TIPS AND TRICKS IN ANGIOLOGY
All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means.
The contents of the present collection might be summarized with the word “regardless…”, namely regardless of whether or not a morbid state is more or less prevalent. We have covered new topics as well as questions that have been neglected or barely touched upon for several reasons: for lack of epidemiological importance or because they are not backed up by the experience necessary to guarantee that the patient can receive evidence-based treatment.

The readers will notice that, surgical and medical topics are addressed equally in an innovative way. This is partly due to the diverse cultural background of the authors and partly due to the great difficulties encountered in medical practice; where the physician is constantly faced with the question of why things are the way they are and consequently, why a particular therapeutic choice is indicated.

A great deal of the book has been dedicated to co-morbidities in arteriopathies and to the concept of the multi-focal nature of arteriosclerotic disease. We should not forget that minimally invasive surgery or endovascular intervention is only one aspect of the therapy. Education on prophylaxis and treatment of complications in a cost effective approach is fundamental in the public health system which is under financial stress due to the increasing number of elderly people.

Much attention has been paid to phlebology, which has seen the most significant therapeutic and preventive advances in comparison to arterial diseases. Today severe pulmonary thromboembolism is an episodic event that can be treated. Also the post-phlebitic syndrome may be avoided.

Anticoagulant treatment is a mainstay in the prevention and treatment of venous thromboembolism. The direct oral anticoagulants perhaps have been adopted too soon considering the current lack of widely available antidotes.

Surgical ablation of the varices, has lost its fundamental role and has been replaced by minimally invasive endovenous ablation techniques. This therapeutical approach is widely used today. In addition to be easy to learn and perform, it is also cost effective as the late John Bergan used to point out. Many phlebologists go so far as to say that the foam in ultrasound guided sclerotherapy irrespective of where and how you inject it; it goes where it has to go.

Lymphology, is the real Cinderella of vascular diseases, partly due to the choice of its adoptive parents and partly due to its diagnostic and therapeutic difficulties. It has recently re-emerged with the advances in the study of vascular malformations.

I believe that, when a second edition of this volume becomes necessary, at the end of each chapter we could add feasibility and cost-benefit criteria; the benefit for the patients in terms of survival time and quality of life should be considered a priority.

We dream of a world inhabited by independent healthy elderly people, and not by frail and ill ones.

Claudio Allegra
Authors

GIOVANNI BATTISTA AGUS
Vascular Surgery and Angiology, University of Milan, Milan, Italy

MARIA Benedetta Agus
Attorney at Law, Milan, Italy

Claudio Allegra
Master on Vascular Diseases, S. Giovanni Hospital, Rome, Italy

Leonardo Aluigi
Angiology Chief of Villalba Private Hospital (GVM Care and Research), Bologna, Italy

Maria Amitrano
Vascular Medicine Unit, Department of Medicine, “Giuseppe Moscati” Hospital, Avellino, Italy

Nicos Angelides
President of the Mediterranean League of Angiology and Vascular Surgery (MLAVS)

Pier Luigi Antignani
Vascular Center, Nuova Villa Claudia, Rome, Italy

Mustapha Azzam
Josef Pflug Vascular Laboratory, Ealing Hospital and Imperial College, London SW7 2AZ and West London Vascular and Interventional Center, Nortwick Park Hospital, Middlesex, UK

Tiziana Anna Baroncelli
Lega Tumori, Florence, Italy

Lena Blomgren
Department of Vascular Surgery, Karolinska University Hospital, Stockholm, Sweden

Francesco Boccardo
IRCCS University Hospital San Martino - IST, National Institute for Cancer Research, Department of Surgery, Operative Unit of Lymphatic Surgery, University of Genoa, Italy

Roshan Bootun
Section of Vascular Surgery, Charing Cross Hospital, Imperial College London, W6 8RF, UK

Daniele Camilli
San Camillo de Lellis Hospital, ASL Rieti, Italy

Sante Camilli
Vascular Surgery, Private Surgery, Rome, Italy

Corrado Campisi
IRCCS University Hospital San Martino - IST, National Institute for Cancer Research, Department of Surgery, Operative Unit of Lymphatic Surgery, University of Genoa, Italy

Corrado Cesare Campisi
Plastic, Reconstructive and Aesthetic Surgery, Lymphatic Surgery and Microsurgery, GVM Care & Research, ICLAS, Rapallo, Genoa, Italy

