical consultation

no fault is found, the medical complication will be compensated by the national solidarity. It will be done if some conditions, in particular the seriousness of the damage, are met. Consequently the national office for compensating medical malpractice (ONIAM) will be financially responsible. The nosocomial infection is a putative error. However, in case of death or of particularly serious after-effects (Partial Permanent Disability higher than 25%), it is the ONIAM, which gives compensation regardless of the existence or non-existence of a civil liability under the act of March 4, 2002 as amended by the act of December 30, 2002 (article L 1142-1-1, 1° of the CSP)

The same rules apply to the amicable settlement procedures, now the most numerous, which are initiated in the Conciliation and Compensation Commission (CCI), the latter being also subject to the seriousness of the damage.

1.2. Criminal liability

In case of a criminal complaint, it is the existence of the offense committed by the practitioner, which is sued. The penalty, delivered by a magistrate's court, can be a fine (a personal one that cannot be covered by the insurance) and/or a prison sentence (usually deferred in the absence of any subsequent offense). The criminal suit can be done in parallel to the civil proceedings: if the victim of the offence is a private party. The plaintiff can also obtain redress from the insurance company for the damage caused.

1.3. Ordinal liability

Finally, in case of complaint before the French Medical Council, it is the respect of ethical obligations, which is examined. A conciliation attempt should be carried out by the departmental council. If this attempt does not succeed, the complaint must be forwarded to the disciplinary division, except for the physicians practicing in a public service. It is the departmental council which hands or not the practitioner over to the court. The sanctions range from a warning to the removal from the medical register.

This article deals exclusively with the civil liability of practitioners but also with the civil or administrative liability of the hospital (public or private) as regards the compensation of the damage related to a medical intervention performed in ambulatory. The criminal or ordinal liabilities are not taken into account.

2. Applicable regulations for ambulatory surgery

If the SFAR (French Society of Anesthesiology and Intensive Care) issued recommendations as early as 1990. The legal recognition of ambulatory surgery in France found its origin in the act of July 31, 1991 [2], and its implementing decrees of October 2, 1992: ambulatory surgery pertains to the hospitalization of less than 12 hours without overnight accommodation. Therefore, it includes the surgical interventions scheduled and performed in the technical conditions that absolutely require the security of an operating block under an appropriate anesthesia and followed by a postoperative surveillance in the recovery room allowing the patient's discharge on the same day of his admission without any potential risk. Unlike other countries, ambulatory surgery cannot be performed in a doctor's office then.

Since 2000, and particularly between 2010 and 2014 (10 texts), the drafting of regulations has been prolific and in favor of the development of ambulatory surgery [3]. The decree of the DGOS (the French General Directorate for Health Care), issued on December 27, 2010, specifies that "it is a question of paradigm shift [...] and of extending this medical care to all eligible outpatients and to the entire surgical practice". Consequently ambulatory surgery becomes the standard reference [4]. Shortly after, the decree of 20 August 2012 aimed at encouraging the development of alternatives to standard hospitalization by relaxing some technical requirements related to its management [5]. But eliminating the concept of specific patient pathway and care map by a medical staff assigned to the ambulatory care unit, the meaning of this text seems ambiguous and carries the risk of looking upon ambulatory surgery as a secondary activity. The DGOS has therefore sent a decree to the ARS (Regional Health Agencies) on November 22, 2012, by the combined request from the AFCA (the French Ambulatory Surgery Association) and from the SFAR, to clarify the specific aspects of the ambulatory and staff pathway. This circular letter recalls that "the decree keeps compulsory a devoted paramedic staff for ambulatory surgery" and "explicitly considers that ambulatory surgery units should have premises assigned to ambulatory surgery".

3. Risk management in ambulatory surgery

3.1. Preoperative assessment and guidelines

3.1.1. Pre-anaesthesia consultation (PAC)

For any scheduled surgery, the pre-anaesthesia consultation must take place several days before surgery, in accordance with article D. 6124-92 CSP issued from the decree of 5 December 1994 [6]. As there is a regulatory obligation, its oversight may constitute a clear case of negligence in criminal proceedings. In case of an emergency, this regulation is not enforced. As part of the ambulatory framework, the problem of iterative interventions performed in quick succession is raised. This comes with the problem of performing or not a new PAC for each surgery. It is possible to hold off, provided that it is for the same type of surgery within a month, in accordance with the opinion of the SFAR in 2001 and on a proposal from its Work/Life Committee [7]. This is only a general estimate and the anaesthesiologist who has examined the file may consider it useful to see the patient in consultation or to call him/her.

