CONNECTING THE DOTS # 3

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.

MARY PRESENTS TO DR. DAVE*

*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.

In July of 2008 Mary presented to Dr. Dave, a chiropractor in California. On the first visit Mary, age 50 completed an intake form that requested information from her regarding why she was in the chiropractor's office and about her health history. Mary stated that she was having neck pain with radiation to the UE on VAS of 5/10 which she believed was related to a prior MVA in 2006. She had seen a chiropractor previously with good results, but had changed to Dr. Dave, because he was closer to her home. Mary reported to Dr. Dave that she had been diagnosed with high blood pressure, was having numbness in her buttocks and groin, was urinating frequently, had a history of low back pain, mid back pain, neck pain, history of alcohol use and had been treated surgically in her knee as well as a hysterectomy. Her family history included diabetes and high blood pressure.

Mary described her neck pain as sharp, throbbing, and radiating to both UE with numb and tingling to the fingers that had been present for "years". She also indicated that prior chiropractic adjustments made things better.

Mary also stated that she was taking medications that included clonidine, benecare and something for her "nerves".

Note #1: both clonidine and benecare are used to treat hypertension. No attempt was made by Dr. Dave to learn what the name and purpose of the third medication was.

THE EXAMINATION

On the first visit Dr. Dave performed an examination. He found that the DTR for the UE were all +2/4, there was a positive foramina compression sign in the cervical spine bilaterally, and a positive right spurling sign. Sciatic nerve tension signs were negative. There was a positive right Fabere sign on the right, positive bilaterally Milgram sign. Ranges of motion in the cervical and lumbar spine were both limited and painful. The body pain diagram revealed considerable pain markings throughout the neck, mid back and low back. Dr. Dave hand wrote some notes during the examination indicating a report of headache by Mary during the exam, numbness in the left hand, carries her stress in the mid back, low back history of short leg, and pelvis, MVA three years ago – collision on left, and chronic symptoms with exacerbation on 07/17/2008. A handwritten diagnosis was provided of: Cervical, thoracic, lumbar sprain strain and cervical disc displacement.

Note #2: Sometimes what is not recorded becomes more important than what is recorded. And sometimes, failure to explore more fully what is recorded can also become problematic. In this case, while there is a finding of a positive foramina compression sign, and report of numbness and tingling in the right hand, all subsequent to an MVA collision three years' prior, there is no neurological examination other than the DTRs. No sensory exam to lite touch or pin prick done in the right UE to localize levels of involvement or sensory deficits. No motor exam to correlate levels of involvement and assess degree of focal neurological dysfunction and or weakness.

Note # 3: Of additional note is that Mary is a 50-year-old women, who three years prior suffered an MVA (age 47). There is no record of any attempt to get the records of the prior chiropractor, no attempt to find out if there were any prior cervical spine or other imaging, and no written notes in so far as considering any current cervical imaging prior to providing treatment.

Note # 4 Additionally, Mary reported a history of headache during the examination. While there is a note of this report, there is no assessment of the headache. No historical information, no consideration of frequency, duration, location, self-treatment, and or associated symptoms etc.

TREATMENT BEGINS

On the same day of her first visit, Dr. Dave commences to provide Mary with chiropractic treatment, consisting of diversified cervical, thoracic and lumbar spinal adjustments. However, the visit notes of the first and all subsequent visits DO NOT record the vertebral level, and the specifics of the adjustments provided.

Note #5: The medical records did not contain an informed consent to chiropractic treatment at any time. While legal requirements for informed consent vary from state to state, in California, an Informed Consent to Chiropractic Treatment is required to be provided in writing and signed by the patient and the chiropractor prior to treatment.

Mary continues with a treatment plan being adjusted several times a week for several weeks. In mid-October, she reports to Dr. Dave that she has had another MVA on 10/09. While Dr. Dave makes note of the MVA, there is no further data gathered. No information regarding the nature of the MVA, no specific MVA history no new examination, and no discussion in regards to any possible imaging.

