Medical Delay By Doctors and Hospital Results In Child's Death

One Sunday night, Suzy, age 6, was suffering from fever, nausea, diarrhea, and vomiting. Early the next morning, Suzy's mother called the doctor's office and was told to bring Suzy in right away. A relatively benign physical exam resulted in the diagnosis of gastroenteritis and dehydration. Doctor A told Suzy's parents to take her home and to call if she vomited again. Unfortunately, the doctor did not review Suzy's blood pressure, which had been taken just before Suzy and her mother left the office. Suzy's blood pressure was low and she was suffering from profound dehydration.

Within three hours of returning home, Suzy vomited again. Suzy's parents called Doctor A and he faxed orders to the hospital, including laboratory tests and twenty-three hour direct admission for observation and hydration.

At the hospital, Suzy's condition critically deteriorated, and she went into shock. The nurse's admission assessment revealed that Suzy had a fever, low blood pressure, lethargy, weakness, and a rapid heart rate and respiration.

Despite Suzy's ominous condition, Doctor A was not called. The hospital nurse testified that Suzy's symptoms were not indicative of shock, but rather were consistent with the presenting diagnosis of gastroenteritis and dehydration. Doctor A later testified that, had he been called, he would have ordered a critical care consultation, aggressively administered fluids, ordered immediate laboratory studies, and changed Suzy's diagnosis to rule out septic shock.

The day that Suzy was admitted to hospital, Doctor A left the office early and never followed up with the hospital staff. He signed the case over to his partner Doctor B, giving only minimal information about the admission. Despite the need for emergent critical care, Suzy received only basic treatment. No new orders were given, despite the fact that Suzy remained in shock and had no output of urine. The night nurse took over and continued the same course of treatment.

Throughout the night and morning hours, the night nurse observed and documented Suzy's condition as it worsened. Suzy's blood pressure continued to drop. Her lack of urine production continued. Her heart rate and breathing quickened, and Suzy began to exhibit generalized swelling. Despite overwhelming evidence that Suzy was in trouble, the night nurse believed Suzy was mildly dehydrated and had the stomach flu.

No communication took place between the hospital staff and the doctor until late in the evening. Unfortunately, when the nurse and Doctor B did finally communicate, in two separate conversations, the nurse never voiced any concerns or suggested that Suzy be more closely examined. In addition, Doctor B failed to grasp from the nurse even a rudimentary understanding of the seriousness Suzy's condition.

The following morning, when Doctor B arrived on rounds, she found that Suzy was much sicker than she expected. Doctor B ordered Suzy to be transferred to another hospital with a pediatric intensive care unit.

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Decisions, Decisions...

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She increased fluid administration, antibiotics, and ordered consultations with a cardiologist and a pediatric intensive care doctor. Unfortunately, none of Doctor B's orders were carried out in timely fashion. Eight hours passed before Suzy was transferred. She did not receive fluids or antibiotics for hours. No pediatric intensive care doctor ever saw Suzy, and a cardiac consultation did not occur until one hour before her transfer. Once at the pediatric intensive care hospital, despite heroic lifesaving attempts by the staff, Suzy died 19 hours after her transfer.

Attorney Cal Warriner resolved this case against the two pediatricians and the first hospital for a confidential sum. The family is hopeful that by exposing the nature of Suzy's illness, and the failures on the part of the doctors and the hospital, no other family will have to suffer the same heartbreak and misery. ■