

# Medication Error Occurs in Pediatric Practice; Infant Dies From Untreated Condition

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## Introduction

As medical practices continue to consolidate, they necessarily employ larger numbers of physicians, advanced practice providers, and support staff. This results in more “moving parts” that must be carefully coordinated to provide efficient service and minimize procedural errors. This interesting case illustrates how a series of errors can combine to produce a catastrophic treatment failure.

## Facts

Dr. D was a board-certified pediatrician who was employed by a large, MedPro-insured pediatric group practice. The patient was a newborn male who was born prematurely at Hospital 1 on October 22 of Year 1, after gestation of 31 weeks and 4 days. The patient’s birth was unremarkable, with Apgar scores of 8 and 9, respectively. His birth weight was 3.04 lbs.

At the time of his birth, the patient was mildly tachypneic, and a chest X-ray showed mild neonatal respiratory distress syndrome. After several brief apneic episodes, he was placed on continuous positive airway pressure. The care team was able to wean the patient off the respiratory assistance by Day 3, with no further apneic episodes. The patient remained in the neonatal intensive care unit (NICU) until his discharge on November 21.

The patient’s discharge differential did not include respiratory syncytial virus (RSV), nor did it indicate that the care team had administered an initial dose of palivizumab injection (a medication used to moderate the effects of RSV). This was despite the fact that the patient had experienced some respiratory compromise in the NICU, it was the start of peak RSV season, and the patient had an older sibling who likely experienced community exposure to RSV.

The patient had his first well-baby examination on November 22. He weighed 4.13 lbs. and had a normal respiratory rate and normal breath sounds. Dr. D inquired whether the patient had received palivizumab while hospitalized, but the mother was unsure. Because he viewed the patient as an appropriate candidate for the medication, Dr. D ordered the hospital records, which he received on November 30. He then completed the necessary paperwork to secure the palivizumab, indicating that it was needed for administration at the patient's next appointment on December 9. The paper trail shows that the practice received the medication on December 8, but no evidence suggests that staff notified Dr. D of its arrival.

At the December 9 appointment, Dr. D found that the patient was thriving, including a normal respiratory rate and normal breath sounds. The documentation for the December 9 appointment does not indicate any discussion with the mother regarding the palivizumab, and the medication clearly was not administered despite being physically present within the practice. The appointment was completed, and the patient was scheduled for another appointment on December 23.

On December 22 (a day before the scheduled appointment), the patient's father brought the

infant to the practice because he seemed quite ill, and his symptoms had been steadily worsening since they first started on December 18. By December 22, the patient had a respiratory rate of 70, and his oxygen saturations were in the upper 80-percent range. He was lethargic, his nasal passages were obstructed with clear drainage, he had coarse breath sounds (including diffuse respiratory wheezes), and he was experiencing coughing sounds consistent with bronchiolitis. Lab results indicated that the patient was RSV positive. An albuterol nebulizer treatment was administered while an ambulance was summoned to transport the patient from the practice to a hospital.

At Hospital 2, the patient was diagnosed with severe bronchiolitis secondary to RSV exposure. He remained in the hospital's emergency department for less than 24 hours before he was transported to Hospital 3 (a large tertiary facility). There, numerous specialists intensively treated the patient, but he died on February 6 of Year 2. The patient's final diagnoses included infection resulting from *Pseudomonas species*, hypernatremia, pulmonary and systemic hypertension, and severe disseminated intravascular coagulation.

Following the infant's death, a medical malpractice lawsuit was commenced against Dr. D and the pediatric group practice (based on the

practice's vicarious liability for the actions of their employees, including Dr. D). The suit was settled early in the litigation process with payments in the high range. Because the case was resolved early in the litigation process, defense costs were in the low range.

## Discussion

When MedPro's Claims Department received this claim, it was sent to a board-certified expert in pediatric medicine for review. Unfortunately, this expert could not support Dr. D's care. The expert felt that Dr. D failed to meet the standard of care in the following ways:

- Although Dr. D completed the paperwork to get the palivizumab, he failed to document his plan to administer the medication in the patient's record — even though he obviously thought it was important for the patient to receive it.
- Dr. D failed to adequately review the patient's record prior to the December 9 appointment. If he had, he may have recollected the details surrounding the patient's birth and his conversation with the mother regarding the palivizumab.
- If Dr. D was notified of the presence of the medication at the practice after December 9 (which is not certain), he failed

to recall the patient prior to the December 23 appointment to administer it. It is noteworthy that palivizumab is contraindicated for administration after the appearance of RSV symptoms; however, the patient did not display symptoms until December 18. Thus, a 10-day period existed (December 8–17) when the medication could have been administered, which may have moderated the severity of the patient's subsequent RSV infection.

- Dr. D failed to advise the mother about his plan to administer the palivizumab. She could have served as a fail-safe to remind him about the plan.

Although corporate entities — such as the pediatric group — cannot practice medicine, they can be held accountable for human and systems errors that contribute to patient harm. In this case:

- The practice did not have a good process in place to track each medication order from the time it was requested until it arrived (including notification to the ordering provider).
- Lack of communication within the practice resulted in Dr. D not receiving notification of the medication's arrival.

- The practice's electronic health record (EHR) system did not have the capability to remind providers about planned events, such as future administration of medications (or the capability had been disabled).
- The practice failed to act on a fax that was received on December 8 confirming that the palivizumab had been delivered.
- The practice was unable to identify where the medication physically ended up in the facility after its delivery.

This combination of factors, combined with the catastrophic outcome, resulted in a settlement in the high range.

This case was exceptionally difficult for Dr. D for two reasons. First, he was profoundly saddened regarding the outcome. Second, Dr. D had no professional liability coverage for this claim. When Dr. D originally joined the pediatric group, his employment contract provided that the practice would pay his professional liability insurance premium as long as he was employed. Sometime after treating this patient,

Dr. D left the group and his professional liability insurance policy was terminated. Dr. D did not secure appropriate insurance coverage after leaving the practice and, as a result, he was unable to report this claim or secure coverage for the claim.

MedPro provided defense services and the indemnity payment on behalf of the pediatric group practice. Unfortunately, because Dr. D had no insurance coverage for this claim, he had to make the sizeable indemnity payment from his personal funds.\*

## Summary Suggestions

The following suggestions may be helpful for providers who treat patients in the office/clinic setting:

- When planning additional treatment for a patient, document the plan in the patient's health record. Doing so will serve as a helpful reminder and inform any other providers who also may treat the patient in the interim.

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\* An in-depth discussion of malpractice insurance policies is beyond the scope of this publication. However, healthcare professionals should take care to understand the different types of coverage and protections. MedPro insureds or practitioners seeking insurance may call 1-800-463-3776 to learn more about policy coverage and options. Healthcare providers also should consider having a personal attorney review the provisions of any employment contracts.

- Use available tracking and reminder features in the practice's EHR system to help remember planned future actions.
- Adequately review patients' health records prior to their appointments for pertinent information, whether seeing them for a new condition or as part of serial treatment.
- Inform patients and/or their caregivers of care plans as an additional fail-safe measure in case of an error or lapse in the continuity of care.
- Ensure that the practice has an adequate system in place for tracking the ordering and receipt of medications as well as providing timely notification to the ordering provider.

## Conclusion

Completely error-free practice of medicine unfortunately is not a realistic goal, but every healthcare practice should have a culture that strives for and emphasizes quality improvement. Doing so requires a firm commitment to the principles of continuous improvement, starting at the highest levels of leadership and filtering down through all levels of the organization. Although errors may still occur, they will serve as learning opportunities and help the organization deliver on the promise of high-quality care.

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