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REVIEW

Analysis of malpractice claims: The Franco-Belgian ''Cœlio Club'' experience

F. Delaunay[a], T. Delaunay[b,*], E. Van Vyve[c], J.-L. Cardin[d], Club Coelio, S. Auvray[e], T. Barthes[f], A. Bellouard[g], C. Bertrand[h], B. Bokobsa[i], D. Burnon[j], L. Charbit[k], J. Closset[j], J.P. Cossa[k], A. Dabrowski[m], J. Delaby[n], A. Deleuze[o], C. Denet[p], J.P. Desfachelles[q], T. Dugue[r], D. Framery[s], G. Fromont[t], P. Hauters[u], P. Herbiere[v], H. Johanet[w], J. Landenne[u], P. Ledaguenel[x], M. Lepere[y], J.H. Longeville[z], F. Maisonnette[aa], E. Magne[x], P. Malvaux[u], P. Marchand[ab], O. Merlier[ac], B. Navez[ad], E. Olagne[ae], A. Piquard[af], R. Portet[ag], R. Rubay[ah], O. Saint-Marc[af], R. Schramm[ai], F. Siriser[e], A. Valverde[aj], L. Vernay[ak], C. Zaranis[al]

[a] *Centre hospitalier du Belvédère, 76130 Mont-Saint-Aignan, France*
[b] *Clinique Saint-Hilaire, 2, place Saint-Hilaire, 76000 Rouen, France*
[c] *Clinique Saint-Jean, 32, boulevard du Jardin-Botanique, 1000 Bruxelles, Belgium*
[d] *Polyclinique du Maine, 4, avenue des Français-Libres, BP 1027, 53110 Laval, France*
[e] *14050 Caen, France*
[f] *86035 Poitiers, France*
[g] *45160 Orléans, France*
[h] *5530 Yvoir, Belgium*
[i] *76083 Le Havre, France*
[j] *1070 Bruxelles, Belgium*
[k] *93290 Tremblay, France*
[l] *75116 Paris, France*
[m] *62175 Blendecques, France*
[n] *49000 Angers, France*
[o] *30100 Ales, France*
[p] *75674 Paris, France*
[q] *14100 Lisieux, France*
[r] *66000 Perpignan, France*
[s] *29600 Morlaix, France*
[t] *62320 Bois-Bernard, France*
[u] *75000 Tournai, France*

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* Corresponding author.
E-mail address: t.delaunay@wanadoo.fr (T. Delaunay).

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[v] 77300 Fontainebleau, France
[w] 75008 Paris, France
[x] 33000 Bordeaux, France
[y] 85000 La Roche-sur-Yon, France
[z] 58000 Nevers, France
[aa] 42030 Saint-Étienne, France
[ab] 14500 Vire, France
[ac] 59300 Valenciennes, France
[ad] 1200 Bruxelles, Belgium
[ae] 69100 Villeurbanne, France
[af] 45100 Orléans, France
[ag] 31600 Muret, France
[ah] 5004 Namur, France
[ai] 76646 Bruchsal, Germany
[aj] 75020 Paris, France
[ak] 38000 Grenoble, France
[al] 17000 La Rochelle, France

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Summary Malpractice claims are a regularly increasing concern in gastrointestinal surgery. The goal of this study was to compare the current status of claims in two different French-speaking communities by a retrospective descriptive study of surgeons' experiences, from the beginning of their practice up until December 31 2014. Data included the number, the reasons, and the results of medicolegal claims and their jurisdictions. Forty-three surgeons participated in this study. Two hundred medicolegal claims were analyzed. The mean number was 5.8 per surgeon. Bariatric surgery, colorectal surgery and parietal surgery were the most exposed. Forty-six (23%) faults were noted, while no fault was pronounced in 139 (69.5%) cases. The main reasons for lodging complaints were nosocomial infections, anastomotic leaks, poor post-operative care, hollow organ perforation, peripheral neurologic complication, and insufficient preoperative information. Forty-four percent of the complaints were analyzed by the conciliation and compensation commissions and 43.5% by the High Court. In the French-speaking group, there were 13 complaints, two of which gave rise to compensation. French surgeons are highly exposed to complaints: in French law, clumsiness or technical maladdress is considered as a fault. The patient should be informed preoperatively of all possible severe risks of a medical procedure. In Belgium, complications are exceptional and are considered random therapeutic events. Adhering to the recommendations emanating from the French High Authority of Health and Learned Societies as well as accreditation issued by the same High Authority should allow to decrease the number of undesirable events related to care and malpractice.

