

# COMMON COMMUNICATION ERRORS BETWEEN THERAPIST, SURGEON, AND PATIENT

Joe Mahon DPT, SCS

# Common Communication Errors Between Therapist, Surgeon, and Patient

- ▣ If communication can fail, it will.

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- ▣ The more communication there is, the more difficult it is for communication to succeed.

# Initial Evaluation

University of Delaware  
UD Physical Therapy Clinic  
540 S. College Ave., Suite 160  
Newark, DE 19716  
tel: (302) 831-8893  
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**Patient:**  
**Gender:**  
**DOB:**

**Visit #1:** 06/09/2014  
**Evaluation Date:** 06/09/2014  
**Injury Date:** 05/08/2014  
**Onset Date:** n/a

**Therapist of Record:** Joseph Mahon PT  
**Referring Practitioner:** Bradley Bley DO

**Provider:** Joseph Mahon PT  
**Provider Email:**

# Medical Diagnoses	ICD9
N/A	

# Treating Diagnoses	ICD9
1) Concussion with no loss of consciousness	850.0
2) Cervicalgia	723.1
3) Headache	784.0

## Reason For Referral

Pt arrived 15 minutes late without paperwork.

Pt presents today with primary complaints of headache, neck pain, and dizziness. On May 8th, 2014 (32 days ago) the patient was involved in a motor vehicle accident. She was stationary, at a red light, and was hit from behind. She notes that the accident was a hit and run. She is unable to accurately state how fast the vehicle that struck her car was driving. She states that her airbag did not go off. She states that she did not lose consciousness. After the collision she felt a headache immediately and was described as "overwhelming." She also had strong neck pain. She is unable to fully recall if she felt dizzy at the scene because the headache and neck pain were so strong. She says the entire feeling felt "like an out of body experience." She does not recall if she hit her head or whiplash moment only. She states there was no bleeding or bruising. She did not go to the emergency room that night. She says that despite the strong pain she thought that a hot shower and rub on creams would resolve her symptoms. The following morning she woke up and her headache and neck pain were worse than the night of the injury. At that time she went to an Urgent Care center and was given muscle relaxers and Ibuprofen. Additionally she was given instructions to take rest breaks from all activity every hour. She notes that at the urgent care her BP was alarmingly high, around 190/90. No imaging was taken of her brain or cervical spine at the urgent care center. After a couple of days her symptoms became "unbearable" at which time she went to Christiana Care emergency room. While there she received a CT scan of her head and neck. She did not receive X-Rays while at Christiana Care emergency room. She notes that the CT scans were negative except for "mild arthritic changes" in her cervical spine from an old injury. After her emergency room visit she was given stronger pain meds and more muscle relaxers. She followed up with her primary care physician, Dr. Yeargon, who then sent her to physical therapy at ATI in Bear. This was 5 days after the initial accident. Her treatment consisted of soft tissue massage, manual traction, and joint mobilization. Her initial session was not overly bothersome however she states the treatment became too aggressive for her and lead to large increases in pain that would last two days and leave her "debilitated." She stopped going after two weeks due to high pain levels.

She notes that she was in a car accident in 2002 that resulted in a fracture of her C6-C7 lamina. This resulted in a 4 day hospitalization as well as wearing a cervical collar for 2 months. She thinks that she also had a concussion during this incident however she is unable to truly recall any concussion like symptoms due to hospital stay. She notes that if she did have some symptoms they were nowhere near as severe as what she is currently experiencing.

Smoke: 1/2 pack a day depends.

Drinking: No.

Do you have a family history of disease? Type 2 diabetes

History of surgeryAppendectomy: 1980's Tosilectomy: 1980

## Medical History

**Prior & Existing Conditions:** Anxiety, Depression, Dizzy Spells, Headaches, High Cholesterol, High/Low Blood Pressure, Smoking, Thyroid Disease, Vision Problems

**Additional Information:** Anxiety began with symptoms (no current treatment), Depression began with symptoms (no current treatment), Dizzy spells began with accident, Headaches with accident, High cholesterol (on meds and managed by pcp), High blood pressure (was high after accident due to pain and has resolved), Thyroid (Not sure if hypo or hyper, on meds, managed by pcp), Vision (glasses, increased blurring since accident). Nausea (began with accident).

