

Independent spine review

How a report separates documented facts, competing explanations, and unanswered questions.

Purpose: This illustrative excerpt demonstrates organization and source citation. Every record, date, finding, and source identifier in this example is invented. It is not an actual retained matter, a signed expert opinion, a treatment recommendation, or a completed jurisdiction-specific disclosure.

Question presented

In a fictional lumbar decompression matter, what does the supplied record establish about a newly documented postoperative motor deficit, and what additional material is needed to evaluate its cause and the response to it?

Material supplied

The entire fictional packet is reproduced on page 3: F-001 preoperative assessment, F-002 operative note, F-003 recovery-room entry, F-004 postoperative imaging report, and F-005 day-one progress note. These identifiers are demonstration labels, not actual production Bates numbers.

Documented sequence

Before surgery: The assessment records left leg pain and left ankle dorsiflexion strength of 5/5. [F-001]

Operation: The operative note describes left-sided lumbar decompression and reports no recognized complication. It does not establish what every omitted source would show. [F-002]

Recovery: A new entry records dorsiflexion of 3/5 and notification of the surgeon. The packet does not include the call record or a complete serial examination. [F-003]

Later that day: The radiology report describes postoperative changes and no large compressive collection. Original images are absent. [F-004]

Day one: Dorsiflexion is recorded as 4/5, with persistent numbness. [F-005]

What can be stated from this packet

The documentation shows a change between the preoperative and recovery-room strength entries and a later improvement in the recorded grade. [F-001, F-003, F-005] The packet does not establish whether differences in examiner, testing conditions, or timing affected those measurements.

What remains unresolved

Mechanism: The temporal sequence identifies a question for investigation. It does not by itself identify the mechanism of injury or establish that the operation departed from accepted practice. The operative account, original imaging, anesthesia record, complete neurological examinations, and subsequent course would need review. [F-001-F-005; missing-material inventory]

Response: Notification is documented, but the exact notification time, assessment time, instructions, and serial findings are incomplete. A response interval cannot be reliably calculated from these excerpts. [F-003, F-005]

Imaging: The supplied report addresses a large compressive collection; it does not resolve every possible explanation for a deficit. The images have not been supplied or independently reviewed in this fictional example. [F-004]

Balanced assessment

The newly recorded weakness warrants explanation. The improving strength entry and the reported absence of a large compressive collection also belong in the analysis. Neither the adverse finding nor the later improvement alone resolves standard of care, causation, permanence, or apportionment. [F-003-F-005]

Additional material and opinion status

Request the original imaging, complete perioperative and anesthesia records, serial neurological examinations, communication timestamps, relevant baseline records, and later follow-up. Then evaluate the care in its actual clinical context and against applicable medical literature and practice at the relevant time.

No ultimate opinion is expressed. A real report must explain the expert's own reasoning, account for contrary evidence, identify assumptions and limitations, and satisfy the disclosure requirements applicable to that engagement. This example supplies no signature or assertion of admissibility.

Invented source excerpts

All five excerpts below were created solely for this illustration. There are no real people, institutions, medical records, or patient identifiers.

F-001 | Preoperative assessment | Day 0, 07:10

Adult patient reports persistent left leg pain. Left ankle dorsiflexion recorded as 5/5. Planned procedure: left L4-L5 decompression. This excerpt does not include the full history, examination, or original imaging.

F-002 | Operative note | Day 0, 10:20

Left L4-L5 decompression completed. No complication recognized in the operative note. The excerpt contains no anesthesia details, neurological monitoring record, or image attachments.

F-003 | Recovery-room entry | Day 0, 11:30

Left ankle dorsiflexion recorded as 3/5. Patient reports increased numbness. Entry states: surgeon notified. Exact notification time, instructions, and repeat assessment are not included.

F-004 | Radiology report | Day 0, 15:40

Postoperative lumbar MRI report describes expected postoperative changes and no large compressive collection. Original MRI images are not included in the demonstration packet.

F-005 | Progress note | Day 1, 08:00

Left ankle dorsiflexion recorded as 4/5. Numbness persists. No later follow-up, permanent impairment determination, or functional assessment is supplied.

Source-accounting check: Five invented source excerpts supplied; five identified in the review. Missing real-world record categories are explicitly identified on page 2. Page accounting is separate from clinical interpretation.