The other characteristic of the pre-anaesthesia consultation in ambulatory surgery is its importance to inform the patient and to prepare the clinical pathway (Table 1). As the ambulatory patient takes part in his/her preparation and postoperative recovery at home, the detailed information on all the stages contributes to the quality, safety and success of this care. The SFAR recommendations drafted in 2009 aim at informing on the preoperative fasting, the management of treatments, the obligation of an accompanying person for the discharge, the instructions related to the potential consequences and the rights of appeal in case of unforeseen events [8].

It is recommended that this information should be communicated orally while providing a written or audiovisual aid. This information is added in the folder for further checking. An ambulatory passport handed to the patient from the consultation onwards gives the possibility to collect various information.

It may be useful to repeat the information few days before surgery, which is usually done with a telephone call the day before.

The lack of information during these steps is a constant source of damage attributed to the anaesthesiologist's malpractice (cf. infra) [9,10].

3.1.2. Pre-anaesthesia visit (PAV)

The PAV, as well as the PAC, is a regulatory obligation; it must be carried out by an anaesthesiologist "within the hours prior to the scheduled surgery" [6]. This visit is not a substitute for the consultation done several days earlier, but it supplements it. The bone of contention in ambulatory surgery is that the admission at the hospital is made on the same day (usually in the hour preceding surgery). In 2005, following a proposal from its Work/Life Committee, the SFAR considered that the wording "within the hours" was to be interpreted literally, including within the minutes [11]. Thus, even in the framework of the ambulatory surgery, this visit should be carried out so as to allow the final review of the file, the check on any recent event since the PAC and on the consistency of the free-will consent [1]. It helps the patient bypass the operating block process as his/her medical record is not complete or his/her health has changed since the PAC.

3.1.3. Eligibility: linked to the patient (medical and social conditions) and to surgery

An appropriate selection of patients is necessary for the success of the medical care in ambulatory surgery. This selection grants to limit the risk of complications and consequently of rehospitalization. The eligibility for ambulatory surgery is based on the benefit/risk analysis for the patient taking into account medical criteria but also psychosocial, environmental and organizational ones [8]. It is therefore essential to identify risk-prone patients. A North American study carried out on nearly 800,000 patients who had surgery in ambulatory has allowed working out index-identifying patients prone to direct rehospitalization [12]. The presence of the following risk factors increased the possibility of rehospitalization: age higher than 65 years, duration of the medical intervention more than 2 hours, cardiac or cerebrovascular pathology, peripheral artery disease pathology, cancer, HIV infection. Although obesity was not a risk factor in this study, it was recognized as a risk factor for rehospitalization in a Canadian study [13], and even as the main factor of comorbidity associated with the risk of rehospitalization in a Finnish study [14].

3.1.4. The duty to provide information (Table 2)

As for any medical care, in the context of ambulatory surgery, the physician has the duty to advise and inform. This has been written down in the code of medical ethics since 1995: "The physician shall impart honest, accurate and relevant information regarding the patient's health. The latter, who is examined, treated or advised by the physician, shall also be given information on the investigations and medical care provided" (article R. 4127-35 et al., 1 CSP).

Based on this statutory obligation, judicial precedents reminded that "the physician is specifically required to inform the patient and he/she has the responsibility to prove that he performed this obligation" (Court of Cassation, 25 February 1997) [15]. The consequence is the loss of chance to prevent an injury as the patient, duly informed, did not make another decision. As the act of 4 March 2002 established this information as a legal obligation (art. L. 1111-2), judicial precedents went further, adding that "if the duty to inform is not fulfilled, it brings about damage done to the patient who had to be legally informed. As a consequence, the judge cannot rule without giving any compensation" (Court of Cassation, 3 June 2010) [16].

Table 2
Key information in ambulatory surgery.

Preoperative information
Preoperative fasting
Treatment management
Regarding the adopted anaesthesia technique
Regarding the surgical act which will be performed
Postoperative information
Discharge conditions
Accompanying person is mandatory for the discharge
Driving a car or motorcycle prohibited
Need to have an accompanying person during the first night at home according to the surgical procedure
Instructions related to the possible follow-up of the medical care
Postoperative analgesia methods
Redress procedures in case of unforeseen events

Therefore, if this legal right to information is not respected, it will lead to two choices for compensation: the loss of chance to prevent abnormal injury and the unprepared psychological harm related to a normal injury [10].

