Examiner

NCMIC
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COMPELLING CASE STUDIES AND PRACTICAL TIPS FOR AVOIDING A MALPRACTICE ALLEGATION

Doctor's Faulty Recordkeeping Impairs Foundation of Defense

Tim Rae was a police officer from 1975 to 1992 before retiring on disability after four surgeries on his knee. He had a torn meniscus in his right knee and suffered nerve damage from a fall down a stairway that was re-injured from falling on the job. After retiring, he received a bayman's commercial license to be able to clam, scallop and fish as an occupation.

Early in 2001, Tim woke up with stiffness and pain in his neck that wouldn't resolve, and he sought treatment with Ron Rossey, D.C., who referred him for an MRI with a neurologist. This MRI revealed degenerative arthritis.

Tim returned to Dr. Rossey for treatment, and his neck pain resolved. He continued to treat sporadically with Dr. Rossey, primarily for gluteal pain radiating down his leg as a result of his bayman activities. Dr. Rossey treated Tim a total of 130 times over a period of six years, but there was no comprehensive treatment plan in the record.

On August 28, 2006, following an 8-month absence from seeing Dr. Rossey, Tim presented with complaints of sharp burning sacroiliac pain. Tim said it was the same pain Dr. Rossey had treated him for during the last 5 to 6 years.

Dr. Rossey routinely performed a complete workup of his patients when they returned for treatment following an extended absence from care. He believed he did this on the August 28 visit, but there were no findings documented in the record. In Dr. Rossey's practice, this lack of documentation meant no new symptoms were elicited during the examination. Therefore, Dr. Rossey adjusted Tim's full spine on August 28 and August 30. Tim didn't voice any complaints that were documented following these visits.

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Case Study Key Takeaways:

- Treating a patient over many years can lead to doctor complacency.
- When clinical records are sparse and billing records are detailed, it can create credibility issues for the doctor.
- Experts who can educate a jury about the pathophysiology of findings are important.

See "What Can We Learn?" on pages 6 and 7 for more takeaways.

WINTER 2015

IN THIS ISSUE

At his next appointment on September 20, 2006, Tim had an obvious ataxic gait, and Tim told Dr. Rossey that he had been experiencing numbness from the nipple down for approximately 10 days. Dr. Rossey examined Tim with a pinwheel to elicit sensation; however, he did not document his findings. He then applied heat to Tim's back. Dr. Rossey recommended that Tim see a neurologist, although he didn't refer him to a particular provider. Tim found a local neurologist in the phone book and made an appointment for two days later.

Patient Sees Neurologist

On September 22, 2006, Tim presented to Kim Yeager, M.D., a board-certified neurologist. Dr. Yeager documented that Tim had progressive neurologic symptoms that began in the leg and radiated upward. Tim told Dr. Yeager that his symptoms began within days of a chiropractic adjustment. Dr. Yeager didn't render treatment to Tim and referred him to a local hospital for evaluation and imaging studies.

At 6:16 p.m. that evening, Tim presented to the ED at the local hospital for the imaging studies. He complained of tingling in his lower legs and numbness from his mid-abdomen to the bottom of his heels. These symptoms had persisted on both sides for the past two weeks.

An MRI of the full spine, without contrast, was ordered. Due to Tim's claustrophobia in the MRI machine, the study was compromised. Tim was instructed not to leave the hospital until the MRIs were reviewed by radiology, but he left the hospital against medical advice. Tim said he would follow up with Dr. Yeager or return to the ED if symptoms worsened.

The MRI findings were:

- Multi-level disc disease and central spinal canal stenosis at C3–C4, C4–C5 and C5–C6.
- Severe central canal stenosis at C5–C6. However, this evaluation was limited due to Tim's movement during the MRI.
- Severe central spinal canal stenosis at T2–T3.
- Grade II Spondylolisthesis of L5 on S1.

The radiology department at the hospital sent Tim's MRIs to a radiology center for an over read. The MRI of the T-spine noted a chronic—not a new—anterior compression fracture of T7, mild-to-moderate canal stenosis at T2–T3 secondary to minimal anterolisthesis of T2 on T3, disc bulging and spondylotic disc ridging with mild myelomalacia in the left paracentral aspect of the cord.

