Medical Malpractice Lawsuit Discussion Course

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Medical Malpractice Lawsuit Discussionコース

コース概要

このコースは12 年以上製薬業界の第一線で活躍する Sharon BeltrandelRio先生が MANABI.st のホームページ上で連載しております医療訴訟のコラムを題材に作成したものです。レッスンは各コラムで記載されていますケースを読みディスカッション形式に行われます。最後に「実際にどう決着したのか」を知ることが出来ます。ケースは全6つ。。

本コースは医療業界又は法曹業界に勤めていらっしゃる方向けのコースとなっております。

授業は1レッスン＝1ケースで進みます（もちろん1ケースに1レッスン以上利用されても構いません）。トピック毎に6－8つの質問が事前課題として記載されております。

コース受講方法

1. ケースは6つあります。以下がケース概要です。

   CASE 1:　Acid indigestion or a heart attack? —胃酸過多か？心臓発作か ？—
   CASE 2:　Hemoptysis and lung cancer —喀血&肺癌—
   CASE 3:　Colon Cancer ー結腸癌ー
   CASE 4:　Retained Foreign Body ー残存異物ー
   CASE 5: Bowl Obstruction— 腸閉塞症 —
   CASE 6: Influenza— インフルエンザ —

2. まず『ログイン後』→『コースを探す』→ 医療英語 > テキストの使用 > Medical Malpractice Lawsuitコースよりご予約下さい。

3. ケースの内最も話しやすいものを選び『先生への伝言』板を利用し先生に伝えてください。

4. 選択されたトピックをよく読み事前課題に対する答えを準備してください。

5. レッスンは質問に沿って行われますが、脱線しても一向に構いません。質問を全てカバーできなくても気になさらないで下さい。本コースの目的はあくまで医療分野におきましてより高いコミュニケーション能力をつけて頂くもので、一つの質問で深い議論になる可能性ももちろんございます。1トピックに1レッスン以上利用されても構いません。ご自分のペースでレッスンを受講いただければ幸いです。

6. 既にやられたトピックを別の先生とDiscussionされるのもお勧めします。その場合、『先生への伝言』を通じ、"I have already done this topic with a different teacher so I would like to have a free discussion using this topic"とお書き下さい。

Case 1: Acid indigestion or a heart attack?
―胃酸過多か？心臓発作か ？―

57 year-old executive woman presented at her local hospital's emergency room complaining of sharp abdominal pain localized just below the sternum, nausea and dyspnea. She had eaten lunch two hours prior at a local restaurant. The woman is the vice president of human resources at a Fortune 500 company and she remarked to the physician that she had been under a lot of stress because the company had just laid off ten percent of its workforce. She has a sedentary lifestyle and is moderately overweight.

Her vital signs were: blood pressure 150/90, heart rate 110 and respiratory rate 17. The following tests were performed: basic EKG, blood chemistry and cardiac enzymes. The results of the EKG and cardiac enzymes were within normal limits. Her blood chemistry showed a cholesterol level of 285 with all other parameters within normal limits.

The woman was diagnosed with acid indigestion and prescribed antacids. She was discharged and instructed to return if the pain continued. She was also told to follow-up with her primary physician to address her high cholesterol levels.
That night the woman died. An autopsy revealed that the cause of death had been an acute myocardial infarction (MI).

The patient did not have a history of acid reflux or other related ailments. It is now well know that women suffering from heart attacks often present with atypical chest pain which appears to be abdominal in origin. With this in mind, the emergency room physician should have expanded his differential diagnosis to include heart conditions. Serial cardiac enzymes and EKG's should have been performed, as it is well known that the enzyme levels and EKG changes characteristic of MI may not appear for several hours. The patient should have been kept under observation for a longer period of time while these additional tests were performed. A patient should not be discharged until a serious potential diagnosis such as an MI can be ruled out.

The patient's family filed a claim against the local hospital and the emergency room physician due to their failure to diagnosis her heart condition.

<u>Discussion questions</u>

1. Please summarize this case. What is the main point of the article?
2. Was the patient's initial work-up complete? If not, what other tests should have been performed?
3. Was the emergency room physician's initial diagnosis justified? Why or why not?
4. What are some of the differences between men and women suffering from a myocardial infarction?
5. Was the emergency room physician negligent? Why or why not?
6. Was the hospital negligent? Why or why not?
7. What should the hospital do to avoid this type of negligence in the future?

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Case 2: Hemoptysis and lung cancer
—喀血&肺癌—

Having suffered from hemoptysis (the expectoration of blood from the larynx, trachea, bronchi or lungs) for a few weeks, a 33-year-old female contacted her primary care physician's office. She spoke to her primary care physician, who prescribed antibiotics and instructed the patient to call again if her condition did not improve.