Francesca Cannavacciuolo
Vascular Medicine Unit, Department of Medicine, “Giuseppe Moscati” Hospital, Avellino, Italy

Joseph A. Caprini
Louis W. Biegler Chair of Surgery, Division of Vascular Surgery, NorthShore University HealthSystem, Evanston, IL, USA

Sylvain Chastanet
Riviera Veine Institut, Monaco

Denis L. Clement
Department of the Dean, Ghent University Hospital, Ghent, Belgium
ANthonY J. ComeRota
Jobst Vascular Institute, The Toledo Hospital, Toledo, OH, USA - Adjunct Professor of Surgery, University of Michigan, MI, USA

Alessandro Ferrari
IRCCS University Hospital San Martino - IST, National Institute for Cancer Research, Department of Surgery, Operative Unit of Lymphatic Surgery, University of Genoa, Italy

Konstantinos Fillis
National and Kapodistrian University of Athens, School of Medicine - Division of Vascular Surgery/1st Propedeutic Department of Surgery, Ipokrateio Hospital, Athens, Greece

George Galyfos
Vascular Surgery Unit, KAT General Hospital of Athens, Greece

Grigoris T. Gerotziafas
Cancer Biology and Therapeutics, INSERM U938, Institut Universitaire de Cancérologie (IUC), Faculté de Médecine, Université Pierre et Marie Curie (UPMC), Sorbonne Universities, Paris, France - Thrombosis Center, Department of Haematology, Tenon University Hospital, Assistance Publique Hôpitaux de Paris, France

George Geroulakos
Department of Vascular Surgery, Athens University Medical School, Attikon University Hospital, Athens, Greece

Sergio Gianesini
Department of Vascular Surgery, Athens University Medical School, Attikon University Hospital, Athens, Greece

Maria Ines Morales de los Rios
Laboratory and Vascular Rehabilitation Service, Centro Medico Rafael Guerra Mendez, Valencia, Venezuela

Marianne G.R. De Maeseneer
Phlebology Department of Dermatology, Erasmus MC, Rotterdam, The Netherlands; Faculty of Medicine and Health Sciences, University of Antwerp, Antwerp, Belgium

Patrizia De Zolt
Istituto Flegologico Italiano (IFI), Ferrara, Italy

Sara Dessalvi
IRCCS University Hospital San Martino - IST, National Institute for Cancer Research, Department of Surgery, Operative Unit of Lymphatic Surgery, University of Genoa, Italy

Jose A. Diaz
Department of Surgery, Section of Vascular Surgery, Conrad Jobst Research Vascular Laboratories, University of Michigan, Ann Arbor, MI, USA

Giacomo Failla
Angiology Unit, “Vittorio Emanuele” University Clinic, Ferrarotto Hospital, Catania, Italy

Jawed Fareed
Thrombosis and Hemostasis Research Laboratory, Loyola Stritch School of Medicine, Maywood, IL, USA

Anthony J. Comerota
Jobst Vascular Institute, The Toledo Hospital, Toledo, OH, USA - Adjunct Professor of Surgery, University of Michigan, MI, USA

Alessandro Ferrari
IRCCS University Hospital San Martino - IST, National Institute for Cancer Research, Department of Surgery, Operative Unit of Lymphatic Surgery, University of Genoa, Italy

Konstantinos Fillis
National and Kapodistrian University of Athens, School of Medicine - Division of Vascular Surgery/1st Propedeutic Department of Surgery, Ipokrateio Hospital, Athens, Greece

George Galyfos
Vascular Surgery Unit, KAT General Hospital of Athens, Greece

Grigoris T. Gerotziafas
Cancer Biology and Therapeutics, INSERM U938, Institut Universitaire de Cancérologie (IUC), Faculté de Médecine, Université Pierre et Marie Curie (UPMC), Sorbonne Universities, Paris, France - Thrombosis Center, Department of Haematology, Tenon University Hospital, Assistance Publique Hôpitaux de Paris, France

George Geroulakos
Department of Vascular Surgery, Athens University Medical School, Attikon University Hospital, Athens, Greece

Sergio Gianesini
Vascular Disease Centre, University of Ferrara, Italy

Maria Ines Morales de los Rios
Laboratory and Vascular Rehabilitation Service, Centro Medico Rafael Guerra Mendez, Valencia, Venezuela

Marianne G.R. De Maeseneer
Phlebology Department of Dermatology, Erasmus MC, Rotterdam, The Netherlands; Faculty of Medicine and Health Sciences, University of Antwerp, Antwerp, Belgium

