

the Reporter

FAILURE TO DIAGNOSE: PEDIATRIC CLOSED CLAIM STUDY

by Felicia Collazo, Risk Management Representative

The following closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. An attempt has been made to make the material less easy to identify. If you recognize your own case, please be assured it is presented solely for the purpose of emphasizing the issues of the case.

Clinical presentation

A 3-year-old female presented to the ER accompanied by her mother at 3:20 p.m., with complaints of fever, lethargy, sore throat, severe leg pain bilaterally with decreased sensation, absent reflexes, weakness and inability to walk. Similar symptoms existed in the upper extremities but were not as pronounced. She was noted to have a non-raised rash on her palms and erythema of her pharynx with a white exudate and possible blisters on her tonsils. Physical examination revealed T 102.7, HR 152, RR 28, O₂ saturation 97 percent, and intact cranial nerves without meningeal signs or facial palsy. Labwork revealed a WBC of 17.8 with a left shift and bandemia with normal hemoglobin, hematocrit, and platelet count. Electrolytes and renal function studies were reported as normal. Her urine was noted by her mother to be amber in color and slightly cloudy. A lumbar puncture was done to rule out meningitis and Rocephin was administered. She was also given an initial bolus of 300 ml NS then started on D5 one-half NS at 60 ml/hr because of dehydration. Tylenol 240 mg and Motrin 120 mg were given for fever. At 4:20 p.m., the ER physician

contacted the pediatrician on call, one of the defendants in this case, and reported the child's condition.

Physician action

The pediatrician on call elected not to come to the ER and, instead, gave a telephone order to obtain a urinalysis via catheterization. She then had follow up conversations with the ER physician at 5:23 p.m. and the ER nurse at 6 p.m. and again at 7:45 p.m., concerning the pending urinalysis.

Later in the evening, the child's condition worsened and the pediatrician on call was contacted again. The pediatrician arrived at 9 p.m., 5.5 hours after the child presented to the ER. She found the patient to have T 98.3, HR 120, RR 24, good capillary refill and warm extremities with no meningeal signs. Neurological exam revealed no deep tendon reflexes or muscle tone of the lower extremities and 1+ deep tendon reflexes on the upper extremities. The child complained of extreme pain in her legs. The physician's impression was viral myalgia or myositis process versus possible Guillain-Barre' syndrome. Her documentation noted the most likely diagnosis being viral illness, but also mentioned Bornholm and Coxsackie virus as possibilities. The pediatrician on call did not communicate directly with the child's mother.

The UA revealed a large amount of blood with a few RBCs. It was reported to the pediatrician on call that only a 6 cc urine specimen was able to be obtained for analysis. No order for a second UA was written;

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however, an order to continue IV fluids was given. The child did not void while in the ER, despite being given the IV bolus of 300 ml and a continuous IV fluid drip at 60 ml/hr. The child's mother expressed concern to the nurses that the patient had not voided since 1 p.m., and the nurses encouraged the child to do so. The child denied the need.

At 12:50 a.m., the pediatrician on call wrote orders to admit the child to the adult ICU, and then left the hospital. The admission orders included telemetry and O₂ monitoring, strict I & O, IV D5 one-half NS at 60 ml/hr and to call the patient's regular pediatrician in the morning. On admission to the ICU, vital signs were T 96.2, BP 119/78, RR 45, O₂ saturation 100 percent. Because the child had still not voided by 4:03 a.m., the pediatrician was paged and returned the call at 4:06 a.m., giving orders to encourage voiding again and to catheterize if unsuccessful. At 4:09 a.m., the mother placed the child on the bedpan and noticed that the child felt "heavy." At 4:15 a.m., the child was catheterized returning only 31 cc of "dark brown coffee colored urine." At 4:18 a.m. vital signs showed changes and the ER physician ordered a stat EKG and arrived in the ICU to see the child at 4:30 a.m. Her BP was 92/48 and her HR 86. The patient coded. The pediatrician on call was paged at 4:35 a.m., and arrived at 4:55 a.m., participated in, and then conducted the code. The child was pronounced dead at 6:15 a.m. An autopsy was performed and concluded the cause of death to be from rhabdomyolysis.

Allegations

Allegations against the pediatrician:

- failure to timely report to the ER to evaluate the child;
- failure to properly evaluate;
- failure to diagnose and treat rhabdomyolysis;
- failure to transfer the patient to an appropriate facility.