The patient went to the primary care physician's office four weeks later, complaining of dyspnea and hemoptysis. A radiologist determined that her chest X-ray was normal except for a small area of infiltrate in her left lobe. The same physician who had spoken to her on the telephone examined her and diagnosed pneumonia. Another course of antibiotics was prescribed and the patient was instructed to return after completing the antibiotics.

The patient did not complete the antibiotics and did not return to her doctor's office until six weeks later, after suffering from hemoptysis again. Another X-ray was taken and the staff radiologist determined that signs of infiltrate in the left lobe were still present. The doctor believed that the infiltrate was pneumonia-related and resistant to the previously prescribed antibiotics. So he prescribed different antibiotics and instructed the patient to take them for seven days and then return. However, within a few days she experienced dyspnea and a sharp pain in her left lung. She called her primary physician and was immediately referred to a respiratory specialist.

When she was examined by the respiratory specialist she also complained of headaches. He performed a CT scan and diagnosed stage IV lung cancer with metastasis to the brain. The patient passed away the following year.

The patient filed a claim against her primary care physician due to the delay in diagnosis and treatment of lung cancer.

<u>Discussion questions</u>

1. Please summarize this case. What is the main point of the article?
2. Was the patient's initial work-up complete? Why or why not?
3. Was the primary care physician's initial diagnosis justified? Why or why not?
4. Do you think the primary care physician suspected lung cancer? Why or why not?
5. Did the respiratory specialist perform the appropriate tests? Why or why not?
6. Should the patient have been informed of the worst possible diagnosis or would this have frightened her unnecessarily?
7. Was the primary care physician negligent? Why or why not?

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Case 3: Colon Cancer
—結腸癌—

A 60-year-old male visited his primary care physician complaining of abdominal cramps and blood in his stool. Upon examination the patient was noted to be severely overweight and a smoker. He mentioned that his uncle had died of colon cancer at the age of 65. Physical examination, including rectal exam, were normal. His stools were guaiac-positive but other laboratory findings were unremarkable. The physician mentioned that a colonoscopy would be advisable and ordered the patient to return in one week if the cramps did not subside.
Three months later the patient returned to the doctor complaining of flu symptoms. The physician treated him with antibiotics. The abdominal cramps, blood in the stool and colonoscopy were not discussed.

Six months later the patient presented with lower abdominal pain. His stools were guaiac-positive again. The physician ordered a colonoscopy. The colonoscopy revealed a large ulcerated lesion five centimeters proximal to the rectum. Biopsies revealed an adenocarcinoma. The patient underwent a colectomy and chemotherapy but died one year later.

The patient's family filed a claim against the physician for failure to diagnose the colon cancer during the patient's initial visit, which would have greatly improved his prognosis.

Since the initial stool samples were guaiac-positive and the patient mentioned a family history of colon cancer, the doctor should have requested a colonoscopy immediately, not just mention that it would be advisable. Furthermore, the doctor should have followed up or asked about the colonoscopy when the patient visited his office two months later.

In addition, the patient was not informed of the potential consequences of a guaiac-positive stool. If the physician had provided additional information the patient probably would have been more inclined to have the colonoscopy. But since the physician did not appear too concerned and the abdominal cramps disappeared within a few days, the patient did not have the colonoscopy.

Discussion questions

1. Please summarize this case. What is the main point of the article?
2. Was the patient's initial work-up complete?
3. Was his second work-up complete?
4. Did the physician provide the patient with sufficient information regarding his guaiac-positive stools? Why or why not?
5. Why is patient education important?
6. Was the physician negligent? Why or why not?

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Case 4: Retained Foreign Body
—残存異物—

Retained foreign body
A 12-year-old boy complaining of abdominal pain was seen in the emergency department. Upon examination, his vital signs were stable and he was afebrile. His right lower quadrant was tender to the touch and showed rebound and guarding. CBC showed a moderately elevated white blood count and urinalysis was normal. The patient had taken Tylenol but the pain did not respond. A consult with a pediatric surgeon was scheduled, after which the surgeon diagnosed appendicitis and decided to operate.

The operation was performed the same day and confirmed the diagnosis of appendicitis. The appendix was removed successfully and the recovery period was without complications. The patient was discharged.

Two months later the patient returned to the emergency department complaining of abdominal pain and fever. The attending physician ordered a CBC and urinalysis. The CBC revealed a slight elevation of white blood cells and the urinalysis was normal. The patient was told to take Tylenol and follow up with his pediatrician if the pain did not subside.

The next day the patient returned to the emergency department complaining of considerably worse pain, fever and vomiting. CBC and urinalysis were unchanged. A CT scan revealed an abscess near the cecum. The physician consulted the pediatric surgeon and he decided to operate. During the operation the surgeon found what appeared to be a piece of gauze that was apparently left during the appendectomy two months before. The abscess was drained, the gauze removed and a Penrose drain was left in the wound so that drainage could continue. The boy recovered without further complications. The pediatric surgeon (who had performed both operations) apologized to him and his family.