There was also a large left paracentral focal disc protrusion at T6–7, causing mass effect upon the spinal cord without evidence of myelomalacia. The MRI of the C-spine noted multilevel degenerative disease within the cervical spine without significant canal or neural foraminal stenosis. Results of the lumbar spine noted bilateral chronic spondylolysis at L5 and grade I anterolisthesis of L5 in relation to L4 and S1. It showed significant bilateral neural foraminal narrowing at L5-S1 with possible encroachment on the left and right existing nerve root. These findings were communicated to Dr. Yeager in a phone call.

Even when treating a patient over the years, a doctor must resist the temptation to provide care on "auto pilot."

Notice of Board Election

Policyholders of NCMIC Insurance Company are members of National Chiropractic Mutual Holding Company and are hereby notified there will be 3 vacancies to be filled on the board of directors at the annual meeting to be held on April 18, 2016. The board of directors will nominate 3 doctors to fill these vacancies.

Neurosurgeon's Evaluation

Due to a cancellation, Dr. Yeager was able to schedule Tim to see a neurosurgeon on September 27, 2006. The neurosurgeon's musculoskeletal exam identified slight paraspinal muscle spasm of the cervical and thoracic spine without tenderness or decreased range of motion. His neuro exam noted negative straight leg raising, muscle strength 5/5 in all groups of Tim's upper and lower extremities. Deep tendon reflexes were 2+, but hyperreflexic bilaterally at the patella. His gait was documented by Dr. Yeager as spastic.

The neurosurgeon's impression was that Tim's symptoms related to spondylolisthesis of T2 and T3 with cord changes. He started Tim on a steroid-tapering dose and ordered an EMG. The EMG was suggestive of radiculopathies of L4-L5 and L5-S1.

Tim returned to the neurosurgeon on October 12, 2006. He reported improvement over the last two weeks. He still had mild weakness proximally in his legs, but his gait and sensation had improved. The surgeon's impression was that Tim had progressed nicely, and he was not inclined to advise surgery at that time.

Over the next six months, Tim had weight loss, difficulties with his left lower extremity (he called it a "dead leg"), an irregular gait and hyperreflexia. By May 2007, Tim experienced increased dysesthesias, primarily in the left flank extending onto the chest wall. He reported to the neurosurgeon that his gait had become more unsteady and his pain increased. Because conservative management of Tim's condition wasn't working, the surgeon switched gears and became more aggressive in his treatment approach. He recommended a follow up MRI and likely decompression surgery at T2–T3.

Surgery Performed

Tim underwent the recommended follow up MRI, which revealed the same stenosis with evidence of signal changes within the cord at T2–T3 that the previous studies had shown. As a result, on May 9, 2007, he had the following surgical procedures performed:

- Partial laminectomy of T1.
- Complete laminectomy of T2–T3.
- Partial laminectomy of T4 for decompression of the upper thoracic spinal cord.
- Posterolateral fusion of T1–T4 with instrumentation.

In the next year and a half, Tim complained of significant cervical pain. This pain extended into his upper thoracic region and included a burning sensation. He also complained of tremors in his left leg and difficulty with ambulation that was secondary to subjective weakness in his left leg and complaints of clonus spasticity pain of the left ankle.

When Dr. Rossey arrived at his office on October 13, 2008, he was served with a lawsuit that alleged he failed to properly record and document the plaintiff's physical signs, symptoms, and complaints. The lawsuit also alleged Dr. Rossey failed to recognize that these

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complaints would reveal a contraindication to manipulations and performed manipulations that were contraindicated. Dr. Rossey reported the lawsuit to NCMIC, and an attorney, Kevin Mason, was retained to defend him against the allegations.

Attorney Mason filed an Answer to the Complaint, and once he obtained medical records and reports and exchanged paper discovery with the plaintiff's attorney, he noticed Tim Rae for his deposition. After Tim gave his testimony, attorney Mason felt that he was a poor historian about timeframes and treatment dates throughout his deposition. At times, he appeared to be disingenuous in that he testified that he did not have any back complaints prior to the treatment with Dr. Rossey in August and September 2006. However, he had a lengthy chiropractic history.

