# Medical Consultant Report and Summary

**Case No:** MD-09-[redacted] **Physician:** [redacted] M.D.
**Date:** July 1, 2009 **Medical Consultant:** [redacted] M.D.

## 1. Detailed (Chronological) Analysis:

11/06/08
Patient [redacted] is a 37y/o female with a past history of neck pain who presented to the [redacted] Emergency Department at 0236 for evaluation and treatment of posterior neck pain that radiates to the right shoulder for the past three months. She describes being under chiropractic care and possibly medical care for this neck pain. She has taken ibuprofen without resolution.

Emergency department documentation demonstrates that Ms. [redacted] was evaluated by Dr. [redacted] at 0242.

Dr. [redacted] documentation demonstrates no evidence that the patient was experiencing an acute neurological emergency. While Dr. [redacted] emergency department documentation is limited, he clarifies, in a response letter to the Arizona Medical Board, that he routinely performs a comprehensive review of systems and physical exam for a patient complaining of neck pain. It is reasonable to assume that he did so in this case and would have documented and addressed any abnormal review of systems or physical exam findings that were present at the time of Ms. [redacted] initial emergency room visit. This is an assumption, yet this form of documentation is commonly practiced as many physicians document only pertinent positive physical findings. Nevertheless, a complete and detailed neurological review of systems and physical exam is not documented.

No pain management was provided in the emergency room and the patient describes her pain as having improved from a 10/10 to a 7/10.

Emergency department documentation demonstrates that Dr. [redacted] wrote a discharge order for Ms [redacted] at 0302. Her diagnosis at the time of discharge was cervical strain with radiculopathy.

While the emergency physician chart documents that the patient received Percocet at the time of discharge, the patient was provided discharge prescriptions for Flexeril and Penicillin VK. Ms. [redacted] was also provided instructions to take Tylenol or Motrin as needed.

Discharge instructions provided by Dr [redacted] instruct the patient to return promptly if her pain worsens or spreads into her arms or she experiences weakness or numbness. The patient was also instructed to follow up with her doctor in 1-2 days for a checkup and a copy of the medical transcription was requested by Dr. [redacted] to be provided to [redacted] D.O.

11/13/08
Ms. [redacted] presented to the [redacted] Emergency Department with persistent neck pain that radiated down her right arm. She complained of paresthesias in her right hand. No documented focal neurological deficit was discovered by physical examination.

MRI of the c-spine w/o contrast performed at [redacted] demonstrated disc protrusions at C4-C5 and C6-C7.

12/10/08
EMG performed by [redacted] D.O. demonstrated a mild right median neuropathy about the wrist with no electrical evidence of radiculopathy.

12/17/08
Ms. [redacted] was evaluated by Dr. [redacted] M.D. at the [redacted] Institute with recommendations for selective nerve root injections.

1/26/09
Ms [redacted] returned to the [redacted] Emergency Department complaining of neck pain, increased numbness and tingling. Physical examination demonstrated decreased sensory over the volar aspect of the right upper extremity as well as over the dorsal aspect of the right thumb. The patient was admitted and subsequently underwent operative management by Dr. [redacted] on 1/27/09.

## 2. Proposed Standard(s) of Care:

The standard of care of a 37y/o female with a past medical history of chronic neck pain who presents to the emergency department complaining of posterior neck pain that radiates to the right shoulder, worsening over the past three months includes: a comprehensive history and physical examination with a focused musculoskeletal, vascular and neurological exam to determine if any emergent process is present.

Without any bony tenderness to palpitation of the spine or objective evidence of vascular or neurological compromise, emergent diagnostics, such as a radiograph or MRI, are not required.

Analgesia should be provided to assist in treatment.

Instructions for urgent follow up should be provided as well as precautions to return to the emergency department immediately if symptoms worsen or progress.

## 3. Deviation from the Standard of Care:

I do not appreciate a deviation from the proposed standard of care.

## 4. Actual Harm Identified:

I do not identify any actual harm to the patient.

## 5. Potential Harm Identified:

N/A

## 6. Aggravating Factor(s):

N/A

## 7. Mitigating Factor(s):

N/A

**8. Consultant's Summary:**

In my professional opinion, the care of Ms. [redacted] provided by Dr. [redacted] on 11/06/08 did meet the standard of care. I do not believe Dr [redacted] failed to diagnose and treat Ms. [redacted] based upon my review of the medical records provided by the Arizona Medical Board. There is no documentation to support any focal neurological deficit that Ms. [redacted] was experiencing at the time of her initial emergency department visit on 11/06/08 that would have required further investigation with an MRI. Follow up and medical therapy was provided at the time of discharge.

I am concerned that the emergency department documentation by Dr. [redacted] was quite poor. There are a number of inaccuracies including an allergy to morphine, which the patient does not appear to have, evaluation of the patient's tonsils with a history of a prior T&A, and final assessment of abdominal pain, which the patient clearly didn't have. An inappropriate medical prescription was provided and the appropriate analgesic was not.

I recommend that Dr. [redacted] include in his future documentation a complete representation of the review of systems and physical examination performed during his evaluation and not continue his current practice of only including pertinent positives.

**9. Records Reviewed:**

Complaint
Initial notice letter
Licensee response
[redacted] Hospital records
[redacted] treating physician records
[redacted] Hospital records

[redacted] M.D. July 1, 2009

Print Name Date

Signature