The boy and his parents filed a claim against the surgeon for negligence.

In general, suits over retained foreign bodies are difficult, if not impossible, to defend. The surgeon refrained from finger-pointing or blaming an assistant, and he sincerely apologized to the patient and his family. In addition, the hospital agreed to waive all charges for the operation to remove the gauze and drain the abscess.

Discussion questions
1. Please summarize this case. What is the main point of the article?
2. Was the patient's initial work-up complete?
3. Were the diagnosis and treatment appropriate?
4. Was his second work-up complete?
5. Were the diagnosis and treatment appropriate?
6. Should the surgeon have apologized?
7. Was the surgeon negligent? Why or why not? If so, what is a fair settlement?

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Case 5: Bowel Obstruction

— 腸閉塞症 —

A 50-year-old male who had undergone gastric bypass surgery one year previously visited the emergency room complaining of severe abdominal pain. The patient described his pain as localized to the lower abdomen and gave it a 10 on a scale of 1-10 during an exam performed by the Emergency Department physician in the early afternoon. The patient's white blood cell count and temperature were normal.

A few hours later, the physician noted that the abdomen was distended, rebound positive and very tender to the touch. A CT abdominal scan was consistent with a partial small bowel obstruction. The attending physician was informed of the results of the CT scan and the patient was admitted.

Surgery was scheduled for the next morning at 8:00 a.m. The patient's pain continued without relief and morphine was administered throughout the night. By 6:00 a.m. the patient developed a fever and continued to complain of severe pain. During the surgery, the attending surgeon found obstruction of the proximal ileum with an area of necrosis requiring that a large segment around the site of obstruction be removed. The patient recovered without incident.

The patient filed a claim against the Emergency Department doctor, the attending physician and the hospital, alleging that they failed to treat his obstruction in a timely manner causing undue pain and suffering as well as the resection of a large segment of his small intestine, all of which could have been prevented.

The physicians should have taken into account the patient's medical history, including his gastric bypass surgery since adhesions can cause bowel obstruction. The fact that the patient's abdominal pain did not improve was a clear sign that urgent surgical care should have been provided. The necrosis in the small intestine could most likely have been prevented by early surgical intervention.

<u>Discussion questions</u>

1. Please summarize this case. What is the main point of the article?
2. Was the patient's initial work-up complete?
3. What additional steps should have been taken after the CT scan?
4. Was the patient's surgery performed in a timely manner?
5. Were the Emergency Department physician, and attending physician and hospital negligent? Why or why not?

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Case 6: Influenza

— インフルエンザ —

A 13-year-old male visited his primary care physician complaining of flu-like symptoms. He had not received a flu vaccination. His peak temperature was 102° F (38.9° C) and he suffered from mild upper respiratory congestion. Group A streptococcus was found to be negative in a rapid screening test. The physician prescribed an anti-pyretic, rest and plenty of fluids. The boy took the medicine, but continued to suffer from fever, nausea, emesis, malaise and restlessness. Two days later the boy was taken to the local emergency department. He was found to be hypotensive. Despite intensive resuscitative efforts, he died ten hours later.

The postmortem examination revealed necrotizing pneumonia and extensive alveolar hemorrhage. Influenza A (H1N1) infection was confirmed in a viral culture and methicillin-resistant Staphylococcus aureus was isolated from a tracheal aspirate.

The boy's parents filed a claim against the primary care physician for failure to recognize the seriousness of his illness, failure to correctly diagnose the viral origin of his illness and failure to prescribe an anti-viral agent.

Influenza vaccination is currently recommended for high-risk persons (including children and pregnant women) and healthy adults who are likely to come into contact with those at risk. Furthermore, there is strong evidence that immunization of healthy persons benefits the community. The major influenza virus that was prevalent during this season was influenza A (H1N1), a strain that was included in the available vaccine. There was no shortage of vaccine supply during this influenza season.

If a person develops influenza, antiviral treatment is routinely recommended for those who are hospitalized and for those presenting to ambulatory facilities in the early phase of illness who are considered to be at high risk for serious consequences. However, it is very difficult to predict the eventual outcomes in the early stages of the illness.

Discussion questions

1. Please summarize this case. What is the main point of the article?
2. Was the patient's initial work-up complete? Why or why not?
3. Based on the boy's history, should the physician have considered him to be at high risk for serious consequences? Why or why not?
4. Who should receive an influenza vaccination? Whose responsibility is it to see that a minor receives an influenza vaccination?
5. Was the physician negligent? Why or why not?

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