Dr. Rossey Testifies

Dr. Rossey testified at his deposition that, among other things, his standard procedure was to perform supine thoracic adjustments, and he would have performed that type of adjustment on Tim. He stated the supine maneuver is the least forceful adjustment on the spine. He also testified that the line of drive for Tim's spine fracture was inconsistent with the supine adjustment. Dr. Rossey didn't recall Tim voicing any complaints after the August 28 and August 30 treatments. Plus, the changes on the MRI were "chronic."

Dr. Rossey testified that Tim stopped by his office in December 2006 to bring in a check from his insurance company for payment of two additional treatments in September 2006, in addition to the September 20, 2006, appointment. However, Dr. Rossey claimed that treatments on these dates did not take place—it was a simply a billing error, and the check was returned to Tim's insurance carrier well before the case began. In addition, Dr. Rossey pointed out there was no documentation that these visits occurred. Attorney Mason was concerned the plaintiff's attorney would use the billing records to corroborate Tim's contention that Dr. Rossey adjusted him more than once in September 2006, harming Dr. Rossey's credibility.

Attorney Mason retained Jill Larson, D.C., to review this matter as an expert consultant. Dr. Larson described Dr. Rossey's documentation in the treatment records as repetitive and lacking in detail regarding Tim's care. In contrast, Dr. Rossey's billing records contained significant details. Dr. Larson thought this might suggest Dr. Rossey had misplaced priorities and further hinder the D.C.'s credibility.

Attorney Assesses Case

In early June 2010, attorney Mason sent a report to the NCMIC claims professional representative assigned to the case, which outlined:

- Due to the lack of documentation and the discrepancy between Tim's testimony and Dr. Rossey's, credibility of the parties may be an emphasis.

Experts from a variety of fields often make the difference in a malpractice defense.

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- The lack of radiographic evidence, combined with the lack of a comprehensive documented neurological examination over many years, will be difficult to overcome.
- If Tim did have a fracture prior to August 2006, the adjustments Dr. Rossey performed would have been contraindicated if the fracture was old and hadn't healed.
- Tim alleged that he saw Dr. Rossey on two occasions in September 2006, and that Dr. Rossey performed an adjustment after he presented with an ataxic gait. If so, Dr. Rossey would probably be found liable because an adjustment would be contraindicated.

Attorney Mason estimated a jury would award Tim between $900,000 and $1 million if Tim prevailed at trial. He felt the case had a settlement value between $500,000 and $600,000, and he estimated he would only be able to successfully defend Dr. Rossey at trial 35 percent of the time.

The NCMIC claims representative discussed the report with attorney Mason and disagreed with the evaluation, pointing out the many angles this case could be defended from a proximate cause perspective. Because the attorney was focused on Dr. Rossey's lack of documentation, he didn't believe he could successfully defend the case. Therefore, the claims representative transferred Dr. Rossey's case to attorney Keith Hoover, who agreed that Dr. Rossey's care was defensible.

Case Options Identified

Over the next several months, NCMIC-retained attorney Hoover and the claims representative worked together closely to determine the specialties of the expert witnesses needed to defend Dr. Rossey and to identify these experts. As the trial date neared, Dr. Rossey started asking his defense team questions about having the case settled.

Attorney Hoover explained that the plaintiff would probably demand at least his full policy limits of $1 million to settle. In addition, the defense had retained excellent experts who would testify that Dr. Rossey didn't cause Tim's problems. Therefore, the defense team advised against settling. Given these assurances, Dr. Rossey agreed it made sense to proceed with the case.

At a July 26, 2012, settlement discussion, Tim's attorney demanded $1 million to settle. He said Tim would rather lose at trial than agree to anything less than $250,000. Therefore, the defense team did not counter this settlement demand. When Dr. Rossey learned the case didn't resolve, he expressed a concern that he would lose up to two weeks of income if the trial took place during his busy summer season. Attorney Hoover filed a motion to continue the trial after the Labor Day holiday, and the judge granted this motion.

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Trial Developments

The trial began and the defense team rated the jury as fair to good, with highlights of the trial as follows:

Day 1—Dr. Rossey was the first witness called to testify by Tim Rae's attorney. Dr. Rossey did an effective job of testifying, and the plaintiff's attorney did not bring up sparse records as much as expected. A huge shock was that Tim's attorney alleged that Dr. Rossey had herniated Tim's T6 disc, even though surgery was performed on T1–T3. Dr. Rossey was strong in his testimony that he adjusted Tim's upper thoracic spine but not T6, and this was substantiated by his treatment records, though sparse.

