Communication Is Key

By Jeff Williams, JD

In the practice of pediatric medicine, physicians care for arguably the most innocent and vulnerable subset of our population, children. When a child suffers an adverse outcome while under the care of a physician and other caregivers, it has a profound effect on the family, the medical providers, and, often, the entire local community. This edition of Closed Claim Review is about a young child who was a healthy, vibrant toddler thought to be suffering from a common childhood ailment. The outcome, however, can be described as nothing less than tragic.

Jessie Givens[1] was an 18-month-old female, who presented with her grandmother to her usual pediatric group. She was seen on that day by Nurse Practitioner, Susan Owens. Jessie had vomited twice earlier in the day but had a normal appetite, normal fluid intake, and no fever. She was negative for abdominal pain, did not have a sore throat, and was voiding regularly. Some coughing had been noted for about a day but no gagging or difficulty swallowing. At that time, labs were drawn. Ms. Owens diagnosed Jessie with

acute gastroenteritis and sent her home.

The next day, during a follow-up call from the practice, Jessie's grandmother stated that Jessie did not have a fever and had experienced less gagging, was happy and playful, still voiding regularly, was drinking liquids, and was able to eat crackers and toast.

On day three, the pediatric group called to report that the labs previously taken were all normal. Later that evening, the grandmother called the after-hours line to report that Jessie had vomited again. She stated that after Jessie vomited, then started playing like nothing was wrong.

The next day (day four), the mother called the practice and reported that Jessie had vomited again. A prescription for Zantac was written at that time. As of day five, it was reported that Jessie had not vomited, and her diet was improving.

Two days passed, and the grandmother called the pediatric group expressing concern that Jessie's condition had taken a turn for the worse. At this point, Jessie had been ill for seven days. During this call, the grandmother stated that Jessie woke in the morning with stomach pain. She conveyed during the call that when she tries to eat, "food gets stuck in her throat and she tries to spit it out." She was instructed to take Jessie to the hospital.

It is noteworthy at this point, that throughout the course of treatment, different family members either presented with Jessie or made calls on her behalf to the pediatric practice. Similarly, differing staff members at the practice had taken calls from the family regarding these issues, which ultimately effected the consistency of communications.

Jessie and her mother presented to the local emergency department later that day. She was seen by Dr. Martha Whitaker. The history & physical noted that Jessie was spitting food out of her mouth but was occasionally drinking liquids. Jessie presented with a mild fever. She was examined, including her neck, throat, and abdomen. The emergency department's records from this encounter noted that Jessie had been vomiting intermittently for several days, but the report from her mother was that the vomiting at times was more like "spitting-up." There was no mention of choking or gagging, but Dr. Whitaker was told that Jessie was not tolerating solid foods.

Dr. Whitaker examined Jessie, noting that the child was not in distress, and her breathing was normal. She ordered another round of labs. During this encounter, Dr. Whitaker took the unusual step of calling the pediatric practice where Jessie was seen during the prior week. Her reason for making this call was to be certain that she knew Jessie's entire history. During her call to the practice, she was informed by a nurse of Jessie's general condition. The nurse, however, did not read the call slip where the practice was told by the grandmother that "food gets stuck in her throat, and she tries to spit it out." Jessie's mother also did not communicate this vital information to Dr. Whitaker or anyone else during this ED encounter. Based on the child's symptoms, Dr. Whitaker diagnosed Jessie with viral syndrome and GERD, prescribing acetaminophen for the fever. Instructions were given to watch the child closely for any continued vomiting, blood, or inability to keep down fluids.

Dr. Whitaker directed the family member to follow-up at the pediatric practice the next day and indicated that a consult by a gastroenterologist may be necessary. Jessie was then discharged home.

Early the next morning, Jessie was found unresponsive in her crib. She was rushed to the local emergency department, but it was too late. Jessie had passed away. An autopsy revealed that a coin was found lodged in Jessie's esophagus.

