Clinical Merit Review: Reacted/Edited Example

I. Executive Summary

This case involves a 76 year-old male, Mr. John Doe, who was admitted to ABC Hospital on *Date Readacted* with a complaint of abdominal pain and diagnosed with recurrent sigmoid volvulus and partial intestinal obstruction. The patient underwent a sigmoid resection and colectomy, performed by Dr. Smith, on *Date Readacted*. The patient had an episode of emesis on *Date Readacted* with aspiration, leading to respiratory failure, cardiac arrest for 17 minutes, sepsis, and multi-organ failure. The patient ultimately expired on *Readacted*.

I have thoroughly reviewed the 1900-page PDF copy of the medical records from ABC Hospital in generating this report.

II. The Four Elements of Medical Neglicence

1. Duty of Care

A physician-patient relationship was established upon the patient's arrival and subsequent care at ABC Hospital throughout the duration of his hospitalization. Attending physicians and the consulting medical team owed a duty to the patient to provide care consistent with the prevailing Standard of Care.

2. Breach of Duty

The Standard of Care was breached in the following critical areas:

- **Failure To Identify and Interpret Changes in Post-Operative Vital Signs**
  Nursing staff and medical providers failed to recognize the worsening trend in vital signs, including worsening hypertension, tachycardia, tachypnea, and significant pain in the two days following the sigmoid colectomy on *Date Readacted*.

- **Failure To Perform Post-Intervention Pain Reassessments**
  Nursing staff performed multiple pain interventions, but failed to document a reassessment within the 30-to-60-minute standard. This violates The Joint Commission's Pain Assessment and Management Requirements and CMS CoP Clinical Record standards, which mandate documenting the "response to pain interventions."

- **Failure To Notify Providers Of Clinically Important Changes**
  Despite clear clinical indicators of deterioration in patient condition, the nursing staff did not notify the necessary providers to alert them of issues prior to the aspiration event on the evening of *Date Readacted*.

- **Failure To Recognize The Clinical Signs of Post-Operative Volvulus**
  Medical staff failed to recognize the classic clinical presentation of an evolving mechanical bowel obstruction—including escalating abdominal pain, persistent nausea, and a failure to progress with standard post-operative milestones.

3. Causation

These breaches of standard of care were the direct and proximate cause of the patient's death. Failure to identify the clinical signs and symptoms of a post-operative volvulus and treat it accordingly directly caused the vomiting episode which led to the aspiration event, respiratory failure, cardiac arrest, and ultimate death. Consequently, the Defendant Hospital's continuous deviations from the standard of care played a substantial and determinative role in the Patient's clinical deterioration, ultimately resulting in a catastrophic lost opportunity for survival and the Patient's preventable death.

4. Damages

As a direct and proximate result of the Defendant Hospital's negligence, malpractice, multiple deviations from the standard of care, and lack of timely medical and surgical intervention, the Patient suffered severe physical injury, conscious pain and suffering, and a catastrophic loss of the opportunity for survival, ultimately resulting in death.

- Conscious Pain and Suffering: Severe physical pain, emotional distress, and mental anguish endured by the Patient during the two days immediately post-operatively and throughout the twelve day ICU stay from *Date Readacted* through his death on *Date Readacted*.

- Economic Damages: Significant medical expenses, hospital charges, ambulance transfer fees, and ICU costs incurred for the extensive treatment of respiratory failure, cardiac arrest, multi-organ failure, and hypoxic ischemic encephalopathy, as well as funeral and burial expenses.

- Wrongful Death Damages: The full value of the life of the Patient, including the loss of companionship, love, society, comfort, guidance, and support suffered by the Patient's surviving heirs and next of kin.

III. Preliminary Conclusion

The medical records demonstrate that the medical staff failed to provide the necessary evaluation, testing, follow-up, and established standard of care, leading directly to the patient's prolonged hospitalization, resulting in immense pain, suffering and ultimate death.

Respectfully,

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