Introduction

Malpractice is a subject of concern for gastrointestinal surgeons in 2018, in particular, because of the steady increase in the number of accidents: 11% and 39% for two insurance companies [1,2], respectively, between 2013 and 2014. According to the information from a third insurance company [3], one surgeon was held responsible for an accident every 25 months in general surgery and one every 30 months in bariatric surgery between 2010 and 2014. Because of this, insurance premiums have increased, especially in bariatric surgery, and sometimes insurance contracts were not renewed [4]. At the same time, management of these events is time- and energy-consuming and disturbing for the physician's peace of mind, so necessary for careful practice.

Currently in France, only insurance companies report yearly on the accidents they have to treat. No hospital service or group of surgeons does the same. The overall rate of accidents for gastrointestinal surgeons remains largely undocumented [5].

The ''Coelio Club'' is a group of 50 French and Belgian surgeons who are strongly committed to laparoscopic surgery. The members proposed to report their accidents and to compare them between France and Belgium, and, for France, to compare the accidents that occurred in the public and private sectors.

Material and methods

This was a retrospective descriptive study of the experience of surgeons from the beginning of their practice in private clinics or their appointment to a hospital position up until December 31, 2014. Inclusion criteria were:

- membership in the ''Coelio Club'';
- a strong, but not exclusive, commitment to laparoscopic surgery;
- practice in a private or public care facility.

Data collected included surgeon age, type of activity, year of start of practice, number of years subscribing to professional insurance, number of insurance companies subscribed to, price of civil liability premiums (CLP), number of medicolegal complaints, list of adverse events treated by the insurance companies (requested by the surgeons), synthesis of the complaints, with details about the courts of law involved, and the conclusions whenever they were known.

Results

Forty-three surgeons participated in this study: eight Belgian and one German French-speaking surgeons and 34 French surgeons. Seven surgeons preferred not to respond to the questionnaire, without any clear explanation. With regard to the francophone surgeons, the German surgeon was qualified in Germany and practiced in the public sector in Germany, all the Belgian surgeons held Belgian diplomas, three were University surgeons with a private sector activity. The five others practiced in the public sector but, unlike the French system, their mode of function was akin to private practice (predetermined fees without any possibility of exceeding the fixed sum with the hospital billing for the surgeon's services).

For the three University affiliated surgeons, the CLP was paid for by the hospital structure.

With regard to the French surgeons, 25 case records were complete or nearly so. In seven cases, the list of adverse events was not provided by the insurance companies and in two cases, the list was available, but no information on the surgeons was provided.

The mean age of the nine non-French French-speaking surgeons was 57 (47—65) years, the mean number of years in activity since obtaining their diploma was 25 (16—28). All together, these surgeons had contracted a total of 225 years of insurance coverage. The annual premium for CLP ranged from 890 to 3266 €. The number of medicolegal complaints was 13, that is, one for every 17 years of insurance; two surgeons did not have any complaints to report.

Medicolegal complaints concerned cholecystectomy ($n = 5$), bariatric surgery ($n = 3$) (2 gastric bypasses after gastric banding and one sleeve gastrectomy), soft tissue surgery ($n = 1$), Nissen fundoplication ($n = 1$), small intestinal surgery ($n = 1$) and appendectomy ($n = 1$).