**Surgical History:** Tonsillectomy in January 1980. Appendectomy in January 1980

**Fall History:** Patient has **not** been injured by a fall in the past year. Patient has **not** had two or more falls in the past year. Patient is **not** at risk for falls.

**Medications:**

Flexeril, 2.5mg, Once daily, Orally. Reason taking: pain/sleep aid.  
 Synthroid, unknown, Once daily, Orally. Reason taking: Thyroid.  
 Lipitor, 10 mg, Once daily, Orally. Reason taking: High Cholesterol.  
 Tylenol, unknown, PRN, Orally. Reason taking: pain.

**Measures**

The following measures were identified for the patient's **Neurological** condition:

Measure	Current (06/09/2014)	Target
<b>Walking short distances (symptoms)</b> Walking short distances without symptoms	Moderate problem: Can walk (11 to 100) yards without symptoms	<i>No problem: Able to walk &gt; 500 yards without symptoms</i>
<b>Housework</b> Performing home cleaning and maintenance	Negligible participation: Impairments prohibit housework	<i>Full participation: Housework is unlimited</i>
<b>Gardening</b> Moving around within a garden - creating and maintaining it	Negligible participation: Impairments prohibit gardening	<i>Full participation: Gardening is unlimited</i>
<b>Put on and take off footwear (intensity of dizziness)</b> Intensity of dizziness with bending forward to put on and take off footwear	Severe dizziness: 6/10 to 9/10	<i>No dizziness: 0/10</i>
<b>Headache (episodes/week)</b> Percent of time experiencing headache during the past week	Daily	<i>No impairment: Has headache (0 to 4) % of time</i>
<b>Dizziness (at worst)</b> Highest level of dizziness during the last 24 hours	Severe dizziness: 8/10	<i>No dizziness: 0/10</i>
<b>AROM (cervical left rotation)</b> Cervical left rotation active range of motion	60°	<i>No impairment: &gt; 75° of rotation</i>
<b>AROM (cervical right rotation)</b> Cervical right rotation active range of motion	60°	<i>No impairment: &gt; 75° of rotation</i>
<b>AROM (cervical left sidebending)</b> Cervical left sidebending active range of motion	25° Pain on R.	<i>No impairment: &gt; 45° of left sidebending</i>

<b>AROM (cervical right sidebending)</b> Cervical right sidebending active range of motion	30° Pain on R	<i>No impairment: &gt; 45° of right sidebending</i>
<b>AROM (cervical flexion)</b> Cervical flexion active range of motion	40° "tightness on R"	<i>No impairment: &gt; 55° of flexion</i>
<b>AROM (cervical extension)</b> Cervical extension active range of motion	50° Reproduction of headache and R. neck pain	<i>No impairment: &gt; 65° of extension</i>

**Additional Evaluative Findings**

**CONCUSSION**

HR (bpm): 85  
HR (regular/irregular): regular  
BP (mmHg; seated):138/78  
SpO2 (%): 97  
BMI (kg/m2):

Date of Injury:May 8th, 2014  
MOI: Motor Vehicle Accident  
Immediate Medical Management:

Post-Concussive Sx (>/=3 for > 6 weeks for Dx of Post-Concussive Syndrome) (N. Less than 6 weeks)

Headaches: Y

Dizziness: Y

\*Sensitivity to Light/Sound (if Yes, indicate which one(s)): Yes both.

Noise Intolerance: yes

\*Concentration Difficulty (Altered speech/Word-finding): Feels frustrated when trying to think due to difficulty focusing. Feels her overall organization is off.

\*Memory Changes: Yes, difficulty finding password.

\*Emotional Disregulation/Lability: No, Generally in a bad mood

\*Depression: Yes, she feels annoyed that she cannot take care of her obligations because of her symptoms. She feels "down" in general because no matter what she does, she is having symptoms.

Fatigue: Regardless of the amount of sleep she gets she still feels exhausted throughout the day. Everything is an effort and she cannot accomplish anything. Laying on the couch and watching television is a chore.

Insomnia: No. Difficulty sleeping at times but more due to pain.

