Surgery: iturralde v. hilo medical center usa

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On January 24, 2001, Arthur Iturralde went to the hospital for severe, debilitating back pain. His pain was caused by degenerative spondylolistheisis L4-5 with stenosis. He was scheduled for surgery several days later, on January 29, 2001 with Dr. Robert Ricketson. Hilo Medical Center (HMC) did not have the proper kits for spinal fusion surgery, so they placed an order with Medtronic Sofamor Danek, USA. The doctor decided that he needed to keep Mr. Iturralde in the hospital until the hospital could obtain the materials necessary for the spinal fusion. Hilo Medical Center placed the order, and the materials were received on January 27, 2001, at 7:30pm. At the time, it seems that no one inventoried the materials that were received, and they were sent to the Operating Room. It was called to Dr. Ricketson's attention by the surgical nurse that the kit was incomplete, but he chose to go forward with the surgery. While he was operating, the hospital contacted the Medtronic sales rep, who offered to bring the missing materials. Dr. Ricketson felt that the 90 minutes the delivery would take would be too long to keep his patient in surgery, so he chose to improvise rather than wait. That decision would have deadly consequences for Mr. Iturralde, but not until after he suffered two years of severe trauma associated with the failed surgery.

Legal Components

None of these facts are at issue. The parties have stipulated to the facts as they are asserted here. The court decided it was a question of law because the parties dispute on which rules should be applied to the facts of the case.

The Defendants dispute whether the lower Court erred in determining which jury instructions should have been given at the conclusion of trial. There are shields in place, HRS sec. 663. 10. 9 limited joint and several damages. Hawaii law holds all parties responsible for part or the full amount of the damages. The recovering party can seek to recover from any or all of the parties, up to the total amount of the jury award.

Malpractice Policies

In the case of Iturralde v. Hilo Medical Center, USA; Arturo Iturralde, the victim, is deceased. His sister Rosalinda Iturralde represented her brother in the malpractice suit with Hilo Medical Center (HMC), Dr. Robert Ricketson, and Medtronic Sofamor Danek USA, Inc. The patient, Arturo, was diagnosed with degenerative spondylithesis L4-5 with stenosis on admission to HMC. This condition required a spinal fusion which was scheduled for January 24, 2001 with Dr. Ricketson, an orthopedic surgeon. The physician, ordered an M8 Titanium CD Horizon Kit from Medtronic. The kit should have included the titanium rods needed for the surgery, though they apparently did arrive separately and were separated before being sent to the operating room. This oversight was discovered on January 29, 2001, when the nurse was completing inventory immediately prior to surgery. The operating room nurse informed the surgeon, but he decided to proceed without resolving the matter. When the Medtronic representative could not get the items delivered quickly enough, the surgeon decided to improvise and use the shaft from the surgical kit screwdriver in place of the surgical grade rods to fuse the spine. Immediately following the surgery Dr. Ricketson neglected to inform the patient or his supervisors of the modifications made during surgery. The

following day, after the patient, Arturo, was given instructions to start physical therapy he fell and the screwdriver shattered, necessitating another surgery. The second surgery took place on February 5, 2001, and Dr. Ricketson removed the screw driver shaft and was able to replaced it with the planned titanium rods that were not available in the previous surgery. After these surgeries the patient had multiple cases of ueosepsis along with many more hospitalizations leading to more surgeries and emergency room visits. All of these complications left Arturo completely bedridden till he passed away on June 18, 2003. The standard of care should never be compromised bydoctors or healthcare professionals when caring for patients. Doctors and other healthcare professionals must make their best medical judgment in circumstances where the facts are often not static, while doing their best to observe their oath to " first, do no harm." As Fremgen (2016) states " This standard also requires that a physician not perform any acts that a " reasonable and prudent" physician would not" (p. 61).

In this case, Dr. Ricketson might have thought waiting for the delivery of the rods placed the patient at greater risk. To mitigate the possibility of harm, Dr. Ricketson decided to complete the surgery with the material he had available to him without a long wait. Dr. Ricketson decided to use of the surgical screwdriver shafts which he first modified and then implanted into the spine of the patient. This decision turned out to be the entire wrong one, as the screwdriver shafts ultimately lead to a three year deteriorating of Arturo's condition until his death in June 18, 2003.

Standard of Care

The standard of care is typically defined as by Fremgen (2016),

" the ordinary skill and care that medical practitioners use and that is commonly used by other medical practitioners in the same locality when caring for patients; what another medical professional would consider appropriate care in similar circumstances" (p. 61).

HMC did extend hospital privileges to Dr. Ricketson without verifying his professional standing. By not doing so the medical center failed to find out the numerous violations against Dr. Ricketson which were: falsifying medical records, violating state and federal drug laws, abusing his authority to write

prescriptions, lying to licensing authorities, and failing to report prior actions against his license (Iturralde v. Hilo Medical Center USA). Dr. Ricketson was placed on probation by the state of Hawaii on October 13, 2000. When HMC permitted Dr. Ricketson to practice at the hospital they violated the standard of care since no doctor in his position would have been allowed to practice with that many prior negligent infractions, the standard of care was breached.

Cultural background

Different cultures have different expectations of the healthcare community. In the case of the Iturralde family, they expected that they would report to a reputed medical center, seeking care for severe pain. The doctor who initially suggested surgery had a long history of practicing medicine and the Iturralde family had no reason to mistrust him. Little did they realize that the Medical Center had not exercised a reasonable standard of care when extending privileges to Dr. Ricketson. Because the family had no prior negative interaction with healthcare, and because they had always relied on medical professionals when dealing with medical issues, they had no reason to mistrust the system. Though they did not have a reason to mistrust the healthcare system, they did take care to go to a hospital they knew to be reputable and to have a high standard of care.

Accountability

The medical center failed the Iturraulde family. They failed the family when they did not exercise a reasonable standard of care in checking the doctor's background They failed the family when the necessary surgical supplies were not properly inventoried and delivered to the operating room. They failed the family when the doctor decided to improvise and none of the other professionals in the room decided to speak up for the patient. And most of all, they failed the patient when the nurse finally brought the entire situation to light and the medical center failed to take responsibility immediately and do whatever they could to mitigate.

The oath is, " first, do no harm." This medical center could have stood to be reminded that their primary obligation, first, last and all along the way, was to " do no harm."

References

- Fremgen, B. F. (2016). *Medical law and ethics* (5 th ed.) Boston, MA: Pearson Education, Inc.
- Iturralde v. Hilo Medical Center USA (Intermediate Court of Appeals of Hawaii March 30, 2012.