The reasons for the complaints included injury to the aorta during pneumoperitoneum creation ($n = 1$), bile duct injury during cholecystectomy ($n = 2$), peripheral neurologic complications ($n = 2$), leaks after gastric bypass ($n = 2$) or after sleeve gastrectomy ($n = 1$), postoperative bowel obstruction ($n = 1$), delay in administering antibiotics ($n = 1$), retained foreign body ($n = 1$) and hemoperitoneum ($n = 1$) while, for one patient, the reason was unknown. Two out of the 13 complaints gave rise to compensation: one bile duct injury during emergency cholecystectomy, where compensation amounted to €81,000, and hemoperitoneum leading to the death of a 14 year old after appendectomy, with compensation amounting to €30,000.

The mean age of the 34 French surgeons was 55 (43—65) years. Twenty-eight surgeons (82%) were in private practice; six were hospital-employed, four of whom also had a private sector activity; the mean number of years in practice was 21 years. The mean number of insurance years was 19.6 (8—32). The number of insurances contracted per surgeon was 1.88 (0—5). The insurance companies were Branchet for 24 surgeons (70%), MACSF for 4, SHAM for 3, AXA and MARSH for one surgeon each. The French surgeons had a total of 667 years of insurance. The mean annual CLP paid for hospital practitioners was €1,580 (€236 to €3,390), that for surgeons in private practice was €15,756 (€10,000 to €32,405). One surgeon did not pay any CLP, which was covered by his facility. The State Health Insurance Office covers 50% of the CLP for surgeons that are accredited by the French High Authority of Health (HAS), up to €8,390 per year.

Two hundred French medicolegal complaints were analyzed, i.e. 1 per 3.33 insurance years, broken down to 1 per 6.4 insurance years for each public sector surgeon, and 1 per 3.04 insurance years for those in the private sector.

The mean number of complaints was 5.8 (0—33) per surgeon. The mean was 2.4 for public sector surgeons and 6.7 for private sector surgeons. The mean number of physicians and/or hospitals involved per complaint was 2.1 (1—9). The mean interval between the beginning of practice and the complaint was 14 (2—25) years. The mean interval between the operation and the complaint was 22 months (1 day to 11 years). The mean number of expert testimonies per complaint was 1.03 (0—3). The different legal jurisdictions involved were the High Court and the Conciliation and Compensation Commission (CCC) in 87 cases each, an administrative court in 10 cases, a Criminal Court in eight cases, and the Medical Profession Council Court in five. Six complaints were settled out of court, and in four cases, the legal instance involved was not known.

Bariatric, colorectal and parietal surgeries accounted for 96 complaints, i.e. nearly 50%. Among the surgical procedures implicated, laparoscopic surgery accounted for 106 complaints (59%). The details of the surgical procedures implicated are indicated in Table 1 and the reasons for the complaints in Tables 2 and 3. No fault was retained in 139 of the complaints (69.5%), faults were found in 46 cases (23%) while 15 cases were still under analysis. Nosocomial infections, anastomotic leaks and pre and/or postoperative management were implicated in 76 complaints (38%). The analysis of the different procedures is provided in Table 4.

Of the 88 complaints analyzed by a CCC, six cases were rejected before any expert testimony while five were still under consideration at the time of our study. Of the 77 remaining complaints, no fault was found in 65 and, no compensation was allocated in 46 cases. Conversely in 19 cases, although no fault was found, damage was considered important, and compensation was allotted by the National Office for Compensation of Medical Accidents (NOCMA). Lastly, in 12 cases, the CCC report after expert testimony went against the surgeon and the insurance company paid the compensation.

Of the 87 complaints adjudicated before the High Court, 47 were dismissed without further ado, 33 led to an indictment, while seven were still under analysis. With regard to the 10 complaints judged by the administrative court, five were dismissed, two led to indictment, while three were still under study. Eight complaints were treated by the Criminal Court and a fault was found in two. Five cases were instructed by the Professional Council and no fault was found.

The faults

Forty-six faults were analyzed in this study. The surgeries performed were colorectal ($n = 13$) and bariatric [gastric banding, ($n = 3$), gastric bypass, ($n = 6$), and gastric bypass after failed gastric banding ($n = 1$)].