Day 2—The plaintiff's standard of care expert consultant, Sam Blackett, D.C., was the first witness of the day. Dr. Blackett nit-picked Dr. Rossey's records, lack of exam and imaging studies. He testified that a supine thoracic adjustment uses a lot of force, and had Dr. Rossey taken an X-ray, he would have known it was a contraindication to adjust a patient with a new T7 fracture. Dr. Blackett did not have an answer for how an adjustment at T1–T4 would affect T7.

Day 3—Tim Rae testified that he was granted disability from the police force because he could no longer run due to his knee injuries and that by mid-September 2006 he could no longer work. However, the NCMIC-retained attorney presented the neurologist's September 22, 2006, treatment record that referenced Tim Rae was still clamming. At day's end, the judge called the parties to the stand to ask if there was any interest in settling, and Tim Rae's attorney quickly responded that they had no interest.

Day 4—The plaintiff's neurology expert testified that he performed a physical examination on Tim on September 22, 2006. He noted that Tim reported severe pain in his upper back and lower neck, as well as upper abdominal pain. He also exhibited painful behaviors in both shoulders and jerking movements associated with the onset of his abdominal, upper back and lower neck pain. He had an unsteady gait related to numbness and weakness of the left leg and upper back pain. This neurologist attributed Tim's issues with his thoracic, cervical, lumbar and sacral spine to chiropractic treatment rendered by Dr. Rossey in September 2006. The plaintiff rested its arguments, and it was time for the defense to put on its case.

Day 5—Expert witness Jill Larson, D.C., did a nice job testifying on behalf of Dr. Rossey. However, when cross examined, she remarkably admitted that in light of no other intervening factors, it could be assumed Dr. Rossey's treatment caused Tim's spine injury. Despite this small setback, the neurosurgeon who testified next stated Tim's problems were not due to an adjustment on August 30, 2006 because:

- Tim's initial complaint of pain wasn't shared until several days after the adjustment.
- Steroid injections resulted in improvement, and when stopped, the patient's condition worsened. An acute injury wouldn't act in this manner, according to the neurosurgeon.

What Can We Learn?

By Jennifer Boyd Herlihy, Boston, Massachusetts, and Providence, Rhode Island

Assessment. Treating a patient over the years can lead a doctor to become complacent and miss a patient's changing condition. A doctor can overcome this tendency through "present-time consciousness." On the flip side, Dr. Rossey claimed he followed standard procedures in his practice. Yet, he sent Tim to a neurologist for an MRI at one appointment, but then didn't after the patient demonstrated neurological symptoms. Also, it was the patient's history not the fracture that presented the red flag because an old/healed compression fracture is not an absolute contraindication to SMT. Numbness of the torso should have prompted Dr. Rossey to reassess the patient.

Documentation. "If it wasn't written down, it wasn't done" has been a legal precedent for decades. Documentation should include a record of responses to treatment, and negative examination findings are just as important to document as are positive findings. A patient's re-evaluation should include how often the treatment took place and under what circumstances. Dr. Rossey's clinical records were repeatedly noted to be non-existent to sparse—inadequate to support his care and therapeutic conclusions. Despite a successful outcome in this case, proper documentation is essential.

Office procedures. Dr. Rossey testified that it was his standard procedure to perform a complete workup of his patients after an extended absence from care, but this wasn't documented. Dr. Rossey also treated Tim a total of 130 times in nearly six years, but there was no comprehensive treatment plan in the record, which could raise questions

- The deficit was essentially sensory and not motor, which suggests chronic degeneration rather than an injury.
- Tim complained among other things of weakness in his arm and T2 is below the arm, which is controlled by C4–C6. This occurred when Tim was found to have hyperreflexia in both arms, which are controlled by the cervical spine.
- The surgery was not effective in relieving the condition.
- There was no evidence of acute trauma on X-rays taken on September 22, 2006. There was no hematoma, bleeding or swelling of tissues or ligaments. If there was an injury to the thoracic spine, it wasn't recent.
- Displacement of the spine takes a great deal of force, especially in the thoracic area where the spine is anchored and held in place by the ribs. The thoracic area isn't "floating" like the lumbar and cervical spine regions.