In ambulatory practice, a significant part of the analyzed claim rate, which involves the civil liability of practitioners, is compensated by the practitioner conviction on the grounds that the information was missing [17,18]. These data reinforce the importance to release the information to the patient as early as the consultation and to give a written text, such as the ambulatory passport.

But, regardless the legal consequences, the release of information is fundamental in ambulatory surgery as it contributes to the success of this type of care (rules in line with preoperative diet, health care professional support, surveillance and postoperative complications...). It also contributes to the patient's effective care in reducing his/her anxiety and in building this trusting relationship.

3.2. Peroperative care

The implementation of a labelled insurance program is recommended by the French National Authority for Health (HAS) and the French National Support Agency Performance (ANAP) in order to make official the clinical pathway of the patient and anticipate the risks (Table 1)[19]. This risk management probably allows hospitals to anticipate complications, reduce their occurrence rate and their seriousness. The existence of medical care protocols will therefore be sought during an expertise so as to pay compensation.

The organization of operating programs is fundamental in ambulatory surgery since some surgeries may require particular logistics and several hours of surveillance before the discharge. This organization is provided for by article D. 6124-93 CSP issued from the decree of 1994 [6]: the operating program "is prepared jointly by the physicians [...] in taking into account the requirements related to hygiene, safety and to the organization of the surgery section as well as admission capacities in postoperative surveillance".

3.3. Can you bypass the PACU?

The itinerary to the operating room for the ambulatory patient is not that different from that of the patient in traditional hospitalization. The regulation being applied is that of the decree of

December 1994, codified in articles D. 6124-97 and the following ones of the CSP. It points out that going to the PACU is absolutely mandatory for any patient who received a general or local-regional anesthesia, in other words any surgery performed by an anesthesiologist [6]. From a technical point of view, it is conceivable that some patients, who had a local-regional anesthesia without sedation and without complication, can do without the PACU under exceptional circumstances. The SFAR started this debate in 2011, but without reaching conclusion [20]. This quickly led the SFAR to recall that today the principle of going to the PACU remains mandatory and without exception [21]. From a legal point of view, only a decree may precisely amend the provisions of a decree. This puts into question the importance of guidance in the ranking of the regulatory texts, such as the one from the HAS or the ANAP [22]. Indeed, if a decision from the Council of State confirmed that the "recommendations of good practices, must be regarded as decisions leading to complaints and likely to be the subject of an appeal because of an abuse of power" (Council of State, 27 April 2011) [23], no decision had given them any level of importance similar to a government decree. The result is that a deliberate violation of the decree in use would nearly entitle to compensation because of its harmful effects and would incur criminal charges according to article 121-3 paragraph 4 of the penal Code. The latter, derived from the Act of 10 July 2000, stipulates that there is an offence if the persons indirectly responsible of a damage did not "obviously and deliberately honor a statutory obligation of care or security as provided for by the law or regulation".

That is why the SFAR, along with the DGOS, explores the possibility to revise the decree of 1994, allowing to bypass the PACU under the specific circumstances of patients who had a regional anesthesia (ALR) with reasonable time after the medical intervention (blood resorption of the local anesthetic), without sedation and having the PACU discharge criteria long before admission. As long as a new decree has not been published in the *Official Journal of the French Republic*, such a bypass remains illegal.

3.4. The hospital discharge authorization

3.4.1. Who sees the patient and who signs the discharge

According to article D. 6124-101 of the CSP, the anesthesiologist authorizes, "the discharge of the patient from hospital when the intervention was carried out in a medical care facility as an alternative to hospitalization, in agreement with the physician who performed the intervention". This reference related to anesthesia is included in the sub-section of the CSP and issued as such in the decree of 1994. It makes sense that this reference focuses on the anaesthesiologist's obligations solely, without mentioning the discharge planning process from an ambulatory surgery unit and without detailing the processes. In any case, it clearly appears that this discharge is given by two physicians, each in his/her field of competence.

Usually, it is generally the surgeon who meets the patient again right before the discharge, but the anaesthesiologist can also do it, each one meeting the patient more carefully since the intervention involves a risk of complications.

