Medical Consultant Report and Summary

Case No: MD [redacted] **Physician:** [redacted] **MD**

Date: [redacted] **Medical Consultant:** [redacted] **MD**

1. **Detailed (Chronological) Analysis:** On 12/12/2007, [redacted] presented to Dr. [redacted] for a 2 year well check. At the time, the mother had the complaint of "Coughs when he runs, always". There is no mention at any previous visit of a chronic cough. Dr. [redacted] performed the usual components of a 2 year well check and also a brief evaluation of the chronic cough. He placed a PPD, ordered a CBC with differential and a chest x-ray, and asked that the patient follow-up for a re-check in 1 week. The patient went to radiology to have the chest x-ray performed but did not go to the laboratory. He returned two days later to have the PPD read. There is no notation of whether his mother asked about the chest x-ray at the time. The chest x-ray results were received by Dr [redacted] s office and one attempt was made by a nurse to contact the patient. Apparently there was no answer and no option to leave a message. At the time, there was only one telephone number available in the chart for the nurse to try. The report was then mistakenly filed instead of being held to make another attempt to reach the family and the result was not brought to Dr [redacted] s attention. The patient appears never to have made an appointment for the 1 week follow-up as requested by Dr [redacted]

   The patient's mother called Dr. [redacted]'s office on 1/10/2008 (nearly 1 month later) at 5:10pm asking about the results of the chest x-ray. An appointment was made with Dr. [redacted] for the following morning to discuss results, re-check the child, and initiate treatment. The patient did not keep this appointment and also missed an appointment re-scheduled for later in the day. On 1/12/2008 the patient kept an appointment with another doctor at Dr. [redacted] s clinic, at which time antibiotics and albuterol were prescribed. At this visit, it was noted that the cough had worsened, though there were no signs of severe respiratory disease on examination. There is no notation on this clinic note as to whether follow-up was recommended. No further information is available as to the patient's response to treatment as he was not seen at Dr. [redacted] s clinic again.

2. **Proposed Standard(s) of Care:** The standard of care in this case is to make a reasonable attempt to contact a patient after obtaining a radiological study and receiving the results, then to initiate appropriate treatment and/or further workup.

3. **Deviation from the Standard of Care:** There is a minor deviation from the standard of care in this case because only one attempt was made to contact the family and then the report was filed without being brought to the attention of the physician who ordered the test.

4. **Actual Harm Identified:** It is unlikely that there was any real harm in this case. The chest x-ray was not very informative and, in the reviewer's opinion, the significance of the "finding" is suspect. In fact, the radiologist's reading states that the film was most consistent with bronchiolitis, which usually does not require treatment. So, antibiotic treatment was likely not necessary and the delay in reporting results to the family probably had little impact. The biggest impact came from the lack of a follow-up appointment, which was never made by the family.

5. **Potential Harm Identified:** If the finding on the chest x-ray had actually been an early acute pneumonia as was listed as an unlikely but possible interpretation, then the patient could have suffered progressive symptoms of worsening pneumonia, which can be very serious. However, the most logical course of treatment after seeing the x-ray would not have involved antibiotics for this child anyway, and the follow-up exam 1 week later (or prn worsening symptoms) would have been much more important than the chest x-ray in the first place.

6. **Aggravating Factor(s):** The medical records kept by Dr. [redacted]'s office are inadequate. There is very little information in the clinic notes. The format of the notes leaves little room, if any, for family history, past medical history, or even a thorough history of present illness. As a result, it appears that all clinicians who have seen this child include very little detail in their histories and in their assessments and plans. Dr. [redacted]'s handwriting is also very difficult to read. Dr. [redacted] states that he remembers reviewing family and past history at the visit in question; however there is no notation to that effect and there is almost no detail in the history of present illness. Also, Dr. [redacted]'s notes have almost no detail in the area of the physical examination. Instead, there is a line through the "Normal" column for everything. There is no listing of pertinent negatives (this applies to all of the visits, not just the one in question). Though it appears that Dr. [redacted]'s assessment, plan, and course of treatment were appropriate, it leaves many potential questions unanswered when reviewing this case.

7. **Mitigating Factor(s):** This is a very difficult case for Dr. [redacted] as it is clear from the medical records that this is a chronically non-compliant family that misses appointments frequently. For example, there are several notations throughout the chart that the mother was told to stop giving the child the bottle, but he still was using a bottle on the last visit. The child did not present for the 2 month or 4 month visits, receiving the first set of vaccines at 6 months of age. Many other visits were missed or cancelled. Dr. [redacted]'s office sent this family 2 letters regarding the no-shows instead of simply asking them to find a new pediatrician as many other pediatricians might have done after such a large number. In this respect, he should be applauded for his patience with this difficult family.

   The non-compliance of this family was a definite factor in the results of this particular illness as well. The family did not follow-up as requested and did not go to the laboratory for the blood test that Dr. [redacted] had ordered. If they had done either of these things, or simply called a few days after the x-ray when they hadn't heard anything and the child was supposedly worsening, then the results would have come to Dr. [redacted]'s attention and the child would have received treatment in a timely manner.

8. **Consultant's Summary:** The reviewer feels that there was a minor deviation from the standard of care on the part of Dr. [redacted] and his office. However the mitigating factors listed above outweigh the deviation from the standard of care. Dr. [redacted]'s office appears to be well-organized when it comes to dealing with telephone calls and reports in general and what happened in this case appears to have been an anomaly. His office has, in fact, improved its system of dealing with reports since this case.

   It is true that more than one attempt should have been made to reach this family with the results of the chest x-ray, but there does not appear to have been any real harm done by this and that the bigger problem was the fact that the patient did not follow up as requested.

Also, it is the recommendation of the reviewer that Dr. [redacted] and his colleagues improve their documentation in order to be more clear of their thought processes in the future.

9. <u>Records Reviewed:</u>

Complete medical records from Dr. [redacted] s office 9/15/2005 through 1/12/2008
Radiology report dictated 12/13/2007
Viewed x-rays taken on 12/12/2007

_____ _____
Print Name Date

_____
Signature