Patrizia De Zolt
Istituto Flegologico Italiano (IFI), Ferrara, Italy

Sara Dessalvi
IRCCS University Hospital San Martino - IST, National Institute for Cancer Research, Department of Surgery, Operative Unit of Lymphatic Surgery, University of Genoa, Italy

José A. Diaz
Department of Surgery, Section of Vascular Surgery, Conrad Jobst Research Vascular Laboratories, University of Michigan, Ann Arbor, MI, USA

Giacomo Failla
Angiology Unit, “Vittorio Emanuele” University Clinic, Ferrarotto Hospital, Catania, Italy

Jawed Fareed
Thrombosis and Hemostasis Research Laboratory, Loyola Stritch School of Medicine, Maywood, IL, USA
Tips and Tricks in Angiology

TOMASZ MROWIECKI
Department of Vascular Surgery, University Hospital, Kraków, Poland

ANDREA OBI
Section of Vascular Surgery, Department of Surgery, University of Michigan, Ann Arbor, MI, USA

WALDEMAR L. OLSZEWSKI
Department of Applied Physiology, Mossakowski Medical Research Center - Central Clinical Hospital, Department of Vascular Surgery, Warsaw, Poland

ALVARO ORREGO
Vascular Surgeon, Viña del Mar, Chile

GUALTIERO PALARETI
Cardiovascular Diseases, University of Bologna, Italy

FRANCESCO PAOLO PALUMBO
Vascular Surgery, Vulnologic Center, Palermo, Italy

FAUSTO PASSARIELLO
Vascular Surgeon at Centro Diagnostico Aquarius - President at Vasculab Foundation ONLUS, Naples, Italy

JAN PITHA
Institute of Clinical and Experimental Medicine, Prague, Czech Republic

PAVLINA PITHOVA
Department of International Medicine, 2nd Medical Faculty of Charles University and University Hospital Motol, Prague, Czech Republic

PAUL PITTLUGA
Riviera Veine Institut, Monaco

PAVEL POREDOŠ
Department of Vascular Disease, University Medical Centre Ljubljana, Slovenia

PAOLO PRANDONI
Department of Cardiovascular Sciences, Vascular Medicine Unit, University of Padua, Italy

KAREL ROZTOCIL
Institute of Clinical and Experimental Medicine, Prague, Czech Republic

MELISSA RYAN
IRCCS University Hospital San Martino - IST, National Institute for Cancer Research, Department of Surgery, Operative Unit of Lymphatic Surgery, University of Genoa, Italy
ANGELO SCUDERI
Angiology and Vascular Surgery of “Santa Lucinda”, University Hospital PUCSP (Pontifical Catholic University of São Paulo-Brazil); Past President of UIP (Union Internationale de Phlebologie)

MAXIM E. SHAYDAKOV
Department of Surgery, Section of Vascular Surgery, Conrad Jobst Research Vascular Laboratories, University of Michigan, Ann Arbor, MI, USA

MARIAN SIMKA
Department of Nursing, College of Applied Sciences, Ruda Śląska, Poland

STEFANO SPINACI
IRCCS University Hospital San Martino - IST, National Institute for Cancer Research, Department of Surgery, Operative Unit of Lymphatic Surgery, University of Genoa, Italy

ANA SPIRKOSKA
Department of Vascular Disease, University Medical Centre Ljubljana, Slovenia

EWA STELMACH
Department of Applied Physiology, Mossakowski Medical Research Center - Central Clinical Hospital, Department of Vascular Surgery, Warsaw, Poland

Medical Research Center - Central Clinical Hospital, Department of Vascular Surgery, Warsaw, Poland

THOMAS J. TEGOS
1st Neurology Department, AHEPA Hospital, Aristotelian University of Thessaloniki, Greece

TOMASZ URBANEK
Department of General Surgery, Vascular Surgery, Angiology and Phlebology, Medical University of Silesia, Katowice, Poland

ADRIANA VISONÀ
Angiology Unit, Azienda ULSS 8, Castelfranco Veneto (TV), Italy

THOMAS WAKEFIELD
Section of Vascular Surgery, Department of Surgery, University of Michigan, Ann Arbor, MI, USA

TAKASHI YAMAKI
Department of Plastic and Reconstructive Surgery, Tokyo Women’s Medical University, Tokyo, Japan