As stated previously, if the decree provides that the discharge from hospital requires the surgeon's and the anesthesiologist's agreement, it does not specify the procedure that ratifies the medical decision authorizing this output. That is why the SFAR, in its 2009 recommendations, advised to ratify this authorization of discharge by scrawling a signature in the folder. This makes clear that the signature belongs to of one of the physicians working in the hospital. Thus, only one signature is enough, either one from the physician who made the intervention or from any anesthesiologist in the hospital [8].

For the practical implementation of these rules, it is important that a procedure outlines it in each hospital. This procedure makes clear who should meet the patient again and who should sign. This is also done according to the type of surgery and anesthesia, so as to avoid any detrimental ambiguity, as far as the safety of the patients and the responsibility of practitioners is concerned

The main purpose of this procedure is to avoid missing any forewarning signs of complication, but also to be able to show, in the case of a lawsuit, that the practitioners and the hospital acted in accordance with the rules of practice.

As for the medical responsibility, each practitioner is responsible for his/her medical intervention: article R. 4127-69 CSP, article 69 of the code of Medical Ethics, states that "medical practice is personal; each physician is responsible for his/her decisions and his/her interventions", before his/her peers and his/her patients. If the patient suffers any injury though he was allowed to leave hospital despite the presence of symptoms, the fault of one or practitioners will be sought in their field of competence. Two judicial precedents illustrate how the magistrates apply these rules.

Therefore, the Court of Cassation upheld the decision of a court of appeal which had sentenced the gastroenterologist and the anaesthesiologist guilty in solidum, in a case of colonic perforation during endoscopy; the first one guilty of technical error, the second guilty of inadequate supervision of the patient who "had suffered from pain after waking up (...) and these pains should have warned the physicians about the possibility of a perforation, in particular the anaesthesiologist who had met the patient before. Because of these pains, the anaesthesiologist should have kept the patient in hospital to monitor his/her status, instead of authorizing his/her discharge after colonoscopy" (Court of Cassation, 26 October 2004) [24].

In another recent case, a female patient was allowed to leave hospital after the surgery of the upper limb infraclavicular block despite the chest pain that occurred shortly before her discharge. Three days later, his physician diagnosed a case of pneumothorax. The anaesthesiologist was sentenced by a civil court to pay 4000 euros, thanks to his insurance, as a compensation for the damage. What has been criticized was not a technical error in the accomplishment of the locoregional anesthesia – the magistrate judged that the complication resulted from an inherent risk in the technique, thus unforeseeable medical complications –, but the fact of having authorized the patient's discharge without having examined her when a new event had occurred. The fact that the anaesthesiologist did not try to find the origin of the chest pains the patient complained about shows the error that he committed during the postoperative follow-up [25].

3.4.2. Is there any scoring system for the discharge?

In accordance with the recommendations of the SFAR [8], anesthesiologists daily use a clinical scoring system to validate the discharge (usually Chung's modified scoring system) in their practice [26]. This competence can thus be validated by the anesthesiologist as early as the admission in the PACU. An ASU (Ambulatory Surgery Unit) nurse can let the patient leave the hospital only when the scoring system allows it. It implies that a written prescription or protocol makes mandatory to warn the physician in case of any abnormal sign.

The scoring system used by Chung is not a scoring system for the discharge. It is a scoring system for home readiness. There are indeed other requirements that allow the discharge from the unit (the presence of the person accompanying for home-return, the presence of a person at home during the first night, discharge prescriptions, surgery report...). This functioning method implies at least a systematic reassessment of the patient by the anesthesiologist before the discharge from the PACU, in order to

grasp the risk of complication in ambulatory surgery and to determine the need or not of a clinic medical control before the discharge.

Here again, even if this organizational method is possible since the authorization and the signature by a single physician is sufficient at the time of the discharge [8], and that the 1994 decree does not stand in the way [6], it is important that this method becomes subjected to a procedure within the institution, with the endorsement from the Medical Commission for Hospitals (CME) and the hospital board.

3.4.3. Returning home from hospital

The patient must be informed during the consultation that the presence of the accompanying person is mandatory for the discharge [8], with the proscription of driving within the 12 following hours. The risk of a mishap is increased after anaesthesia and two cases of serious injuries have been observed among patients who drove their cars after the discharge from the ambulatory unit [27]. Concerning the presence of the accompanying person at the postoperative place, it is recommended that "it should be assessed in relation to the patient-intervention outcome and defined beforehand by the hospital professionals according to the approved organization" [8].

