## **Medical Consultant Report and Summary**

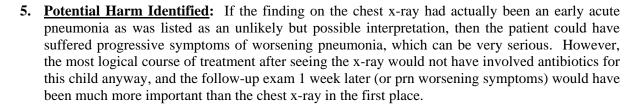
Case N	No: MD	Physician:	MD		
Date:		Medical Consultant:	MD		
1.	Detailed (Chronological) Analysis: On 12/12/2007, a 2 year well check. At the time, the mother had the complaint of "Coughs when he runs always". There is no mention at any previous visit of a chronic cough. Dr. performed the usual components 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. so 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. so attention. The patient appears never to have made an appointment for the 1 week follow-up as requested by Dr.				
	asking about the results of the following morning to discuss the keep this appointment and a 1/12/2008 the patient kept an antibiotics and albuterol were though there were no signs on this clinic note as to whether	br. 's office on 1/10/2008 (not chest x-ray. An appointment we results, re-check the child, and initial also missed an appointment re-scholar appointment with another doctor at a prescribed. At this visit, it was not of severe respiratory disease on exper follow-up was recommended. No treatment as he was not seen at D	for the state treatment. The patient did no seduled for later in the day. Or to Dr. s clinic, at which time ed that the cough had worsened camination. There is no notation to further information is available.		
2.		Care: The standard of care in this of the care in the care obtaining a radiological study and/or further workup.			

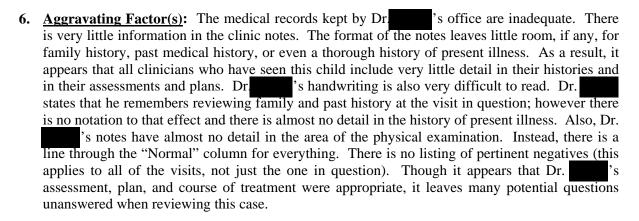
3. Deviation from the Standard of Care: There is a minor deviation from the standard of care in

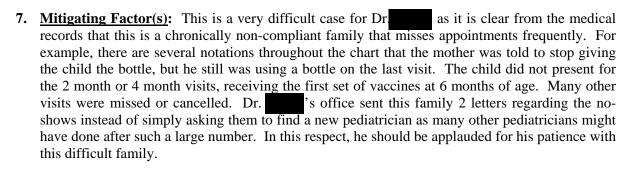
without being brought to the attention of the physician who ordered the test.

this case because only one attempt was made to contact the family and then the report was filed

**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.







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. 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. '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. and his office. However the mitigating factors listed above outweigh the deviation from the standard of care. Dr. '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.

Case	No.
Date	

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	Also, it is the recommendation of the reviewer that Dr. and his colleagues improve their documentation in order to be more clear of their thought processes in the future.				
9.	Records Reviewed:				
	Complete medical records from Dr. Radiology report dictated 12/13/2007 Viewed x-rays taken on 12/12/2007	s office 9/15/2005 th	nrough 1/12/2008		
Print Name		Date			
Signat	ture				