MARZANNA T. ZALESKA
Department of Applied Physiology, Mossakowski Medical Research Center - Central Clinical Hospital, Department of Vascular Surgery, Warsaw, Poland
Contents

Foreword ........................................................................................................................................ III
  C. Allegra

Authors .......................................................................................................................................... V

1. How to avoid vascular malpractice ................................................................. 1
  G.B. Agus, M.B. Agus

2. The status of vascular surgery in the Mediterranean countries ....................... 5
  N. Angelides

3. Microcirculation: shade and light ................................................................. 9
  C. Allegra

4. How to manage the patients with polyvascular disease ........................................ 13
  P. Poredoš, A. Spirkoska, M.K. Ježovnik

5. Non-invasive imaging of the vulnerable atherosclerotic carotid plaque ............. 16
  L. Aluigi

6. Assessment of cardiac morbidity/mortality after CEA or CAS ......................... 24
  K. Filis, G. Galyfos

7. Horton’s disease ........................................................................................................ 28
  E. Kalodiki, P.L. Antignani

8. Vascular dementia: an integral part of the metabolic syndrome ......................... 33
  T.J. Tegos

9. Endovascular rotational thrombectomy of the superior mesenteric artery for the treatment of acute mesenteric ischemia ......................................................... 36
  P. Latacz, T. Mrowiecki, M. Simka

10. Isolated iliac artery aneurysms ......................................................................... 38
    K.G. Moulakakis, J. Kakisis, A. Lazaris, G. Geroulakos

11. Foot pulse palpation to detect occlusive artery disease in the lower limbs .......... 44
    D.L. Clement

12. Tips and tricks on the Ankle-Brachial Index ....................................................... 46
    K. Roztocil, J. Pitha

13. Validity of diagnostic procedures in patients with peripheral arterial disease .................. 49
    P. Poredoš

14. Tips and tricks in peripheral arterial disease .................................................... 52
    A. Visonà
15. The diabetic foot - a serious diabetic complication .......................................................... 56
   P. Pithova

16. Thrombophilia .................................................................................................................. 62
   G. Palareti

17. Direct oral anticoagulants and the potential impact of new reversal agents ............... 66
   F. Davis, A. Obi, T. Wakefield

18. The “SEAP” classification and an up-date on superficial vein thrombosis ..................... 71
   E. Kalodiki, C.R. Lattimer, J. Fareed

19. Superficial vein thrombosis - it is no more a benign disease!
   Be careful and follow the disease course ........................................................................... 76
   T. Urbanek

20. Deep vein thrombosis: a view from the basic science ................................................... 79
    M.E. Shaydakov, J.A. Diaz

21. The use of the Caprini score in clinical practice ............................................................ 83
    J.A. Caprini

22. Tips and tricks for the management of venous thromboembolic disease ....................... 88
    G.T. Gerotziafas

23. Calf vein thrombosis: what can we do? ......................................................................... 97
    M. Amitrano, F. Cannavacciuolo, S. Mangiacapra

24. Catheter-directed treatment of iliofemoral deep vein thrombosis .................................. 101
    A.J. Comerota

25. Residual thrombus in patients with deep vein thrombosis and pulmonary embolism: prognostic implications ................................................................. 105
    P. Prandoni

    C. Jeanneret

27. What is the practical value of diameter measuring in an office setting? ....................... 112
    E. Mendoza

28. The VascuLab manoeuvre: a dynamic simulation of an “in situ” step;
    definition and description ................................................................................................. 117
    F. Passariello

29. The range of motion of the ankle joint as part of the evaluation of patients with chronic venous insufficiency ................................................................. 122
    C.L. Maduro-Maytin, E. Kalodiki, M.I.M. de los Rios

30. Evaluation of chronic venous diseases using near-infrared spectroscopy .................... 125
    T. Yamaki

31. Surgery of varicose veins .............................................................................................. 130
    A. Scuderi

32. Tips and tricks for successful endovenous laser ablation .............................................. 135
    D. Kontothanasis, P. De Zolt

33. Foam sclerotherapy ........................................................................................................ 141
    C.R. Lattimer, M. Azzam
34. **Cyanoacrylate adhesive injection** ................................................................. 145  
   R. Bootun, T.R.A. Lane, A.H. Davies

35. **Reflux abolition and venous drainage preservation: both are essential for durability of varicose veins treatment** ................................................................. 150  
   D. Camilli, S. Camilli

36. **Saphenous sparing options for chronic venous disease: let us make it as simple as possible** .... 155  
   S. Gianesini