3.5. The patient's follow-up

The postoperative period is certainly the most crucial phase because it breaks away from the direct medical supervision. The patient must therefore receive at the time of the discharge, all the written and oral information related to the postoperative surveillance and the potential complications. Thus, according to the terms of article D. 6124-304 CSP, resulting from the decree of October 2, 1992, "each patient receives a discharge slip before leaving the hospital. This slip, signed by one of the hospital physicians, states the identity of the medical professionals who took part in the intervention, the course to follow in relation to the postoperative or anaesthetic surveillance and the contact details of the hospital ensuring the constant and continuing care". Judicial precedents mandate that after ambulatory surgery "the breach of the duty to inform on the signs that may warn the patient after surgery, settles a fault in the postoperative follow-up" (Administrative Court of Rouen, 16 October 2014) [28]. For instance, a patient who has undergone an inguinal hernia operation in the ambulatory unit suffered from testicular pain on the right side along with fever the following day. The fact of not having been informed about the potential complications related to the intervention led to the removal of the gonads since a testicular ischemia had been diagnosed with 48 hours of delay. The hospital was sentenced to pay the patient 2500 euros in damages through the insurance company for the lack of information and the loss of chance to prevent the injury.

3.5.1. The day-after phone call

The day-after call or within the 48 hours is a telephone interview conducted with the ambulatory patient after his/her return home. "It allows you (...) to repeat the postoperative instructions, to check the follow-up (e.g. the monitoring of postoperative pain, food intolerance, ambulation capacity, state of anxiety) and to make sure that the patient does not have adverse effects that should lead to rehospitalization" [29]. Some staff use telemedicine new technologies like text messaging or e-mails to keep in touch as early as the following day and to check the postoperative surveillance [30]. The use of telemedicine is governed by articles L. 6316-1 to 9 CSP – derived from the HPST act of July 21, 2009 – and R. 6316-1 to 11 – derived from the decree of October 19, 2010 – and must be done in compliance with the patient's consent, the confidentiality and security of the data being transferred.

3.5.2. The risk of complications and/or rehospitalization

North American studies found low complication rates for large series after ambulatory surgery. Thus among 13,433 ambulatory surgery, Natof found 106 complications which had required 16 hospitalizations [31]. A study by Gold found that among 9616 adults who had surgery 100 were readmitted, mainly because of pain (18), hemorrhage (18) or inexhaustible vomiting (17) [32]. Finally, another large series of 38,598 adult patients found 31 complications (that is to say a morbidity rate of 1/1366) and 4 deaths [33]. A recent Danish study carried out by Majholm, on a prospective follow-up of a group that counted 57,709 interventions over 3 years, showed that the impact of the chronic or long-term complications was 0.17% and the rate of rehospitalization was 1.21%, for hemorrhage (0.5% of the cases), infection (0.44%) or a thromboembolic event (0.03%) [34]. The average time when the complications occurred was 5 days. The surgery that were more at risk of complications were tonsillectomy (11.4%), the termination of pregnancies (3.1%) and inguinal hernias (1.2%). A recent study suggests to use as a quality indicator the consultation rate for urgent care within 7 days after surgery, rather than the rate of hospitalization after a stay in ambulatory, which is minor in comparison [35]. As for compensation, the data of the ASA Closed Claims Analysis show that in the USA, where more than 50% of surgical procedures are performed in ambulatory, this activity is only at the origin of 23% of the claims. On the whole, a lot of damage is less severe with hospitalized patients, with fewer folders going to trial and a compensation less high on average [36]. These data, accurate to the type of patients and surgery, do not present any particular risk for the ambulatory patient's anesthesia, at least when it is performed in health care institutions. It is not the same for anesthesia performed in doctor's offices which, according to the same North American database, include a greater proportion of deaths and brain sequelae, preventable thanks to a better monitoring in the ambulatory activity carried out in health care facilities [37]. These elements tend to make the ambulatory patient's anesthesia a safe practice when it is performed in comparable conditions to those imposed by the current regulatory and professional framework in France [38]. The French insurance data did not consider ambulatory care as causing an increase in the complication rates, with rehospitalization in particular. The claim rate is mainly due to technical errors during surgery or nosocomial infections, and not to the specificity of ambulatory care [17,39]. In addition, a recent report from the research, studies directorate of assessment and statistics in the ministry of health (DREES) noticed a slight increase in the rate of readmission within 30 days between 2005 and 2008 and a small decrease in the average length of stay, without being possible to establish a causal link between the two [40]. This result was noticed for the entire surgery – conventional and ambulatory. In the future, the broadening of instructions and the carry out of more and more complicated interventions may change these data in ambulatory surgery. The risk is possibly linked to a delay in diagnosis or in the medical treatment of a serious complication. As previously indicated, it is therefore important to identify patients prone to readmission because of a complication after ambulatory surgery. The reason is that a delay may entail the responsibility of the practitioners [12].