After this testimony, Tim's attorney lowered his demand to $700,000. The defense team considered making a counteroffer of $100,000, but ultimately decided against it.

Day 6—The neuroradiologist retained for Dr. Rossey's defense was extremely effective in educating the jury. He explained what the imaging studies meant and why the areas of injury couldn't have been caused by a chiropractic adjustment. This testimony discredited the opinions of the plaintiff's neurology expert who admitted that he had not viewed any of the numerous imaging studies—he had just read the reports on them. Following closing arguments, the plaintiff made a new settlement demand of $350,000, and attorney Hoover believed the plaintiff would accept $250,000. The jury then began its deliberations of the evidence.

The following morning, the jury reconvened deliberations, and the judge asked the attorneys if there had been any settlement talks. The defense team had decided earlier that morning not to make any offer of settlement, and attorney Hoover shared with the judge that they were prepared to accept the jury's decision.

Within two hours, the jury returned with a unanimous defense verdict for Dr. Rossey, including the standard of care issue. NCMIC's legal expenses to defend Dr. Rossey totaled $213,593.

Examiner case studies are derived from the NCMIC claims files. All names used in Examiner case studies are fictitious to protect patient and doctor privacy.

WHAT CAN WE LEARN AUTHOR

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What Can We Learn? cont.

about whether the chiropractic care resulted in any improvement. Moreover, Dr. Rossey's sparse clinical records were in contrast to his detailed billing records, which could be perceived by a jury that money was more important to him than the care he provided.

Defense team. In rare instances, a case may take an unexpected turn, and a different attorney may evaluate the case differently and have further suggestions. In that event, NCMIC will go the extra mile to find the right attorney for the case. Expert witnesses, defense counsel and the claims department are all important. Most of all, having a company that is truly committed to standing behind its doctors is critical to making all aspects of the defense come together.

Consent to settle. At NCMIC, a doctor has the right to settle—or not settle—a case, which then gives the defense the opportunity to attempt to resolve the case (with no guarantee that it will resolve). Of course, the decision to settle might be determined to be the right one by the defense team. In this case, the defense team rightly decided against settling this case in light of the strong experts they identified, as well as facts that pointed to a likely favorable outcome.

Experts. In this case, the plaintiff's standard of care expert was unable to explain how an adjustment at T1–T4 would affect T7. In contrast, the neurosurgeon obtained by the defense team was able to clearly delineate the clinical reasons why Dr. Rossey was not negligent. An expert who will educate a jury about the pathophysiology of findings and who can clarify unsupported claims is important. NCMIC utilizes outstanding experts from all fields to defend its doctors.

Obstacles with DOT Examinations

By Brian J. Niceswanger and Stephanie A. Preut

Doctors of Chiropractic who perform Department of Transportation (DOT) examinations face possible claims and lawsuits if the examination and certification are not done properly. The crux of these claims is that the examiner has an obligation to properly perform DOT physicals. Doctors who fail to do so may face significant liability including:

1. Liability to third parties for death or injury caused by an improperly certified driver.
2. Liability to the company that employs the driver for a poorly performed examination (to recover damages or recoup the cost of work-related injuries).
3. Liability to the driver who is injured due to improper certification, or interference with employment due to improper withholding of certification.
4. Disability discrimination actions.

Case Examples

In one case, a driver's employer brought suit against the examining doctor when the driver drove off the highway and collided with a parked car containing a family. The crash killed one child and caused severe injuries to other family members. Prior to the collision, the driver had a number of medical conditions that resulted in the driver being 100 percent disabled. The practitioner did not identify the disabling conditions and certified the driver to operate a truck. The court found that the accident was a reasonably foreseeable consequence of the improperly performed examination.

In another claim against a DOT physician examiner, a man who had experience as a long-haul trucker had applied for a job as a truck driver. The examiner refused to certify the driver without a "skill performance evaluation." The man was not hired and later accepted employment elsewhere, incurring lost income, moving expenses, etc. The suit claimed that the doctor "wrongly interfered" with his relationship with his employer by making "scandalous, defamatory and libelous statements."