37. **ASVAL technique: how to understand the concept, set the indications and perform the technique with simple tools** ................................................................. 159  
   P. Pittaluga, S. Chastanet

38. **Treating incompetent perforating veins** ............................................................. 164  
   A. Orrego

39. **Tips and tricks for the diagnosis and management of vulvar varicose veins** ...................... 168  
   K. Gibson

40. **How to avoid and treat recurrences after varicose veins treatment** .............................. 172  
   L. Blomgren

41. **Tips and tricks for treatment of varicose veins in post-thrombotic syndrome** .................. 177  
   M.G.R. De Maeseneer

42. **The modern approach to venous ulcers** ....................................................................... 182  
   G. Failla, F.P. Palumbo

43. **Management of Klippel-Trenaunay syndrome: how to avoid complications, bleeding and/or thrombus!** ................................................................. 185  
   B.B. Lee

44. **Cryptic bacteria in various veins and lymphatics of the lower limbs** .............................. 190  
   W.L. Olszewski, M.T. Zaleska, E. Stelmach

45. **Lymphatic compression** .................................................................................. 194  
   T.A. Baroncelli

46. **Lymphatic surgery for lymphedema** ........................................................................ 198  
   C. Campisi, F. Boccardo, M. Ryan, L. Molinari, S. Spinaci, S. Dessalvi, C. Cornacchia, A. Ferrari, C.C. Campisi

47. **A novel method of edema fluid drainage in obstructive lymphedema of limbs by implantation of hydrophobic silicone tubing** ........................................... 203  
   W.L. Olszewski, M. Zaleska
How to avoid vascular malpractice

G.B. Agus, M.B. Agus

“A spectre is haunting the medical world: the spectre of malpractice” and “the times when the physician used to answer for his actions, but to his conscience and his peers, is over”. These adapted quotes are now fundamental of every medical malpractice lawsuit.

The problem of adverse events in health is relevant. Today 5 patients of 100 entering the hospital suffer one preventable complication in nearly 50% of cases. Fortunately vascular surgery, angiography and phlebology, are not among the most frequent causes of lawsuit as is the case with orthopedics, gynecology, general surgery and anesthesiology. However, since 1997 the ad hoc committee on reporting standards in the USA presented a method, upgradeable in the endovascular era, to evaluate the quality of care in vascular surgery. This is defined as “a great beginning on something that, whether we like it or not, we will need to face” (Table 1.1).

Even the much less invasive venous surgery is not free from certain complications like hematoma, ecchymoses, scars, nerve injury, lymphatic damage, infections, thrombosis etc. The authors have personal experience from Italian records from many cases of malpractice in missed or erroneous prevention of venous thromboembolism; in overestimated indication about the true need to operate upon aortic aneurysms; in vascular trauma; cases of aesthetic damage (appearance of telangiectasiae and scars after varicose veins surgery); underestimated the risk of deep vein thrombosis in varicose vein surgery etc. This should be discussed well in advance with every single patient, in particular to protect the surgeon against litigation.

Res ipsa loquitur (simply translated means “it speaks for itself”). The classic example of res ipso loquitur is leaving a swab in the abdomen after a surgical procedure. This is an obvious example of malpractice.

Sine cura meaning “without care”. The condition of not being treated safely. “To err is human,” which asserts that the problem in medical errors is not bad people in health care - it is that good people are working in bad systems that need to be made safer (National Academy of Sciences, 2000, Washington, DC).

The knowledge that we do not cause avoidable medical errors, is the best method to avoid malpractice.

The value of the practice guidelines: tip, trick, or trap?

The guidelines (GL) by a professional society, in an attempt to avoid liability, are often accompanied by disclaimers stating that such GL are simply “suggestions” for treatment, and that the ultimate treatment must be
Avoid “defensive medicine”

Each action of the specialist will have to take these aspects into consideration, without getting into the practice of “defensive” medicine “for their own interest and to the detriment of their patient.