The hospital and the ER physicians were also named in this suit.

Legal implications

No experts reviewing this claim were fully supportive of the defendant's treatment of the child in this case. Defense consultants found that the pediatrician fell below the standard of care in the following areas:

- delay in arrival to the hospital — 5.5 hours after the child presented to the ER;
- failure to recognize clinical signs that would have led to appropriate treatment and transfer of patient for dialysis — including anuria since 1 p.m., abnormal lab results, elevated T- wave;

- failure to order appropriate testing even after receiving abnormal results — repeat UA, CPK, electrolytes;
- failure to properly handle a code — monitor strips clearly showed a severe electrolyte problem which was not recognized and therefore inappropriate medications were given.

The damages of this case centered around the untimely death of a 3-year-old child. Consultants agreed her death could have been prevented had the appropriate care been delivered. Chances of a successful defense were further marred by the negative depositions of the nurses at the hospital regarding the defendant.

Disposition

Total settlement on behalf of all defendants was \$2.25 million. This case was settled on behalf of the pediatrician for \$500,000 and the entire practice entity for \$325,000. Legal expenses in the defense of this case totaled more than \$113,000.

Risk management considerations

For optimal patient outcomes it is necessary to carefully and comprehensively communicate, evaluate, monitor, and follow up on a patient's condition. All of these factors played key roles in the outcome of this case.

Physicians may face additional liability exposure when on call to an emergency department. In many instances, the patient is not an established patient presenting additional challenges to the on call physician. The pediatrician on call in this claim fell below the standard of care in her failure to come to the emergency department in a timely manner to examine and evaluate this child. Availability and a commitment to respond quickly are vital characteristics of a conscientious practitioner, as are the ability to recognize when emergency transfer is the best course of action, especially when treatment choices such as pediatric ICU or dialysis are unavailable in the hospital.

Pediatricians have an obligation to communicate with the child's parents. Effective physician/patient/parent communication is the foundation of a sound relationship and medical management. In hospitals where physician specialists are not staffed 24 hours a day other than the ER, the obligation for on call physicians rises concurrently.

Reviewing claims against physicians retrospectively allows conjecture and opinions by all concerned. In this case, however, the on call pediatrician's medical management was not supported by either defendant or plaintiff expert reviews. Failure to meet the standard of care is negligence and cannot be defended.

risk management 101

PIAA releases national closed claim data

by Barbara Rose, Senior Risk Management Representative

The information that follows is a summary of nationwide medical malpractice claim data from member companies of the Physician Insurers Association of America (PIAA).

Physicians in pediatrics ranked sixth in the number of malpractice claims reported from 1985 through 2000 according to the most recent update of PIAA's Data Sharing Project. Obstetricians/gynecologists ranked first in the number of malpractice claims.

A decade ago, PIAA identified improper performance, diagnostic error, failure to monitor the case, and medication errors as the most prominent "medical misadventures" for all specialties combined. The list in the latest report is basically the same. What has changed is the average indemnity (payout). Primary care physicians have been especially affected. Average claim payments increased from \$150,011 in 1995 to \$270,460 in 2000.

PIAA defines primary care physicians as internists, family and general practitioners, pediatricians, and gynecologists. Among these physicians, the most often cited misadventure is diagnostic error. Second is "no medical misadventure" which means a doctor has been named in a suit but there is no allegation of inappropriate medical conduct on his/her part. This category includes those allegations against an entity, such as the clinic or practice in which a physician is a partner, associate or employee.

The medical conditions that most often resulted in claims against primary doctors were, in order of total claims, myocardial infarction, cancer of bronchus and lung, breast

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Top 10 reasons for claims against primary care physicians — 1985-2000

Misadventure	Closed claims	% closed w/payment	Average payout
Diagnosis errors	12,602	37%	\$171,501
No medical misadventure	8,254	5%	\$109,212
Improper performance	5,370	36%	\$118,256
Failure to monitor case	3,637	39%	\$157,984
Medication errors	3,127	41%	\$112,861
Not performed *	1,278	42%	\$180,425
Failure/delay in referral/consult	1,146	46%	\$177,388
Performed when not indicated	1,128	37%	\$119,983
Failure to recognize complication	1,056	36%	\$115,915
Delay in performance	785	46%	\$179,643

* the physician allegedly failed to perform an indicated treatment or procedure, and that failure was the main reason for the malpractice action

Who is sued and what is the outcome?