The reasons behind these complaints included poor operative technique and/or incomplete operation ($n = 6$), retained foreign body ($n = 7$), poor postoperative care ($n = 8$), delay in reoperation ($n = 5$), and intestinal perforation ($n = 5$). The High Court ruled in 32 while the decision in the remaining 14 cases was made by the CCC.

The largest amount of compensation laid down by the High Court was €1,421,636. For two complaints,

Table 1 Number of malpractice claims, and faults according to the type of surgery and procedure.

Surgery/procedure	Number of malpractice claims	Faults with conviction
Bariatric surgery	37	10
Colorectal surgery	31	13
Parietal surgery	28	2
Laparoscopic cholecystectomy	12	1
Soft tissue surgery	9	2
Gynecologic surgery	7	2
Appendectomy	6	2
Gastrectomy	6	
Thyroidectomy	5	
Hiatal hernia	5	2
Small intestinal surgery	5	2
Anal surgery	5	
Variceal surgery	4	
Esophageal surgery	3	
Biliary and pancreatic surgery	3	1
Appendectomy and parietal surgery	2	2
Implantable chamber	2	
Explorative laparoscopy	2	
Aortic surgery	1	
Percutaneous drainage/hepatic pedicle injury	1	
Retroperitoneal tumor and colectomy	1	
Endoscopic sphincterotomy	1	
Laparoscopic choledochotomy	1	1
Colonoscopy	1	
Unknown	21	5
Surgical abstention	1	1
Total	200	46 (23%)

Table 2 Pre- and intraoperative reasons for malpractice claims and faults.

	Number of malpractice claims	Faults
Preoperative		
Insufficient information	13	2
Wrong diagnosis	3	1
Bad operative indication	3	3
Unjustified preoperative imaging study	1	1
Intraoperative		
Incomplete operation	6	4
Poor operative technique	3	3
Faulty intraoperative diagnosis	2	2

the compensation was close to €1,400,000 and concerned two surgeons in each case. In the first, the patient sustained a bile duct injury during ambulatory cholecystectomy: the surgeon who performed the initial cholecystectomy had to pay €700,000 because no intraoperative cholangiogram was performed. The second surgeon, who reoperated the patient a total of ten times, had to pay the same sum, the reasons being an unjustified indication for reoperation and a Roux-en-Y loop too short.

In the other case, the patient sustained a recto-urinary fistula after prostatectomy: a gastrointestinal surgeon and urologist were concerned.

The NOCMA refused to reveal the sums of compensation paid for fault, in spite of contact by e-mail and ordinary mail to participate in this study. The largest sum of compensation ruled by the administrative court was €240,953.68, for a patient who died after gastric band placement, without any surgical fault being declared.

Discussion

Frequency of claims

Gastrointestinal surgery represented 30% of the medicolegal complaints in 2016, all specialties taken together [6], with two main risk factors: laparoscopy and bariatric surgery. According to the MABSF insurance company, 34% of gastrointestinal or general surgeons declared an adverse event in 2016 [7].

In our study, one adverse event was recorded for every 3.3 years of insurance coverage. These numbers are probably under-estimated because we did not receive complete lists of all the adverse events from the insurance companies and some may have been forgotten. The frequency was higher in the 2013 Branchet report where it concerned one adverse event for every 2.7 years of insurance coverage [3]. All surgical specialties taken together, the frequency of adverse events was one every 3.25 years.

Table 3 Postoperative reasons for malpractice claims and faults.

Postoperative reason	Number of malpractice claims	Faults
Nosocomial infection	27	3
Anastomotic leak	25	3
Poor postoperative management	24	8
Hollow organ perforation during surgery	21	5
Peripheral neurologic complication	18	3
Retained pad/foreign body/catheter	8	7
Residual pain	7	
Intestinal functional disorder	7	1
Delay in reoperation	6	5
Hemoperitoneum/postoperative bleeding	4	1
Bile duct injury/post-cholecystectomy leak	5	
Anastomotic stricture	4	
Great vessel injury (aorta, iliac)	3	
Death	5	
Gastric band slippage	2	
Post gastrointestinal surgery ischemia	3	
Refused reoperation	1	
Anastomotic ulceration after gastric bypass	1	
Lymphedema after vein stripping	1	
Bleeding after percutaneous drainage	1	
Poor postoperative outcome	2	2
Wrong-side operation	1	
Bilateral carotid thrombosis after thyroid surgery	1	
Insufficient explanation of death	1	1
Decreased visual acuity	1	
Postoperative anesthetic complications	1	
Argument with patient	1	1
Testicular atrophy	1	
Urethral stricture	1	
Absence of intensive care unit in care facility	1	
Unknown		6

Table 4 Liabilities and/or courts involved in the claims and faults.