Disability compliance is also an important consideration with DOT physicals. In one case, a driver went in for a DOT exam and was failed—without agility testing—due to morbid obesity. The company did not hire the driver, and he filed a lawsuit against the doctor who conducted the exam. Under DOT regulations, morbid obesity alone is not a disqualifying condition.

A Practitioner's Perspective

By Steven J. Gould, D.C., DACBR

Many D.C.s are performing DOT examinations or are considering becoming certified to perform these exams. I recently became certified and find providing DOT examinations allows me to take advantage of my full scope of practice, gain patients, service existing patients and expand my referral relationships.

However, as the adjacent article clearly illustrates, problems with DOT exams can result when doctors short-change the process because they aren't aware of their full scope of responsibility in conducting these exams.

Even though the DOT says the examinations do not form a doctor/patient relationship, it is important to remember that D.C.s still have an ethical responsibility to take complete histories and conduct thorough physical examinations on the drivers.

These cases demonstrate that performing DOT examinations can expose a D.C. to liability for how they perform the exam, as well as any resulting injury or damages.

Reducing Risk

When performing a DOT examination, the examiner must follow the federal standards, comply with the advisory criteria, and consider other available guidance and reports. The doctor should only execute the medical certificate after completing all required steps to determine that the driver is able to perform all driving and work-related tasks.

Doctors performing driver exams are expected to fully understand the standards of the Federal Motor Carrier Safety Regulations (FMCSRs) and related guidance. Before doctors perform driver examinations, they must enroll, complete necessary training, and pass a certification test to be listed on the FMCSR National Registry.

To become a certified medical examiner, a practitioner must:

- Be licensed, certified, or registered in accordance with applicable state laws and regulations to perform physical examinations.
- Register on the National Registry and receive a unique identifier.
- Complete required training and pass the medical examiner certification test.
- Report results of driver exams performed every month via the National Registry system.
- Submit to periodic monitoring and audits.
- Maintain certification by completing additional training every five years and recertify by passing the certification exam every 10 years.

The FMCSR lists four conditions that require denial of certification: insulin-treated diabetes mellitus, seizure disorders, significant vision deficits and significant hearing deficits. However, there are exemptions that can be applied for through FMCSA.

Practitioners should be familiar both with conditions that outright preclude driver certification as well as those that may not, such as hypertension and some vision and hearing deficits. They also should be aware that any condition can be disqualifying if it is severe enough to affect a driver's ability to safely operate a vehicle.

A Doctor's Best Defense

While cases may not often be pursued against examiners, practitioners must understand their potential liability and how to protect themselves. A doctor's best defense is to perform these examinations within the strict guidelines provided by the DOT and use the best clinical practices possible.

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Pommerenke (1998) Am Fam Physician 58(2):415-26 [PubMed]

Resources

Federal Motor Safety Administration, www.fmcsa.dot.gov

DOT Rules and Regulations, www.fmcsa.dot.gov/regulations.htm

NCMIC and Attorneys—Behind the Scenes

In September, NCMIC gathered the country's leading defense attorneys to hear from speakers with great knowledge in a variety of fields. NCMIC's singular goal in hosting this conference was to continue to focus on providing NCMIC policyholders with the best legal defense possible.

It's one more example of how NCMIC works behind the scenes to ensure our policyholders benefit by having the best informed, chiropractic-conversant attorneys ready to defend them, should the need arise.

In addition to giving defense attorneys the opportunity to discuss chiropractic cases and exchange strategies with colleagues and experts, the conference featured topics to enhance their defense of chiropractic cases. These included programs on the latest chiropractic research and regulatory issues and developing trends in social media.

What This Meeting Means to You

Being subject to a malpractice claim or simply accused of wrongdoing or unethical behavior is stressful enough without having to wonder if you'll be defended effectively. NCMIC provides you with a powerful defense team to be there every step of the way. When it really matters, you don't want to trust your reputation to just anybody. Thanks to the shared knowledge and expertise provided by this conference, our doctors benefit from having attorneys who are better prepared and more familiar with the latest issues, trial and defense strategies, and research available.

You want—and deserve—the best when it comes to defending your reputation. As a result of this conference, that's exactly what you'll get from NCMIC's defense team.