A lawsuit was filed by Jessie's parents alleging the wrongful death of their child. Dr. Whitaker and Susan Owens, N.P. were named as individual defendants in the suit. The pediatric practice and the hospital where Jessie was seen in the emergency department were named as defendants based on the theory of vicarious liability for the individually-named defendants. The primary allegations against each defendant were failure to properly assess and examine the patient, failure to obtain an adequate history from the family due to the child's inability to communicate, and failure to order an x-ray. Because this was a wrongful death claim, the applicable statute provided certain damages measured by the injuries to the decedent but also allowed for an award of damages for injuries to the beneficiaries as well. The amount of damages that a jury could potentially award in this case was a concern given the facts and the child's age.

The plaintiff's expert opined that the symptoms with which the child presented were typical of a history of foreign body in the esophagus, which an x-ray would have detected. Consequently, in the expert's opinion, Susan Owens, N.P. and Dr. Whitaker deviated from the standard of care by not ordering an x-ray.

The defense theme was that the child did not present with symptoms that would warrant an x-ray. Counsel for the defendants produced several experts to support this theme.

Was an x-ray warranted given the child's symptoms? An x-ray is an accepted means to detect the presence of a radiopaque object like a coin.[2] Coins are the most common object swallowed by children in the United States.[3] An estimated forty percent of foreign body ingestions in children are not witnessed, which was the case here.[4] But, Jessie's symptoms were relayed by differing family members, at different times and places, sometimes in person and sometimes over the phone. This information was received and charted by various healthcare providers at the pediatric practice's office and then at the hospital's emergency department.

A pediatric surgeon opined specifically pertaining to the disease process. This expert opined that the cause of death was due to mediastinitis caused by the coin, as opposed to death from a foreign body. This is an important distinction because this particular disease process was known to rapidly progress. The surgeon pointed out that the patient's white blood count while at the emergency department was normal, which indicated that the disease process had not yet started. This expert believed that what the family described to Susan Owens, N.P. was more in line with a description of a viral ailment and not a foreign body obstruction.

Another pediatrician was offered as a defense expert. This expert also was of the opinion that based on the symptoms conveyed by the family, there was nothing suggestive of the presence of a foreign body. Further, it would be irresponsible to x-ray every child that presented with the symptoms described by the family. Given the circumstances, the standard of care did not require an x-ray.

Yet another pediatric expert disputed the plaintiff's expert's conclusion that an x-ray was warranted. This expert performed a "blind review" without the benefit of knowing the outcome of the case and reported that a foreign body obstruction was never a consideration.

Applying hindsight, it may seem to some that a foreign body was evident. The medical experts retained by each side could not agree on whether the child's symptoms indicated the presence of a foreign body. A major issue in this case was that the number of people involved in the communication process proved to be a complicating factor.

What can be learned from this tragedy? As a reminder, some symptoms of a foreign body obstruction are refusing to eat, vomiting, gagging, choking, neck or throat pain, and drooling.[5] With very young children who are unable to effectively communicate, clear and consistent communication between a patient's healthcare team and the family is imperative to properly diagnose and treat a child's illness. If presented with a similar scenario, where multiple people have called multiple times on behalf of a patient, the provider should consider asking the caregiver to bring the patient back in to obtain an accurate clinical picture. This could potentially reconcile any prior inconsistent communications between the caregivers and the provider. Foreign body obstructions are extremely difficult to diagnose without clear information from the family or an obvious symptom. Past retrospective studies have indicated that most children with confirmed foreign body ingestions were asymptomatic.[6] Be certain all encounters are charted in the same place, so that these notes can easily be located for future reference during treatment. Lastly, do not hesitate to make follow-up inquiries by phone or otherwise with the child's parent or primary caregiver to be certain that a thorough history is obtained.

Given the nature of this case, all parties agreed to mediate the matter. Ultimately, it settled without the necessity of trial.

1 Names and identifying details have been changed for confidentiality.

2 Tintinalli, J. Swallowed Foreign Bodies. Tintinalli's Emergency Medicine – A Comprehensive Study Guide. 7th Ed. 2011; p. 552.

3 Uyemura, M.D., M., Foreign Body Ingestion in Children. American Family Physician. 2005, July 15, 72(2); 290.

4 *Id.* at 287.

5 Tintinalli, J. Swallowed Foreign Bodies. Tintinalli's Emergency Medicine – A Comprehensive Study Guide. 7th Ed. 2011; p. 552.

6 Id. at 287.