Note # 6: At this point, the sloppy record keeping and documentation begins to become a pattern in this case. Failure to adequately document the effects or lack of effects of an MVA regardless of any first impression by patient or doctor regarding severity establishes a medical legal limitation imposed upon the patient by the doctor in so far as any potential future issues may be concerned. In this case it had an adverse effect on Dr. Dave's medical decision making.

YEARS OF TREATMENT

Over the course of time from 2009 through early 2014, Mary continued to present to Dr. Dave on a sporadic PRN basis, each visit for essentially the same problems involving her neck and UE, and each visit receiving the same treatment – diversified cervical, thoracic and lumbar spinal adjustment.

Note #7: During the course of nearly 5 years, Dr. Dave never provided a history update, never performed a new physical examination, never inquired of Mary, what other health care challenges she may have been dealing with and never updated her medication list.

THE REST OF THE STORY

Completely unknown to Dr. Dave, during the time that Mary would present to him for her occasional chiropractic treatment, (from 2009 through 2013) she was concurrently under medical care for her neck and UE problems and was also receiving care on a general medical basis.

During the course of her treatment by Dr. Dave, Mary was being treated for diabetes, hypertension, back pain, neck pain and hyperuricemia (high uric acid). She had been prescribed a regimen of Norco (opioid for pain), Celebrex (arthritis pain), ondansetron (anti-nausea/vomiting) and venlafaxine (depression). The records also indicated that during the tenure of her treatment with Dr. Dave, Mary was taking Trazadone (anti-depressant), clonidine (hypertension), Toprol (hypertension), simvastatin (hypercholesterolemia), allopurinol (gout/uric acid), furosemide (hypertension-diuretic), soma (muscle relaxant), Nexium (gastritis), amitriptyline (antidepressant), ranitidine (gastritis) and alprazolam (anxiety).

Also during the time from 2009 through 2013 the following took place:

- Cervical x-ray study performed by Mary's medical physician on 06/30/2009 revealed mild degenerative changes at C5/6.
- A cervical MRI was provided at the request of Mary's medical physician (an osteopath) on 07/31/2009 which revealed sufficient cervical degenerative changes at all levels with disc bulges at all levels with significant stenosis at C5/6 where there was abutment to the cervical cord.
- On 01/16/2011 Mary had presented to neurosurgeon complaining of neck pain with radiation to both UE and numbness and tingling in both hands and fingers.
- A cervical MRI on 1/6/2012 revealed disc herniations at C4/5, C5/6 and C6/7 with a C6/7 extrusion affecting the left nerve roots.
- As a result of the 01/06/2012 MRI findings and the ongoing symptoms, Mary's osteopathic physician referred her to a neurosurgeon. The neurosurgeon in a 01/16/2012 found hyporeflexia in all UE DTR. On the basis of the symptoms, the hyporeflexia and the MRI findings he ordered an EMG and referred Mary to PT.
- On 01/30/2012 Mary consulted with an interventional pain specialist regarding her neck pain, UE pain and numbness/tingling This resulted in a recommendation for a cervical epidural steroid injection.
- In a 03/05/2012 EMG study revealed bilateral carpal tunnel syndrome right worse than left, and no signs of radiculopathy.
- In a 01/25/2013 Interventional pain consultation a left sided C2 – C6 medial branch block was recommended, and if the injection result is positive to be followed by a radiofrequency rhizotomy.
- On 03/25/2013 a left medial branch block was performed from C2 – C6.
- On 04/30/2013 a left medial branch block was performed from C2 – C6.
- On 06/11/2013 a right C2 – C6 radiofrequency ablation was initiated, but was terminated due to patient pain levels.

Note 8: The medical records during the time frame from 2009 – 2013 contained a few tangential reports on the part of Mary, to Dr. Dave, that some of these treatments and diagnostic studies were or had taken place. However, at no time, did Dr. Dave follow up be getting further information, and or seeking copies of imaging reports medical records etc.

