
Preface

When I started practicing Obstetrics and Gynecology in Porto, some 25 years ago, obstetric emergencies were looked upon by healthcare professionals as events of an almost “supernatural” nature. After such emergencies occurred, people almost invariably put on an expression of fear and fatality. “I pray that this never happens to me when I’m on call” was commonly heard. The occurrence was usually recounted in detail from individual to individual, with some consequent distortion of the facts, and normally very little was learnt from it. Some doctors appeared to be very sure of what should have been done, but opinions frequently differed among them. As a junior doctor at the time, I felt very unsure of what to do should an obstetric emergency happen to me. Memories remain of very stressful cases of acute fetal hypoxia, shoulder dystocia, and postpartum hemorrhage, with many people talking at the same time, contradictory orders and some adverse neonatal and maternal outcomes.

The wide dissemination of evidence-based practice did not do a lot to improve this situation. Acute events are poor candidates for studies providing the highest levels of evidence. Obstetric emergencies were consequently given limited relevance at scientific meetings and medical journals, as there was not a lot of good evidence to discuss, and also because doctors who become well-known in these environments were frequently not involved in the clinical activities where the majority of these situations occur.

The largest contribution to the management of obstetric emergencies over the last decades probably came from the development of clinical guidelines, many of which were based mainly on expert opinion and small case series. Another strong contribution came from the development of more realistic obstetric simulators and the dissemination of simulation-based training courses.

After being involved in the co-ordination of local, national and international guidelines on these subjects, having run simulation-based courses in obstetric emergencies for more than 10 years, and being a medical advisor for the development of a high-fidelity obstetric simulator, I felt the time had come to share some of these experiences in a book. A lot can be learned from observing multiprofessional teams manage obstetric emergencies in the protected environment of simulation, and then formulating an objective and structured way of teaching them to junior doctors. Similar experiences can be gained from developing the requirements of a high-fidelity simulator. Priorities can be reconsidered and the relevance of existing recommendations can be re-evaluated.

With the natural limitation of the quality of existing scientific evidence to support many of the recommendations, I trust that the present book will constitute a useful contribution to healthcare professionals involved in the clinical management of obstetric emergencies, and an opportunity to revise and re-think some of the necessary attitudes.

Obstetric Emergencies

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