CONNECTING THE DOTS # 1

Connecting The Dots is an E-Newsletter regarding Chiropractic Malpractice cases. Periodically, I review a malpractice case involving a chiropractic physician and patient. After discussing the allegations made and the facts of the case, I will offer my opinions as to what lessons can be learned from each case. It is my intention that chiropractic physicians will learn how to reduce their risk of malpractice liability and improve the quality of their services. I also hope that the legal community will gain some insight into the nuts and bolts of a chiropractic experts perceptions of these cases.

GEORGE HURTS HIS LOW BACK*

*Actual names of individuals have been changed to protect the privacy of all parties. Otherwise, the following comes directly from the medical and legal records.

George a 44-year-old male injures his low back when he loses footing and falls backward to the ground landing on his backside.

FIRST STEP THE FAMILY DOCTOR

As a result, he experiences low back pain. George visits his family medical physician that same day with symptoms of low back pain. The family medical physician does not perform any kind of orthopedic and or neurological examination. The medical physician has x-rays of the lumbar spine done. The films reveal no fractures and age appropriate degenerative changes. George is diagnosed by his family physician with a lumbar sprain/strain. He is prescribed a course of Ibuprofen and told to perform exercises at home that are described on a handout he received from his physician.

Returning to his family physician one week later George is still in pain in his low back and cannot perform all of his work duties due to the pain. His family physician again prescribed medications for pain and inflammation.

GEORGE GOES TO A CHIROPRACTOR

3 weeks later seeing no improvement after taking medications and doing exercise, George presents to a doctor of chiropractic. The DC performs an intake consultation consisting of a demographic form, medical history form, and current symptoms form. George provided a history of no prior low back pain before his fall 3 weeks previous. He also disclosed that he was regularly active and had no loss of function due to pain prior to the fall. George described his symptoms as low back pain that was constant 6/10 and radiating pain into both legs, and on the right extending all the way to his foot along with numbness of his foot and lower leg. When completing the medical history form, George left questions regarding prior treatment for his 3 weeks of low back pain blank and did not inform the DC that he had been medically examined, and had x-rays followed by being treated medically.

THE DC EXAM

During the physical examination, the DC performed an exam that included range of motion (ROM) of the lumbar spine, orthopedic testing of the lumbar spine (SLR +, bilateral, Braggard +, bilateral, Kemps + bilateral, Lewins +, Soto Hall +, Fabere Patrick negative, and Lindner +. A Valsalva

maneuver produced pain increase into the right lower limb). With the exception of VAS rated 6/10 pain on ROM testing and loss of lumbar ROM due to muscle guarding the rest of the orthopedic examination was negative. The DC diagnosed vertebral subluxation complex (VSC) at L4/5 and L5/S1.

It bears noting that there was NO NEUROLOGICAL EXAM. No DTR, no sensory and no motor exam.

At this point it is important to consider that despite the incidence of trauma (fall injury) the DC did not provide and or order any **lumbar spine imaging.**

THE TREATMENT PLAN

The DC recommended a treatment plan of the lumbar spine of chiropractic manipulation (CMT) at L5 using a side posture technique, with post CMT lumbar mechanical traction. The DC told George to return the following day for his next chiropractic visit and treatment. The DC also told George to refrain from any weightlifting exercise until further notice and to avoid any lifting more than 5 pounds or any repeated lifting or forward bending at all.

It is particularly important to note that the DC did not provide George with an **INFORMED CONSENT FORM** to review and sign. Rather there were some albeit brief and cryptic notes in the file about "talked about consent" in the first day's record.

SOME EARLY PROGRESS

On his second visit George reported a decrease in low back pain, but an increase numbness and tingling into his right leg. The DC, on the basis of the increased numbness and tingling, took a two-view lumbar spine x-ray study. The lumbar x-rays revealed that there was no sign of acute fracture, age consistent loss of lumbar disc heights and some degenerative changes in facet joints particularly at L5/S1. The greatest degree of facet degeneration was at the right L5/S1 facet. Joint. The DC informed George that the L5/S1 degenerative changes could be the related to a disc pathology not able to be seen on X-ray, and was likely part of the reasons there was numbness and tingling in the right leg.

George returned to the DC three days later for his next visit. He reported a decrease in the low back pain, and an absence of any leg pain or numbness and tingling. George told the DC that he was having some difficulties with his weight lifting routines due to the back pain. The DC reminded George that he had previously advised him not to weightlift and to keep his exercise routine to non-weight bearing activities. The DC recommended a treatment plan over the next two weeks of three visits per week to which George agreed.

George kept his next three visits and reported successively minor slight improvements assuring the DC that he was following his home care instructions. After completing the two weeks of recommended treatment, the DC again examined George. During the re-examination, George reported mild low back pain and no leg pain and no numbness or tingling in the leg. The exam findings revealed only slight loss of ROM in the lumbar spine, with no muscle guarding, and no abnormal orthopedic findings. The DC discharged George with a diagnosis of "resolving lumbar sprain/strain". Discharge instructions included a caveat to avoid any weight lifting exercises until he was completely pain free at least one week and had no loss of motion in the lumbar spine. The

DC also advised George that he should return if there were any increased pain, loss of motion or other symptoms such leg pain, numbness or tingling.

DIFFERENCES IN PERSPECTIVE?