Law court	Malpractice claim	No fault	Fault (%)	Ongoing
HC	63	37	22 (35)	4
HC then court of appeal	8	2	5 (62.5)	1
HC then RCCC	5	4	0	1
RCCC	71	62	8 (11)	1
RCCC then HC	7	3	4 (57)	
RCCC then criminal	1	0	1 (100)	
Criminal	6	6	0	
AC	10	5	2 (20)	3
Out-of-court	16	11	2 (12.5)	3
HC and RCCC	2	1	0	1
HC and RCCC and MPC	1	1	0	
HC and criminal	1	0	1 (100)	
RCCC and MPC	1	0	1	
Unknown	4	4	0	
Total	200	140	46 (23)	14

RCCC: Regional Conciliation and Compensation Commission; HC: High Court — Civil liability; AC: Administrative Court — administrative liability; Criminal court: Criminal liability; MPC: Medical Profession Council.

Exposure of surgical procedures

In our study, the three types of surgery most exposed to complaint were bariatric, colorectal and parietal surgery. The increasing prevalence of bariatric surgery today presages an increase in adverse events [3]; in anticipation to this rise, the insurance companies have increased their premiums or have chosen not to renew contracts. Five surgeons were confronted with this problem in 2015 and had to search for an insurance company hastily [4].

For ASSPRO, an association for the prevention of operative risks, the high-risk operations in 2015 were gastroduodenal and colorectal [8].

Reasons for the claim

The two most common reasons for the claim filed were nosocomial infections and anastomotic leaks. Both are difficult to foresee or to entirely avoid because their origin is multifactorial.

The next three most common reasons leading to medicolegal claims are much easier to avoid: insufficient preoperative information, intraoperative organ injury and poor postoperative care.

Preoperative information must be given in the presence of a trusted third party, and when surgery is major, repeated during a second consultation. The quality of information given to patients seems to have improved slightly. In a study between 2012 and 2016, the quality of information was judged satisfactory in 57% of cases, compared to 55.5% between 2010 and 2014 [6]. Evidence that information was provided is therefore capital. Technical brochures, validated by learned societies, should be given to the patient and the name of the patient and the date of the exchange noted in the patient's file [9]. Operative indications for cancer or obesity surgery should be discussed and validated during a multi-disciplinary consensus meeting [10] and surgeons should refer to the recommendations of the HAS and Learned Societies [11]. The Court of Cassation in 2016 underscored that the risk of adverse events associated with a medical procedure must be explained to the patient, even if this risk is exceptional [12].

The circumstances leading to intraoperative adverse events occur rarely but since an intraoperative adverse event or fault can lead to postoperative complications, the surgeon can therefore be held liable.

In our study, there were several instances of retained foreign bodies that led to reoperations. This is always considered a fault. Even if the surgeon does not count the swabs and pads himself or herself, he or she is responsible for any error in that count. The checklist should be filled in [5,13]. One study totaling 845 adverse events found that poor organization was potentially implicated in 44% of cases, and team dysfunction in 38% of cases [14].

Poor quality of surgery can be occasion for a suit: these were associated with 11 intraoperative adverse events and 21 hollow organ perforations diagnosed postoperatively in our series.

Again, according to a 2009 Court of Cassation report [15] ''the surgeon should be irreproachable in his or her surgical technique and the quality of the surgical act is an obligation of safety''. A technical blunder or clumsiness can be considered as a fault. This must be distinguished from a haphazard or random incident. For instance, a perforation of the small intestines during a difficult viscerolysis or splenic decapsulation during splenic flexure mobilization should be considered as a random incident, not a fault.

