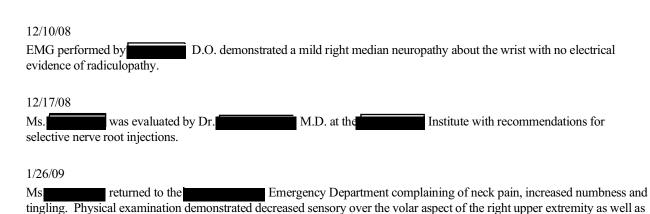
# **Medical Consultant Report and Summary**

Case No:	MD-09-	Physician:	M.D.
Date:	$July 1, \overline{2009}$	Medical Consultant:	M.D.
1. Det	ailed (Chronological) An	alveie•	
1. <u>Det</u>	ancu (Cin onological) And	<u>arysis</u> .	
shoulder for the	Emergency Department at 0236	female with a past history of neck pain who present for evaluation and treatment of posterior neck pain ribes being under chiropractic care and possibly me	that radiates to the right
Sile ilds taken	ioaproteir without resolution.		
Emergency de	partment documentation demo	onstrates that Ms. was evaluated by Dr.	at 0242.
While Dr. Board, that he pain. It is reas of systems or an assumption	emergency department do routinely performs a comprehe conable to assume that he did so physical exam findings that we a, yet this form of documentation	evidence that the patient was experiencing an acute ocumentation is limited, he clarifies, in a response le ensive review of systems and physical exam for a proposition in this case and would have documented and address present at the time of Ms. initial en on is commonly practiced as many physicians documented and detailed neurological review of systems and physical proposition.	etter to the Arizona Medical atient complaining of neck essed any abnormal review energency room visit. This is ment only pertinent positive
No pain mana 10/10 to a 7/10		nergency room and the patient describes her pain as	having improved from a
		onstrates that Dr. wrote a discharge order for ervical strain with radiculopathy.	at 0302.
provided disch	ergency physician chart documenarge prescriptions for Flexeril otrin as needed.	ents that the patient received Percocet at the time of and Penicillin VK. Ms. was also provide	
arms or she ex		instruct the patient to return promptly if her pain vess. The patient was also instructed to follow up with ption was requested by Dr. to be provided to	ith her doctor in 1-2 days for
11/13/08			
Ms.		Emergency Department with persistent neck pather right hand. No documented focal neurological	
MRI of the c-s	spine w/o contrast performed at	demonstrated disc protrusions at 0	C4-C5 and C6-C7.



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

on 1/27/09.

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.

over the dorsal aspect of the right thumb. The patient was admitted and subsequently underwent operative management by

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):

## 8. Consultant's Summary:

care. I do not believe Dragona failed to diagn records provided by the Arizona Medical Board deficit that Ms. was experiencing at	provided by Dr. on 11/06/08 did meet the standard lose and treat Ms. based upon my review of the medical. There is no documentation to support any focal neurological the time of her initial emergency department visit on 11/06/08 that MRI. Follow up and medical therapy was provided at the time	al ıt
inaccuracies including an allergy to morphine, w	documentation by Dr. was quite poor. There are a number which the patient does not appear to have, evaluation of the patient assessment of abdominal pain, which the patient clearly didn't havided and the appropriate analgesic was not.	's
	re documentation a complete representation of the review of syste evaluation and not continue his current practice of only including	ms
9. Records Reviewed:		
Complaint Initial notice letter Licensee response Hospital records treating physician records Hospital records		
M.D.	July 1, 2009	
Print Name	Date	
Signature		