THE CAMEL AND THE STRAW

In the summer of 2014 Mary again presented to Dr. Dave with ongoing neck and UE symptoms, Dr. Dave proceeded to continue to peform diversified cervical spine adjustments and the records continued to fail to identify level of specifics of each adjustment.

Note 9: Dr. Dave again failed to update Mary's medical and health history.

On 07/03/2014 immediately after receiving a cervical adjustment from Dr. Dave, Mary experienced severe neck pain with radiation of pain, numbness and tingling into both arms and hands/fingers.

This was the last time that Dr. Dave would see Mary in the doctor patient relationship.

THE ER

Following the eventful visit with Dr. Dave on 07/03/2014, Mary reported to the local hospital ER with severe neck pain and radiation into the bilateral UE on 07/06/2014. A 07/07/2014 CT of the cervical spine revealed disc herniation occupying the left C6/7 lateral recess and underlying moderate canal stenosis. A Cervical MRI performed the same day revealed a C6/7 left disc herniation filling the lateral recess and foramen.

THE SURGERY

Subsequent to these findings Mary was treated surgically with an anterior cervical discectomy and fusion of C6/7 with anterior plating and allograft. Follow up medical evaluation performed one-month post-surgery described Mary as having been in abject pain and agony, bedbound with left handed weakness and loss of sensation prior to the surgery, which post surgically had resolved.

THE LAW SUIT

In late 2014 Mary filed an allegation of malpractice negligence against Dr. Dave. Mary alleged that Dr. Dave negligently treated her cervical spine causing and or contributing to the herniation of the disc at C6/7, which in turn required surgical intervention. The allegation as is typical of such cases, also alleged pain and suffering, loss of ability to work and multiple other factors related to the alleged negligence of Dr. Dave.

THE DUEL

Both Dr. Dave and Mary engaged separate chiropractic experts to opine as in Dr. Dave's case, he was not negligent, and on Mary's behalf, how and why Dr. Dave was negligent.

The expert for Dr. Dave testified that Dr. Dave was not responsible for the herniation of the C6/7 and that a cervical spinal adjustment could not cause such an injury in any case under any

circumstances. As a foundation for his arguments, he referenced his own studies and published writings on the subject.

Dr. Dave's counsel argued that Dr. Dave could not be held responsible, or liable for the things that he did not know (ie the ongoing deterioration of her cervical spine as found on x-ray and MRI).

STANDARD OF CARE

"What a (licensed) prudent, competent doctor of **chiropractic** in the same region would do in the same or similar circumstances."

The expert for Mary offered a Standard of Care case time line sensitive discussion that started at the time of the first visit of Mary with Dr. Dave. His arguments focused on standard of care issues, and various instances of Dr. Dave's breach of standard of care that began with a failure to develop an adequate patient health history, a failure to provide an adequate physical examination, failure to secure compliant informed consent, and a failure to update Mary's medical history over the course of 5 years. One of the primary breaches of the standard of care was described as a failure to either order cervical imaging or secure imaging reports and actually view imaging ordered by other physicians. Mary's expert also pointed out an ongoing breach of standard of care for the following: failure to adequately work up the subsequent MVA reported to Dr. Dave by Mary, failure to adequately document the history of her reported flare up, failure to adequately take a history and perform an examination when Mary reported a fall injury with head strike to Dr. Dave, failure to update Mary's general health history and history of other treatment regarding her neck over the course of five years of treatment by Dr. Dave. It was the opinion of Mary's expert, that these breaches of the standard of care were emblematic of what placed Mary at risk of injury during the course of chiropractic spinal adjustments. Mary's expert could not say to a degree of reasonable medical probability that Dr. Dave, did indeed **cause** the herniation of C5/6 that ended up being treated surgically. However, he did opine that by depriving himself of applying and Mary of receiving a different form of spinal adjustment rather than manual diversified adjustment Dr. Dave exposed Mary to unnecessary risk of injury that could within reasonable medical probability have worsened the cervical disc to the degree necessary to cause the documented response.

