心導管手術醫療事故之刑事責任

The Criminal Liability for the medical Malpractice in Cardiac Catheterization

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令和3（わ）年第1097號業務上過失致死事件
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摘 要

被告為患者A施行心導管手術，卻於插入導管後忘記拔除導引線，使其遺留於患者A體內長達兩個月；期間被告為患者A進行X光影像檢查，均能可見導引線在心臟中形成環狀結構，惟被告卻無任何作為；直至患者A轉院後，因導引線已刺入右心室壁並癒合，導致他院醫師拔除導引線時，刺穿右心室壁而致心包填塞，最終患者A死亡。法院認為，由於難以排除轉院方醫師在拔除導引線時導致心肌損傷，故不難斷定被告行為即是傷害主因；法院仍須考量無論心肌損傷是被告或轉院方醫師所致，被告均須負起責任。經查，被告人未盡早確認X光影像是否為導引線遺留並予以拔除，其帶來

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的風險促成了後續轉院方醫師的介入行為，進而導致死亡結果的現實化，故而該過失與A死亡之間具有因果關係。儘管後續接手醫師在拔除操作中缺乏謹慎，但倘若被告人能夠儘早拔除，便能夠避免後續接手醫師的拔除操作，因此即便後續接手醫師之操作可能對A死亡結果帶來影響，其程度仍然有限。

The defendant performed a cardiac catheterization procedure on the Patient A but forgot to remove the guidewire after insertion, leaving it inside A's body for two months. It is clear from the X-ray imaging examinations conducted by the defendant that the guidewire formed a ring-like structure within the heart. The defendant didn't take any action. The issue only became critical after A was transferred to another hospital. The guidewire had penetrated and adhered to the right ventricular wall. When the physicians at the new hospital tried to remove it, the guidewire perforated the right ventricular wall, causing cardiac tamponade. A died eventually. The court ruled that it was not unreasonable to conclude that the defendant's actions were the primary cause of the harm, given that it was difficult to rule out myocardial damage caused by the transferring hospital's physicians during guidewire removal. The court ruled that the defendant was responsible for the myocardial injury, regardless of its origin. The investigation revealed that the defendant failed to promptly confirm whether the X-ray image depicted a retained guidewire and remove it. This failure created a risk that necessitated intervention by the receiving hospital physician, thereby causing the fatal outcome. This negligence undoubtedly caused A's death. The subsequent physician's failure to exercise due care during the removal procedure as a key factor in the incident. Had the defendant removed the

guidewire promptly, the subsequent physician's removal procedure would have been unnecessary. It is clear that even if the subsequent physician's actions contributed to A's death, this contribution was limited.

壹、事實概要

一、事件概要

患者A（當時68至69歲）患有路易氏體失智症等疾病，入住失智症共同照護中心，因原因不明的褥瘡惡化，遂至大阪府某社會醫療法人甲醫院（被告醫院）治療，主治醫師（被告人）考量A的營養狀況不佳及日後的藥物施打需求，於2017年11月22日為A進行心導管手術。被告人從鼠蹊部插入心靜脈導管時，本應於插入導管時確實掌握導引線，並於完成導管插入後確實拔除，卻於插入導管後遺忘拔除導引線，使其遺留於患者體內。術後A在甲醫院住院期間共接受8次胸部X光檢查，所有影像中均可見從下腔靜脈進入心臟並形成環狀結構、延伸至頸部的白色線狀陰影（實際上為導引線的影像）。其中陰影的環狀部分在2017年12月4日之前呈現圓滑的形狀，但自12月9日以後，其前端變得鋒利。對於X光片中的陰影，被告人從未進行調查與確認，未採取任何處置或對家屬做任何說明，即便A於2018年1月31日轉院至他院時，被告人亦未向轉院方交接任何有關X光片陰影事項，或進行必要的說明。最終，A於2018年2月5日由轉院方醫師進行拔除導引線手術時，因導引線移動等因素刺穿右心室壁，引發心包填塞而死亡。

依醫療水準，在將心導管插入靜脈時為了正確地將導管導入靜脈內，通常需要先將用於引導導管的導引線插入靜脈，然後沿著導引線插入導管。此過程中為防止導引線與導管一同滑入靜脈內，必須從導管尾端露出導引線的尾端並加以掌握。