Chain of Medical Mistakes Causes Tragic and Preventable Death from Chicken Pox

John Doe was 45 years old when he died of varicella (chicken pox) and adrenal insufficiency at a health care facility in south Florida on October 8, 1998. His death was preventable with basic treatment, which he did not receive due to the tragedy of medical errors and undisputed incompetence on the part of several health care providers that were responsible for treating him. As part of the settlement that was eventually reached in this case, the identities of the parties remain confidential.

Chicken pox is normally a benign illness. In adults, it is a more serious disease, but rarely fatal. If the adult has a compromised immune system, the mortality rate of chicken pox increases if basic, proper treatment is not given, as the chicken pox can invade internal organs (visceral varicella). Mr. Doe had a long history of asthma and had been taking Prednisone pills for that condition for years. Patients on long-term Prednisone therapy become reliant on the drug. Stopping Prednisone treatment without steroid replacement can leave the patient at risk for cardiovascular collapse. Long-term Prednisone therapy also causes immunosuppression, leaving the patient vulnerable to infection and other physical stress. Mr. Doe's long-term treatment with Prednisone made him reliant on the drug, and also made him a prime target for visceral varicella.

In September 1998, Mr. Doe, who had never had the chicken pox, was exposed to the disease in his home. Chicken pox has a two-week incubation period between exposure and formation of the pox on the skin. On October 4, Mr. Doe began feeling poorly. The next morning, October 5, he had severe abdominal pain and sought treatment. The health care provider noted Mr. Doe was "taking lots of Prednisone", and sent Mr. Doe to a local health care facility. Although the initial health care provider had three separate telephone conversations with Mr. Doe's other health care providers, he never told anyone that Mr. Doe had been taking Prednisone for years, and taking a lot of it lately. Had he done so, that information would have dramatically altered Mr. Doe's treatment and Mr. Doe would not have died.

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When Mr. Doe arrived at the health care facility, he had a fever, nausea, abdominal pain so severe that it required narcotics, and an abdominal rash - classic signs and symptoms of an infection. At initial admission, Mr. Doe stated that he had a history of asthma and was currently taking Prednisone. Testimony revealed that no one had taken a competent history from Mr. Doe, and that a proper history would have resulted in a completely different treatment. Another health care provider also admitted that he departed from acceptable standards of care by failing to take a history of the abdominal rash, and that if he had done so, the exposure to chicken pox would have been noted and would have resulted in an infectious disease consultation that day. An infectious disease physician is competent to diagnose and manage a patient with chicken pox and chronic Prednisone use, but one was not consulted.

Later that evening, Mr. Doe was admitted to the health care facility for further evaluation and treatment. By this time, Mr. Doe had been in the health care facility for eight hours, taking narcotics for pain, but there was still no diagnosis. Mr. Doe was admitted by a health care provider that had never met him or visited him at the facility. Thus, Mr. Doe's health care providers squandered a fourth chance to evaluate his fever, nausea, extensive Prednisone use, abdominal pain, abdominal rash, and exposure to chicken pox and consult an infectious disease physician.

The health care provided by others was also substandard. While initially it was noted that Mr. Doe said he was currently using Prednisone, no health care provider asked how much he was taking and how long he had been taking it. No health care provider assessed Mr. Doe's abdominal rash for nearly 24 hours after he appeared at the facility. The substandard care continued after admission to the facility, when another health care

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IMPROPER DIAGNOSIS CAUSES TRAGIC DEATH

provider failed to complete a simple form that actually included questions that would have led to a proper, competent history of Mr. Doe's Prednisone use and exposure to chicken pox. Incredibly, no health care provider even took Mr. Doe's temperature from the time he arrived at 10:52 a.m. on October 5, until 7:15 a.m. on October 6. Such an omission is unimaginable in the care of a patient with signs and symptoms of an infection.

On the morning of October 6, Mr. Doe's rash exploded, spreading from his abdomen to his back, face, neck, arms and legs in less than three hours. Yet it was hours later before any health care provider contacted anyone about it, and that occurred only after Mr. Doe's wife actually made the diagnosis of chicken pox herself. That morning, yet another health care provider came to perform an admission history and physical examination of Mr. Doe, but failed to take a history of Mr. Doe's Prednisone use. While this health care provider admitted that he was not competent to diagnose or treat the chicken pox, he wrote in the chart that he doubted Mr. Doe had the disease.

After another eight hours passed, Mr. Doe was visited for the purpose of evaluating the rash that had spread over his body. This health care provider, admittedly not competent to treat the chicken pox, proved that incompetence by ordering the wrong treatment. That health care provider later testified that visceral involvement of the chicken pox was suspected and that it was serious, but that no one was informed because the provider "didn't have a duty to do so".

The next morning, October 7, yet another health care provider came to evaluate Mr. Doe, and saw that no one had conducted the laboratory tests that had been ordered the day before. This health care provider was also not competent to diagnose or treat the chicken pox. Nevertheless, this person, who had the last chance to obtain the proper infectious disease consultation and save Mr. Doe's life, ignored the diagnosis of chicken pox, the Prednisone use, and the improper treatment. Instead, he prescribed nothing but a "regular diet" and promised to see Mr. Doe the next day. But the next day, October 8, Mr. Doe died in front of his wife.

It is often said that the medical history is 90% of the diagnosis. Throughout the final four days of Mr. Doe's life, each and every one of the health care providers responsible for his care was presented with the information necessary to diagnose disseminated, visceral varicella infection and steroid dependence, and thus prescribe the proper treatment that would have saved his life. The information needed to make the diagnosis was either in the chart or readily available, if only one of the health care providers had taken a basic, competent history from Mr. Doe. The information was either ignored or overlooked.

It was undisputed that not one health care provider involved in Mr. Doe's care was competent to treat the chicken pox. Consequently, not one health care provider involved in Mr. Doe's care provided the basic, proper treatment for chicken pox and steroid dependence. That basic treatment would have saved Mr. Doe's life, but he never received it.

Mr. Doe is survived by his wife and two children. At the time of Mr. Doe's death, his daughter was 15 years old and his son, nine years old. Mr. Doe was the glue, the mainstay of his family. His sudden, unexpected and preventable death left his wife and children heartbroken and lost, and in severe psychiatric distress. All have been under medication and psychiatric care for depression.

The family filed a wrongful death case against the health care facility and the several health care providers involved in Mr. Doe's care. Attorneys Lance J. Block and James W. Gustafson, Jr., represented the estate of Mr. Doe, his wife, and their two children. In September 2005, a settlement was reached in the amount of $4,251,000. ■