Specialty	Number of claims	% closed w/payment	Average payout
Ob/gyn (surgical)	22,980	36%	\$235,059
Internal medicine	21,591	27%	\$169,381
Family/general practice	19,043	36%	\$132,356
General surgery	17,974	35%	\$151,810
Orthopaedic surgery	16,440	30%	\$138,799
Pediatrics	5,022	29%	\$232,499
Otorhinolaryngology	2,654	32%	\$167,855
Neurology	2,607	22%	\$266,881
Cardiovascular (non-surgical)	2,402	19%	\$199,378
Emergency medicine	2,337	29%	\$144,092
Gynecology	1,904	32%	\$117,343
Dermatology	1,854	31%	\$94,347
Gastroenterology	1,286	21%	\$147,234

Top 10 conditions in suits against primary care physicians

Condition	Closed claims	% closed w/payment	Average payout
Acute MI	1,432	39%	\$193,439
Cancer of bronchus and lung	894	36%	\$171,565
Breast cancer	829	43%	\$190,252
Colon and rectal cancer	707	43%	\$222,335
Diabetes	613	33%	\$120,087
Abdominal/pelvic symptoms	521	23%	\$201,818
Pneumonia	531	28%	\$141,734
Chest pain (not further defined)	476	29%	\$197,101
Appendicitis	500	37%	\$65,040
Hypertension	457	30%	\$180,922

Closed in 2000

Condition	Closed claims	% closed w/payment	Average payout
Acute MI	34	39%	\$265,173
Chest pain (not further defined)	30	37%	\$304,727
Abdominal/pelvic symptoms	29	17%	\$124,250
Obesity	26	0%	\$0
Back disorders *	19	37%	\$152,143
Pneumonia	19	37%	\$43,333
Soft tissue disorder	18	28%	\$265,000
Color and rectal cancer	18	50%	\$338,519
Diabetes	17	53%	\$397,500
Injury to multiple body parts	17	35%	\$67,961

* including lumbago and sciatica

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cancer, colon and rectal cancer, and diabetes. Cases closed in 2000 alone reflected changes to this list.

The most often cited procedures resulting in claims were the diagnostic interview, evaluation or consultation followed by prescription of medication, general physical exam, failure to render care and injections/vaccinations.

Primary care physicians have an ever expanding myriad of responsibilities and claims can develop both as a consequence of doing something wrong or an omission such as failure to do routine annual screening. "Primary care physicians must stay abreast of current practice standards in order to minimize liability. As patient care standards shift, so will the patterns seen in morbidity, mortality, and eventually medical malpractice claims."

Sources

1. Weiss, Gail. Malpractice: Don't wait for a lawsuit to strike. *Medical Economics*. 2002; 6:82.
2. PIAA Research Notes: Primary Care Managers Focus on Internal Medicine and General and Family Practice. Winter 2002.

Top 10 procedures in suits against primary care physicians 1985-2000

Condition	Closed claims	% closed w/payment	Average payout
Diag. interview, evaluation/consultation	15,159	27%	\$167,370
Prescription of medication	6,012	39%	\$118,699
General physical exam	3,096	30%	\$182,294
No care rendered	1,644	10%	\$95,895
Injections & vaccinations	1,506	38%	\$139,253
Diag. radiologic procedures, not CT scan & contrast	1,135	44%	\$158,551
Diag. procedures, cardiac & circulatory functions	997	37%	\$218,300
Misc. manual exams & non-operative procedures	906	43%	\$181,616
Diag. procedures of large intestine	489	37%	\$160,529
Misc. non-operative procedures	459	31%	\$63,262

Closed in 2000

Diag. interview, evaluation/consultation	339	30%	\$276,053
General physical exam	183	26%	\$370,413
Prescription of medication	162	28%	\$215,996
Injections & vaccinations	47	40%	\$405,377
Misc. manual exams & non-operative procedures	44	48%	\$234,568
No care rendered	34	3%	\$130,000
Diag. radiologic procedures, not CT scan & contrast	30	33%	\$130,450
Diag. procedures, cardiac & circulatory functions	28	54%	\$336,283
Diag. procedures of large intestine	20	50%	\$190,500
CT scan	17	47%	\$163,422