To consider the standard of care

The standard of care (SoC) concept is currently embodied by physicians as a discredited legal term that has been long ignored by the medical profession. It is nevertheless at the center of medicine’s opportunity to improve and formulate a sustained, preventive ethics response to the professional liability crisis. Reliable judgments about what should be considered a SoC are not adversarial; they are scientific and should be guided by the standards of high-quality evidence-based medicine prevailing at the time the case occurred. Such judgments should be based on currently available high-quality evidence-based disease management protocols and other clinical GL as well as rigorous review of current peer-reviewed literature; a review that categorically requires an unbiased expert witness. Today the defendant in a medical malpractice case admits that he or she breached the SoC in the treatment of the patient. A plaintiff who is a medical expert may establish the SoC. If even a layperson would know that the SoC has been violated, no expert testimony is necessary. An example of this would be not performing heparin prophylaxis in well indicated cases. Equally important also are the diagnostic and therapeutic pathways in patients with vascular disease for their appropriateness, particularly in use today in Italy.

The role of a medical expert witness

As an example between vascular and endovascular treatment is one vascular specialist testifies that the correctness in the treatment of a patient with significant carotid artery stenosis is angioplasty and stenting, whereas a second vascular surgeon testifies that carotid endarterectomy is the SoC for the treatment of such patients. It would then be up to the judge to decide which witness is telling the truth. Unfortunately, this can be quite difficult for the lay individual who is unaccustomed to critically evaluating medical data.

The evolution of new scientific studies

These contributions coupled with rapid advances in medical technology, naturally alters the customary
practice of physicians. This constant modification of the customary practice in medicine can lead to a significant conflict for physicians who believe that the present SoC is dangerous, but a new SoC has not yet been generally accepted. In most cases, the legal system has been unwilling to allow evidence that discredits the present standard unless a new standard has been established.

**Informed consent**

This is another key issue of jurisprudence; the proper informed consent from the patient which is essential.8-10

**Always speak with the patient**

A right doctor-patient relationship can avoid malpractice lawsuits. Good communication with the patient is fundamental in achieving a strong physician-patient relationship.11 This relationship requires the physician to provide the patient with the acceptable standard of care. To include patient and his family satisfaction with the outcome is also important. When injuries or other adverse reactions incur, the physician needs to apologize to the patient. A typical vascular example is the mortality of thoracic or abdominal aortic aneurysms which is high whether an operation takes place or not. The knowledge of the risk by relatives with the empathy of the doctor can be decisive. Some rules help too.

The EU Commission stated recently how to receive information on safety and quality standards within the EU Countries. “A national contact point in each member state shall provide information to patients on their rights to healthcare across Europe. Access to information on the quality and safety of care will allow to make informed decisions. These contact points can also provide information on the European reference networks where one can receive highly specialized healthcare in the case of complex, low prevalence or rare conditions.”12

**Risk management**

Risk management refers to strategies that reduce and minimize the possibility of an adverse outcome or harm. The systematic gathering and utilization of data are essential. Good risk management techniques improve the quality of patient care and reduce the probability of an adverse outcome or a medical malpractice claim.

We would like to re-enforce here that non-medical and medical risk management is a three-step process which involves: 1) identifying risk; 2) avoiding or minimizing the risk; and 3) reducing the impact of harm when it occurs. Medical risk management focuses on risk reduction through improvement of patient care. Liability (responsibility) for medical malpractice might have financial implications.

Another issue is the psychological trauma of a malpractice suit. The physician’s actions are considered negligent when: 1) the physician has failed his/her duty to treat the patient; 2) the physician’s interaction with the patient fell outside the accepted SoC; 3) the patient was harmed as a result of this interaction. Risks anticipating severe injury or adverse reactions must be given priority over risks that anticipate minor harm.

The physician should also develop a system to minimize injury or adverse reactions, utilizing the resources at his or her disposal. Compassion and empathy are part of the physician’s care for the patient, and the physician should readily express these feelings without fear of repercussion.13 When physician negligence causes a patient injury, transparency and openness should be implemented instead of distance and avoid communication. The physician should assume responsibility and make amends for the patient’s loss. Negligent actions injuring patients are primarily due to misinformation and lapse of good judgment and rarely are due to malicious recklessness. When appropriate, the physician should inform the patient about any changes that are being implemented in response to the event or situation to prevent future occurrences. Patients understand and readily accept apologies and clear explanations. Deceit and feelings of abandonment raise suspicion of malpractice.

Implementation of systems of risk management and creation of patient safety scores will reduce the risks, including organizational and structural risks.14

**Legal education**

To introduce educational courses for physicians in universities and hospitals, in order to acquire more experience and professionalism regarding clinical risk.

**Insurance**

Establish national single contracts, valid throughout the country in order to ensure equal protection to
all NHS physicians. Pending these, “good luck” in finding a reliable but not so expensive individual insurance.

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