Risk management opportunities for Pediatrics/Neonatology

1. Understand high-risk presentations (meningitis, kernicterus/hyperbilirubinemia, appendicitis) and conditions missed during routine health checks that may initially appear relatively benign. Be able to identify which patients present with a higher risk of catastrophic outcome (eg, Sub-Saharan African, Middle Eastern, Arabian or Southeast Asian ancestry at higher risk for bilirubin encephalopathy, per AAP guidelines.)

2. Provide parents with clear oral and written instructions on the signs and symptoms of high-risk conditions and what to do should they appear. Train office personnel on the symptoms of high-risk conditions and protocol for escalating calls to clinical personnel for urgent response. Staff members taking phone calls from parents should document presence and/or absence of key symptoms.

3. Medication errors: Children are at a threefold risk of harm due to medication errors, often because medication dosing is weight-based.[1] Be vigilant about protocols for taking, recording and reviewing patients' weights and standardize the units in which weight is recorded (pounds vs. kilograms).

4. Recognize early signs of child abuse and neglect and use clinical decision support tools such as TEN-4-FACESp and LCAST.

5. Appreciate the value of parental concerns. Be aware of anchoring bias in your diagnostic process and consider alternative causes, particularly if parents report ongoing concerns. Thoroughly document the absence of signs that would lead you to a more serious diagnosis.

[1] Mueller BU, et al: AAP Council on Quality Improvement and Patient Safety, Committee on Hospital Care: Principles of Pediatric Patient Safety: Reducing Harm Due to Medical Care. *Pediatrics*, 2019, 143(2)e20183649.

Pediatrics/Neonatology Case Study

An infant girl was born via vaginal delivery with no complications to first-time parents and was subsequently treated by her pediatrician at appropriate intervals for her first three years of life. Regular hip exam findings were conducted and documented, including "full hip abduction with no click." The girl's parents raised concerns at several points about the child's crawl and gait and were reassured. Due to a family move, the child established care with a new pediatrician shortly after seeing her regular pediatrician for an annual exam. The chief complaint was noted as "Problem with walking, started when she started walking." The notes reflected the mother's report that the child walked with her left leg turned outward. The new pediatrician performed a physical exam and noted a visual leg length discrepancy of about 2-3 cm. The child was referred for bilateral X-rays of the hips and knees and was diagnosed with congenital hip dysplasia, a condition which is often successfully corrected via non-invasive treatment when diagnosed in infancy. The child subsequently underwent several corrective surgeries; her parents filed suit against the original pediatrician alleging negligent failure to diagnose and treat developmental hip dysplasia resulting in the need for corrective surgeries and a pronounced limp. Although the original treating pediatrician had conducted hip exams, documentation did not include details of physical exams such as whether there is shortening of the thigh on either side, asymmetry of gluteal and thigh folds, or presence or absence of toe-walking, waddling, or limping. Nor did the notes address presence or absence of risk factors for developmental dysplasia of the hip (DDH), including that the patient is female and that she was the first pregnancy for her mother. (Other risk factors may include breech presentation, family history of DDH, and any condition that leads to a tighter intrauterine space, such as large birth weight.) Although it is not necessarily below the standard of care to miss this diagnosis, the fact that the parents had raised concerns on multiple occasions and that the subsequent treating physician identified a potential problem immediately presented challenges for the defense. **The suit was settled for $200K.**