3.5.3. Home care network

Facing the risk of complications that can occur at home, it is essential to inform the patient on the medical care proceedings and to conceive the protocol for the stages and the surveillance. The documents detailing the surveillance and the possible complications

as well as the correspondence with the physician (general practitioner and/or surgeon) must be handed over to the patient.

When there is the use of specific techniques, such as the technique of continuous postoperative analgesia through perineural catheter, it is necessary to entrust the surveillance to a paramedical care network, which will supervise the nurse follow-up at the patient's home. A nurse may therefore visit at home once or twice a day to give medical care within his/her field of competence (bandage, anticoagulant injection, checking the local-regional anesthesia catheter...). When abnormal signs occur, the nurse shall be able to detect them, take the necessary measures and inform the surgeon and/or the anesthesiologist according to the nature of the problem. Because failing to do this he/she may be held responsible.

For example, the day after the stripping of varicose veins performed in ambulatory, the nurse did not remove the support tape despite the appearance of clinical signs indicating a compression of the external popliteal nerve. The surgeon did not plan to meet the patient the following day and was not informed by the nurse. The nurse was sentenced to compensate the damage (for 80%) in joint liability with the surgeon (for 20%) [41].

3.5.4. What is the role of the treating physician?

The general practitioner is lynchpin in the postoperative care of the patient who had surgery in ambulatory. He is the preferred contact that patients call on in case of pain or complications. He ensures the supervision between the various contacts (nurse, physical therapist...). He can be held liable if there is a delay in the treatment of a complication.

In addition, making available the information between the hospital and the city poses a problem. Therefore, a faulty communication between the hospital and the city is added to the shortage of analgesia and/or a lack of information to the patients. A French epidemiological study recently showed that 63% of the interviewed general practitioners found that the prescription of analgesics was inadequate and more than 70% complained about the lack of information given by the hospital about emergency analgesia [42].

3.5.5. The problem of telephone health advice

Generally, a supervising physician from the Samu (emergency medical assistance service), a general practitioner or even the surgeon may be contacted by the patient so as to be told what to do if there is a new event or a change in the treatment. The difficulty is then to detect with accuracy the patient's condition in order to determine the actions that should be called for. Moreover, the patient can minimize the signs either because he does not know much or because he wants to avoid rehospitalization.

So we can only advise practitioners the greatest caution, which urges to meet with the patient in order to carry out a thorough clinical examination and prescribe the actions adapted to the patient's real condition.

Indeed, the telephone advice can entail the practitioner's responsibility. For example in the case of a child who had surgery for phymosis and whose condition had quickly deteriorated because of a sepsis, the judge ruled that "the substitute physician who answered the phone for a piece of advice relying only on the oral information given by the parents, without having access to the file; while refraining from meeting a 20-month-old child, since he had little information about the child, (...) was guilty of professional negligence and held responsible" [43].

4. Conclusion

As with medical care during conventional hospitalization, ambulatory medical care must comply with the regulatory constraints of our specialty and is likely to entail the responsibility of practitioners in case of damage. Even if the various published studies have shown that ambulatory surgery had a relatively low rate of serious complications that led to rehospitalization, ambulatory medical professionals (in particular the anesthesiologist) must remain cautious. As the medical intervention is the same in ambulatory surgery and in conventional hospitalization, it is the careful selection of patients and the organization of the patient pathways, which allow the management of this risk. After the discharge, informing the patient on the possible complications and warning signs as well as making available all the information for the treating physician and the private nurse contribute to the most favorable security. The analysis of judicial precedents shows that in terms of legal risk, the important points are the anesthesiologist's respect for the duty to inform on the potential complications and a greater supervision when the decision to leave hospital is taken.

Disclosure of interest

The authors declare that they have no competing interest.

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