Child Dies Following Misdiagnosed Infection

$1 Million Settlement:
NEGLIGENCE IN DIAGNOSING FATAL INFECTION

Most American families look forward to the summer season as a time when they can share vacations, spend time together, and enjoy family outings. The M family anticipated the summer of 2001 with great excitement. Their children, ages two and four, were looking forward to trips to amusement parks and visits with grandparents. Unfortunately, that summer would bring an unexpected tragedy to the family – one that could have been prevented had proper medical care been rendered.

On July 2, four-year-old R.M. came down with a raging fever, said to be between 103 and 105.5 degrees. Her parents made an immediate call to their pediatrician's group and made an appointment for later that day. Upon arrival, R.M. was examined by a nurse practitioner, and her parents gave a thorough history of her fever and of noticeable red spots that had appeared on her arms. The nurse practitioner explained these away, suggesting that they could be a result of the Tylenol they had used in an attempt to lower the fever. Nevertheless, blood was drawn, and the next day the sample indicated a positive finding for Epstein Barr, the virus causative of mononucleosis. Earlier in the spring, R.M.'s brother, age two, had contracted mononucleosis, so the nurse practitioner and physicians assumed that R.M.'s fever was likely the result of having contracted the illness from her younger brother. A more tragic assumption could not have been made.

The medical staff failed to recognize a common, yet fatal, bacterial infection that warranted early treatment with antibiotics.

The following day, R.M.'s condition worsened. Her fever remained high and she began to develop labored breathing. Her parents placed another call to the pediatrician's office, reporting R.M.'s short and fast breaths and the development of a cough. Soon thereafter, R.M. and her parents returned to the office, and this time saw the pediatrician. Once again, the doctor believed that the child had mononucleosis and that there was really nothing to be done other than to monitor the fever and wait it out.

Over the next few days, R.M.'s condition failed to improve. Her parents placed multiple calls to the pediatric group, continually complaining about labored breathing and continued high fever. R.M.'s parents also called the pediatrician's home telephone number at least three times over those days. The parents began to perceive that the pediatrician's group was becoming annoyed with their frequent calls and, at one point, an unidentified worker at the pediatrician's group responded by saying, *"When your child's blue, call 911."*

At 7:30 a.m. the following morning, R.M.'s father drove her to the pediatrician's office without an appointment. They were seen by another pediatrician within the group, and R.M.'s fever at that point was 103.7. The physician recognized that R.M. had become dehydrated from her ongoing fever, and therefore recommended that R.M. be hospitalized immediately. Still, no attention was paid to R.M.'s respiratory status.

Upon R.M.'s arrival at the hospital, emergency room personnel immediately commented that, *"It looks like she has pneumonia."* A chest x-ray revealed that all of one lung and approximately half of the other lung were filled with infectious fluid. By late Sunday evening, R.M. was placed on a ventilator to help control her respirations. She then underwent an emergency surgery in an attempt to remove most of the pus-like material from her lungs. Nevertheless, her condition continued to deteriorate, and she was transferred on July 13 to Miami Children's Hospital for a last-resort procedure called an ECMO, or extracorporeal membrane oxygenation. Unfortunately, despite the heroic measures of those in Miami, R.M. passed away on July 18. Her cause of death was listed as pneumonia and related septicemia.

The M family retained attorney F. Gregory Barnhart to investigate the treatment rendered to their daughter by her pediatricians and nurse practitioners. A lawsuit was later filed against the group alleging that the examination and treatment of R.M. failed to recognize a common, yet fatal, bacterial infection that warranted early treatment with antibiotics. The family alleged that the pediatric group failed to take an adequate history and chart the examinations, failed to establish a differential diagnosis, failed to adequately dictate follow-up instructions to the parents, failed to take chest x-rays and blood cultures, and failed to administer antibiotics in the face of an ongoing infection.

In November 2003, after approximately one and a half years of litigation and just before trial, Mr. Barnhart settled this matter for $1 million. ■