Mary's counsel argued that the very fact that Dr. Dave did not know what he would have known had he practiced within the standard of care (and gotten cervical imaging) deprived both Dr. Dave and Mary from giving and receiving an adequate Informed Consent to Chiropractic Treatment. Mary's counsel argued that had Dr. Dave secured cervical imaging and became aware of the degree of degenerative change, he could have considered alternative methods of cervical spinal adjustment, thus reducing the risk of exposure to harm on Mary's part.

THE CASE GOES TO ARBITRATION

Mary's counsel had filed suit for $300,000.00. The parties agreed to submit to binding arbitration. The arbitrator ruled in favor of Mary and awarded her $250,000.00. Considering the added expense of trial on the part of Mary's counsel, this was considered a satisfactory settlement.

LESSONS LEARNED?

1. I have been practicing chiropractic for 40 years. When I went to chiropractic college in the 70s, we were taught that the standard of care included an x-ray examination of each patient prior to providing any spinal adjustments with only a few exceptions such as young children, pregnant women etc. Since that time, the health care world in general, and the chiropractic profession have gone through a few changes. I encounter more and more chiropractors who believe that an x-ray prior to providing chiropractic care is no longer necessary. In my 40 years of experience, and looking back to understand why a DC might believe this, I am not able to determine any rationale for this other than the political and economic pressures placed on all of health care and chiropractors in particular. Even at least one of our national associations asserts that spinal x-ray examination is a pre-requisite for spinal adjustment. This need is enhanced by most if not all authorities in our profession when the circumstances of Mary, (age, prior MVA history, new MVA history current symptoms) are taken into account. Finally, on this subject, an insurance carrier's coverage of an x-ray exam, or a patient's ability to pay out of pocket for an x-ray exam should have no bearing on the chiropractic decision making process when it comes to x-ray. In this case, timely initial and subsequent imaging over 5 years could have saved Dr. Dave a judgement of $250,000.00

2. While there are and have been chiropractors over the years who have boasted of their practice volumes, laying claim to daily patient numbers that defy practicality and make the rest of us wonder about the quality of care, chiropractic should never be about the chiropractors' volume of patients. Each patient deserves not only the best chiropractic care that the DC can provide, but they also deserve a DC who takes the time to understand the patient's full health history (regardless of whether the DC is treating for other concurrent health problems or not). Taking the time to talk to patients and document what they are telling us lets a patient know that we care, but more importantly, it keeps the DC in the loop of the patient's total health care experience. In this case, such information could have saved Dr. Dave a judgement of $250,000.00!

3. I can still remember the tedium of taking a comprehensive history and performing a comprehensive physical examination on patients in the Student Clinic when I was in chiropractic college. I can recall classmates remarking as to how they could not wait to be done with this stuff, and that they would never need to do all this "stuff" in the real world. Hmmm I wonder how that turned out for them. Our professional rhetoric claims that we are "nerve system" doctors. Is it not reasonable to believe that the learning process at chiropractic college, and our own rhetoric deserve to be applied? If Dr. Dave had practiced like a "nerve system" doctor and had performed a better neurological examination at least on the first visit all those years ago, and then at least on periodic basis over 5+ years might he have identified neuro exam findings that would have hopefully given him pause before again adjusting Mary's cervical spine with a diversified adjustment? Could that have saved him from a judgment of $250,000.00?

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

Richard K. Skala DC QME
510-657-6366 Office
530-762-0381 Office
510-657-3849 FAX
530-762-0905 FAX
www.drskaladc.com
www.drskalachiroexpert.com
dr.rick.skala.dc.qme@gmail.com

Certified Industrial Disability Evaluator
Certified AMA Impairment Rater
Fellow Academy of Forensic Industrial Chiropractic Consultants
Certified Disability Analyst
Fellow American Board of Disability Analysts
Certified in Neuro-Electro-Diagnostics
Board Eligible Chiropractic Neurologist

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