You Can Trust NCMIC for Business and Personal Insurance

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It's important to protect your practice with more than malpractice insurance.

That's why NCMIC also designs customized business and personal insurance programs exclusively for D.C.s, including:

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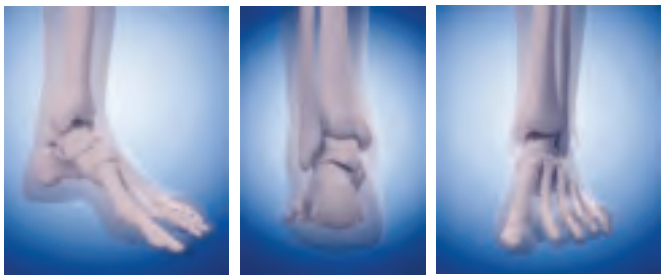
NCMIC Insurance Services

Ottawa Ankle Rules for Radiography

Why They're as Important as Ever to D.C.s



By John C. Pammer, D.C., DACBR

It has been reported that the most frequently radiographed area of the body is the ankle joint, and 85 percent are determined to be inversion injuries.

In the practice of chiropractic, ankle injuries are a common presentation. The decision on whether to X-ray the joint is often a complicated decision that requires thoughtful care and training. It is important that the patient is treated effectively. Also, with the use of X-ray there is a cost to the patient and thus to the healthcare system. "Most of the patients with ankle injuries are in the 19-to-25 age group, and the injuries are the result of a sports-related activity, with basketball as the most common sport where ankle injuries occur. There are 1.8 million ED visits per year nationally and the chief complaint for 4.3 percent of ED patients is ankle injuries. However, just 15 percent of patients presenting with an ankle injury have a fracture." [1]

Due to this small yield of positive X-ray results, the Ottawa Ankle Rules (OAR) were developed in 1992 to avoid unnecessary radiography. The OAR is taught in the chiropractic colleges and universities, so doctors should be familiar with these rules. However, here are some points doctors may use to re-familiarize themselves on key OAR concepts.

The OAR state that an X-ray of the ankle is only necessary if the patient cannot walk four steps, there is pain in the malleolar zone, and there is:

- Bone tenderness at the posterior edge or tip of the lateral malleolus.
- Bone tenderness at the posterior edge or tip of the medial malleolus.
- Inability to bear weight immediately and in the ED/office.
- Bone tenderness at the base of the fifth metatarsal.
- Bone tenderness at the navicular.

The OAR has been found to be 98-to-100 percent sensitive and 20-to-40 percent specific.[2] Sensitivity (also called the true positive rate, or the recall in some fields) measures the proportion of positives that are correctly identified as such (e.g., the percentage of sick people who are correctly identified as having the condition). Specificity (also called the true negative rate) measures the proportion of negatives that are correctly identified as such (e.g., the percentage of healthy people who are correctly identified as not having the condition).

Since the utilization of OAR, there have been 1.28 percent fewer ankle films; 2.14 percent fewer foot films; and shorter ED stays (36 minutes shorter on average). In addition, the OAR has saved $85 per ankle, per patient, which amounts to up to $153 million in annual savings nationally for ED patients alone.[3]

Information from the creators at University of Ottawa

Tips:

- Palpate the entire distal 6 cm of the fibula and tibia.
- Do not neglect the importance of medial malleolar tenderness.
- "Bearing weight" counts even if the patient limps.
- Be cautious in treating patients under the age of 18.

Precaution—Clinical judgment should prevail if examination is unreliable due to:

- Intoxication
- Uncooperative patient
- Distracting painful injuries
- Diminished sensation in legs
- Gross swelling which prevents palpation of malleolar tenderness

The OAR may not apply if:

- There is impaired lower extremity sensation such as with diabetes or nerve damage.
- The patient is taking steroids, is immunosuppressed or under age 18.
- The patient is over age 55 or has a history of osteoporosis.
- The mid-foot radiographic assessment covers the ability to walk and notes localized tenderness of the navicular or the base of the fifth metatarsal. The instrument is designed to rule out fractures of the malleolus and the mid-foot. It has been validated and modified in several clinical settings.

It is also important to remember that the OAR is a clinical decision-making tool for the evaluation of the traumatized ankle. It is not meant to replace the practitioner's clinical judgment or training.

