

Emergencies Require Emergency Care

Dennis Semlow, DC

Betty June, a 65-year-old factory foreman, entered Dr. Baldwaithe's office for emergency care in November 1987. Ms. June was on vacation and had tripped and fallen over a four-inch diameter tree. She complained of midback and right hip pain. Dr. Baldwaithe had her complete a history and discussed it with her thoroughly and then documented the type and duration of all complaints, illnesses, accidents, etc. Dr. Baldwaithe then conducted an examination to determine the necessity of care. Due to Ms. June's apparent pain, it was impossible to perform the entire examination at that time, which was noted on the patient's file. An x-ray examination was performed which showed osteoarthritis, demineralization of the bone, and an osseous component of vertebral subluxation. The patient was cared for, using a low force technique and low back distraction/flexion technique. The following day a written report of findings was done, outlining possible disc protrusions, explaining parameters of care for the condition and options to the patient. The patient stated she must return home; she was feeling much better and thought she would be able to tolerate the six-hour drive. Dr. Baldwaithe reaffirmed the severity of the condition and that the patient should not drive home at that time, and should spend at least the weekend before proceeding home. The patient stated to Dr. Baldwaithe, "I am going; I have to get there."

Three years later, Dr. Baldwaithe received a letter, alleging that his treatments had caused fracture of a vertebra and payment was demanded for permanent disability and loss of income. Hospital records did indicate that there was a healed fracture of the L3 vertebra, without displacement. Time frames and etiologies could not be determined. The patient did not recall telling Dr. Baldwaithe she had fallen; in fact, she denied it. Dr. Baldwaithe's records showed she had written it in her own handwriting. The patient further denied having any pain when she first saw Dr. Baldwaithe. It was also noted in Dr. Baldwaithe's records that he had explained to Ms. June not to return home on that day. Dr. Baldwaithe's records were clear, complete, and also noted that when she returned home, she said she planned to visit her family doctor immediately. The records show that it took Ms. June approximately three months to do so.

Outcome: Due to Dr. Baldwaithe's documentation of patient care, the plaintiff's attorney was unable to find a chiropractic expert that would come forward and refute Dr. Baldwaithe's care.

Prevention: Thanks to Dr. Baldwaithe's clear and complete history, record keeping, and documentation, the plaintiff's attorney dropped the case. Whether you are dealing with an emergency or a chronic patient, you must take the time to completely document histories, complaints, accidents, etc.

This case study is provided from the OUM Group Chiropractor Program Claims files. The study is based on actual incidents, however circumstances have been changed.

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