Reduced Alcohol Tolerance: Does not drink

[\*Requires comment in the Assessment for weekly monitoring]

Physician (if multiple, list with roles): Dr.Bley is managing her concussion at this time. Dr. Yeargon is her primary care physician. sent to PT ATI in Bear 5 days after the accident. Massage of the neck (tolerable), second visit: was still tolerable. Following week "more aggressive" manual traction and aggressive STM causing pain for two days that would resolve and then return after more treatment. The impact of PT was debilitating. She went to two weeks of physical therapy.

Next MD visit (with whom): Dr Bley July 11th,

Medications: Extra Strength Tylenol PRN. Flexeril 2.5 mg at night.

Baseline Concussion Testing (Y/N): N

ImPact Testing (Y/N; where; when): N

SCAT-2 (Y/N; where; when): N

Other Diagnostic Testing (Y/N; where/when/results):

Radiographs (c-spine): No

CT scan: Yes

MRI: No

Vestibular testing: No

MD Restrictions : MD instructions are to do what you can do.

Working (Y/N): Yes

Occupation: Works as an accountant. Works in Northern NJ takes 2-4 hours to drive there. She does note that driving can trigger her headaches and dizziness.

Work Requirements:

A typical work day could be all day looking at a computer screen, creating calculations in a spread sheet and looking at numbers. She spends most of her day sitting. Her computer screen is wide. She has a "cheap chair" with poor arm rests. She does not have a key board tray. She does spend most of her time leaning forward to look at her screen. She is actively looking for a better chair. She spends a significant amount of time looking to her left to read numbers and then looking back towards the screen to type them.

Cleared for return to work (Y/N) Y

PMHx (prior concussions with timeframe & sx) (Y/N): Y (2002, unable to recall symptoms from concussion due to neck fracture)

Hx of motion sickness: N

Personal Hx of migraines: N

Family Hx of migraines: N

Learning Disabilities: N

HEADACHES (HA) [If no improvement with trial of treatment, will refer to MD.]

Rating (0-10; note what makes better/worse)

Current: 3/10 with Tylenol

Best: 3/10 with Tylenol

Worst: 8/10

Immediate/Delayed Onset: Immediate at impact.

Better/worse/status quo since concussion: slightly better, in terms of initial impact, however not much change otherwise.

Frequency of HAs: daily

Duration of HAs: With pain meds and lying down, 20-30. If she does not take Tylenol and lay down it does not go away.

Location of HA: Across front bilaterally.

Side-shift (N): Always frontal and bilateral

Triggers (light, noise, alcohol): Staring at computer for an hour. Noise (motorcycle drove by). Anything that creates tension in her neck increases headache and vice versa. Two examples are driving and computer work.

HA PMHx: Sinus occasionally.

DIZZINESS [Requires vestibular consult visit 2.]

Rating (0-10; note what makes better/worse):

Current: 5/10 woozy.

Best: 1/10 (rest helps to resolve symptoms)

Worst: 8/10 driving, bending forward to tie shoes. Grocery Shopping. "Nothing else in particular."

Immediate/Delayed Onset: Immediately (calmed down as she calmed down but did not resolve.)

Better/worse/status quo since concussion: same to worse

Select descriptor(s)-e.g. vertigo (i.e. spinning), fogginess, lightheadedness, motion sickness, unsteady/disequilibrium:

Sometimes vertigo (if bend head forward to tie shoes and comes back up), foggy, lightheaded, motion sickness, a little bit unsteady.

Dizziness Triggers (e.g. positions/noise/light):

Description of 1st episode of dizziness: Felt like she was going to pass out, nausea. not so much spinning.

Description of subsequent/current episodes of dizziness: woozy, spinning, nausea.

PMH of similar dizziness sx: N

Falls History:N

Vision Issues (Y)

Diplopia: N

Blurred: Y

Oscillopsia (i.e. jumpy): Initially, she was having B eye twitching, rarely feels it any more. Was constant for the first few days.

Hearing Issues (Y)

Tinnitus: Yes, relatively constant.

Hearing Loss: N (pt denies)

NECK PAIN

Rating (0-10; note what makes better/worse):

Current: 7/10

Best: 2/10 with heating pad and tylenol

Worst: 8/10

Immediate/Delayed Onset: Noticed neck pain immediately, "thought a hot shower, couple of Advil would resolve pain" but it did not. Neck pain from original car accident in 2002 did resolve.

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