[1] Heyworth, 2003: McCraig, 2004
[2] Bachman et al.BMJ, 2003
[3] 2004 CDC survey of ED utilization and BIDMC reimbursement

Dr. John Pammer has over 50 years of experience as a practicing chiropractor. He is a graduate of Palmer College and has served as president of the American Chiropractic Association, the American Chiropractic College of Radiology, and the Pennsylvania Chiropractic Association. He recently completed an 8-year term as a council member of the Council on Chiropractic Education. Dr. Pammer has been a Diplomate in Chiropractic Radiology for over 30 years and has a vast background of presentations of the most common conditions seen in a chiropractic practice from a clinical and imaging perspective.

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1. McKay GD, Goldie PA, Payne WR, Oakes BW. Ankle injuries in basketball: injury rate and risk factors. Br J Sports Med. 2001; 35(2):103–108;
2. Bachmann LM, Kolb E, Koller MT, Steurer J, ter Riet G. Accuracy of Ottawa ankle rules to exclude fractures of the ankle and mid-foot: Systematic review. BMJ 2003;326:417-23.
3. Ithan D. Peltan, MS IV Gillian Lieberman, MD Harvard Medical School
4. American Family Physician www.aafp.org/afp Volume 74, Number 10 November 15, 2006.

Say "Hello" ... and "Goodbye" to Anna Allen

Anna Allen, Senior Professional Relations Representative

Senior Professional Relations Representative Anna Allen, RN, MSN, CPEHR, has given hundreds of presentations throughout the U.S. since joining NCMIC in 1998. These have included seminars on professional boundaries, risk management, social media, ethics and more.

Prior to joining NCMIC, Anna's 35-year nursing career included working in cardiac care and emergency rooms. She taught emergency room procedures, handled fraud investigations and managed clinics and offices. This extensive background gave her the knowledge and expertise to provide D.C.s with key risk management insight.

Sadly for her many friends in the chiropractic profession, Anna will retire on December 31.

In this new chapter of her life, Anna hopes to spend time quilting, redesigning old furniture, chalk painting and interior decorating. She is expecting her first grandchild in April, so baby pampering is also in her future.

Anna looks forward to having the flexibility to just "get in the car and drive" and visit friends. So, you never know—she might turn up in your driveway! We all wish Anna the best in her future endeavors.

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Speaker: Lori Holt, RN-BC

Topic: How to Identify and Handle Medical Emergencies in your Practice (2 hours)

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Q One of my patients is chronically angry. I'm not sure if he is just cranky or has real concerns about my practice. What should I do?

A Most doctors feel that angry patients are among the ones they least want to deal with. These patients may or may not have a legitimate gripe, but it's difficult to tell because they complain about everything. Your office hours aren't convenient, the practice is too hot or cold, their health insurance didn't pay, they're not improving as quickly as they'd like. The list goes on.

They may be naturally angry, facing difficult times or unhappy with the care you provided. Regardless of the reason, you need to be careful because the patient's anger may escalate to the point where it becomes more than a headache for you. Therefore, it's essential to do what you can to help—or at least calm—these irate patients.

For example, if the patient is going through relationship problems, a referral to a mental health professional may be advisable. In the event of a financial problem exacerbated by chiropractic bills, a payment schedule may help.

The situation gets trickier when the patient has a concern about the treatment itself. Even if you're confident you did nothing wrong, it can be helpful to follow up with care and concern. After a two-week cooling off period, you may offer to go over the charts with the patient and explain the treatment you provided. This may be all the patient needs to feel comfortable with the situation and decide not to escalate it further.

Conversely, there may be times when the patient is simply too enraged to be reasoned with. In these cases, it's critical to diffuse the situation to the best of your ability. Empathize with the patient, but don't get drawn into the conflict. Instead, use reflective statements such as, "I understand you are upset about …"

If a situation escalates, it is advisable to take formal steps to terminate the doctor/patient relationship. Of course, if you sense a potential danger to you or your staff, remove yourself and staff members from harm's way and ask for assistance from law enforcement.

The ability to neutralize a patient's hostile behavior is an essential risk management skill for all Doctors of Chiropractic. It is also important to keep in mind the words of Daniel Webster who once said, "Keep cool; anger is not an argument."

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