Managing the accusation

Each claim is a source of stress and destabilization for the surgeon, and in extreme situations, has led to suicides [16,17]. Discussion between colleagues and presentation of the case in morbidity and mortality conferences are means of evacuating the anxiety and determining the causes of the complication and the eventual error committed [14]. Morbidity and mortality conferences are mandatory in hospitals and private facilities but the case presentations where liability is engaged are voluntary for the moment.

Each of these claim files can take several years before they are closed or judged. The patient has the possibility of taking his or her complaint to several courts or instances. In our study, the number of instances involving the CCC and High Court were similar.

Claims were accepted 87% of the time by the CCC. In the High Court, many claims end up with indictments: 36.7% in our study, comparable to the 38% rate reported elsewhere in 2014 [5]. Effectively, once the liability of the facility or the physician has been judged by the CCC, patients often then go the High Court without even waiting for the propositions of the insurance company or the NOCMA because the amount of compensation is higher.

Amounts of compensation paid out

The highest amount of compensation in this study was €1,421,636. The MACSF insurance company, reported three instances of compensation of more than one million euros in a 2016 study on malpractice claims for physicians working outside of hospital structures [7]. In a malpractice report of more than 10,000 cases between 2012 and 2105, the ASSPRO insurance company found that the number of claims leading to compensation decreased from 25% in 2015 to 21% in 2016 but the amounts paid out were higher [6].

Comparison between France and Belgium

We noted several differences between French and French-speaking Belgian surgeons. There were very few claims among the latter, but it was impossible to obtain complete information with regard to malpractice suits in the hospitals and insurance companies involved. The number of complaints against French surgeons was three times higher than for the Belgian counterpart. The premium paid by the French-speaking Belgians never exceeded €3,266, somewhat similar to the amounts paid by French hospital-based surgeons who have a private sector activity in their establishment. In Belgium, the insurance companies insure the entire hospital structure and the premiums are paid by the hospital. Malpractice claims therefore have to be addressed to the hospital structure. Moreover, when the risk of an operative complication is estimated less than 2%, specific preoperative information is not mandatory in Belgium. In 2010, a funding system was set up to compensate patients who had been victims of health care adverse events in the absence of fault, but very few scenarios have given rise to compensation. In Belgium, the damage must be considered ''very severe'' in order to give rise to compensation.

In France, the March 4, 2002 Law on Health radically changed the relationship between patients and physicians by introducing the notion of a no-fault medical adverse event without fault or a random medical event. This law seems to be at the origin of increased malpractice claims in France [5]. For the SHAM insurance company, the incidence of malpractice claims doubled between 2009 and 2014, with a 11% increase between 2013 and 2014 [1].

Malpractice suits and innovation

The risk of malpractice suits has led some surgeons to be very cautious or even refuse to perform certain high-risk or

major operations, to use innovative techniques or even to conduct research projects.

In a study proposed to the members of our group on the use of mesh in parastomal hernia repair, several French surgeons refused to participate in view of the potential risk of lawsuit in case of infection [18]. A 2016 inquiry showed that avoiding high-risk operations was a good way for young surgeons to avoid malpractice suits [6].

Conclusion

This retrospective study, the only of its kind as far as we know, highlights the differences between surgical practice in Belgium and France as well as between the public and private sectors.

Respecting every step of the clinical pathway, including the pre-, intra- and postoperative periods, team-work, adherence to recommendations and obtaining accreditation should help decrease the number of malpractice suits.

Strong points

The rate of malpractice suits was 1 for every 3.4 years of contracting an insurance policy for surgeons in private practice and 1 for 6.4 insurance/years for surgeons working in hospitals.

The three most commonly incriminated surgical procedures in malpractice suits were bariatric, colorectal and parietal surgeries.

The most frequently cited reasons for malpractice claims were insufficient information to patients, nosocomial infections, anastomotic leaks, poor postoperative management and hollow organ perforations.

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Disclosure of interest

The authors declare that they have no competing interest.

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