Four weeks later George returned to his Primary Care Physician and described symptoms of ongoing low back pain with leg pain and numbness and tingling, all in the right leg. George told his PCP that the he had been seeing a chiropractor, but that it had been of no benefit to him. The PCP referred George to a neurosurgeon. George told the neurosurgeon, that the pain in his leg as well as the numbness and tingling in his leg had started while he was being treated by the chiropractor, and that during the treatment, these symptoms got progressively worse.

SURGICAL TREATMENT

An MRI of the lumbar spine revealed that George had a moderate L5/S1 disc herniation effacing the thecal sac and impinging the right S1 nerve root. The neurosurgeon prescribed 6 weeks of PT which was modified and limited by the insurance company to two weeks. After no improvement with PT, the neurosurgeon prescribed a lumbar epidural steroid injection. 4weeks after the epidural injection, George reported no change in his condition. George was next scheduled for an L5/S1 laminectomy, laminotomy and discectomy. Following surgery, George was absent of any low back pain, there was no leg pain and there was no numbness or tingling in the leg. However, George ended up with a permanent motor weakness of the right leg / foot flexors.

THE LAW SUIT

6 months after surgery, George filed a malpractice law suit against the DC.

The law suit alleged the following against the DC:

- Failure to secure a full history:
- Failure to perform a full exam
- Failure to obtain informed consent
- Failure to refer for medical evaluation

George alleged that as a result of the chiropractic treatment, his pain had worsened, and the treatment caused the disc herniation which in turn caused the leg pain, numbness, tingling and need for surgical treatment.

Demand was made for all current medical bills, future medical bills, past and future pain and suffering, loss of consortium and permanent disability/impairment.

THE EXPERTS WEIGH IN

The parties brought in their experts.

THE DEFENSE SIDE (THE DC EXPERT)

At deposition, the defense chiropractic expert testified that the DC had met the standard of care, using the medical records to prove that conclusion.

The defense neurosurgery expert citing several studies regarding the incidence of disc herniation and spinal manipulation testified that it was highly unlikely that the chiropractic treatment caused the disc herniation, or worsened a preexisting herniation.

THE PLAINTIFF SIDE (GEORGE'S EXPERT)

Georges chiropractic expert testified that the DC had failed the standard of care on multiple levels including inadequate physical examination (that pesky neuro exam), no informed consent, failure to timely get an MRI, and related negligence.

Georges treating neurosurgeon testified on the basis of his strong belief given what George reported to him at intake that, the DC had indeed caused the HNP due to spinal manipulation.

THE TRIAL

The plaintiff chiropractic expert testified at trial as to multiple failures of the standard of care. When cross examined, he admitted that while there was no written informed consent agreement or form, the medical records did included notations of "talked about consent" but the expert testified that such a note did not constitute the principal behind informed consent. The expert also testified that the examination was incomplete and should have included an MRI. However during cross examination, when shown examination guidelines for cases with low back pain and no abnormal neurological findings or other red flags which indicated that imaging was not necessary he admitted that while the Guidelines made that assertion, he believed that absent a neuro examination, there was no means of determining whether or not there were any abnormal neurological findings and that MRI should have been done anyway given the positive Valsalva maneuver and the presence of sciatic nerve tension signs.

The Plaintiff treating neurosurgeon again testified to his belief that the chiropractic manipulation had caused the herniation and thus the permanent impairment related to the leg weakness. Upon cross examination, the neurosurgeon admitted that indeed injury to the nerve root during surgery is a not uncommon complication in laminectomies and that the nerve could have been injured during the surgery, thus causing the permanent weakness.

The defense chiropractic expert testified that the DC had followed the appropriate guidelines in so far as imaging, treatment and discharge were concerned. He also testified that the records indicated George had failed to follow home care directions during the chiropractic treatment.

The defense neurosurgery expert testified the same as during his deposition. He further testified that he could not exclude continued weight lifting as a factor of aggravation to the disc. Plaintiff counsel argued that if the weightlifting could have aggravated the disc, why then didn't the manipulation similarly injure the disc. The neurosurgeon pointed out the weightlifting placed axial load on the spine and that axial loading is a known hazard to a disc, while the manipulation did not cause or create any axial loading and this was not a cause of disc injury.

VERDICT

After a short period of deliberation, the jury verdict was unanimously in favor of the DC defendant.

COMMENTARY

This case points out the vagaries of human interest and the fact that none of us are perfect. Obviously, there were contradictions between what George alleged, and to a degree what the treatment record described (particularly about reported improvement). Despite the variations of George's perspective of what caused what, we cannot ignore that the DC could have done a better job. The examination was deficient in so far as a neurological examination. The argument can be made that imaging should have been obtained early on. Whether or not the result of imaging would have changed any of the treatment methods or outcomes, is pure speculation. Was justice served? Well more than likely from the DCs point of view, the answer is yes, and from George's point of view the answer is no. From the jury's perspective, I suspect that they were not blind to the assertion of George that the DC treatment had made him worse, versus the DC records that failed to substantiate that.

If you have questions, comments, or just want to argue with me over the issues I discuss in this case, please by all means send me an email at dr.rick.skala.dc.qme@gmail.com

Hopefully you do not need to contact me because you need my services as a chiropractic expert, but if you do please send me an email at dr.rick.skala.dc.qme@gmail.com

Yours Truly

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"Good philosophy must exist if for no other reason, because bad philosophy must be answered." CS Lewis