SAMPLE DOCUMENT. This memo illustrates the format and depth of a standard merit screen. The case described is a **composite constructed for illustration** — it is not a real patient, not drawn from any actual medical record, and contains no protected health information.

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Merit Screen Memorandum

Emergency Department / Urgent Care Standard-of-Care Assessment

To: [Retaining Counsel]

From: Joshua Dumoch, PA-C — Emergency Medicine

Date: [Date]

Re: Composite Case A — delayed diagnosis of perforated appendicitis following ED discharge

Materials: ED record, index visit (14 pp.); ED and admission records, return visit (63 pp.); operative report; nursing flowsheets both visits. 77 pages total.

Bottom Line

> There is a **documented reassessment and documentation failure at the index visit** that a reviewing clinician would identify as falling below the standard of care. It is real and it is defensible to plead.
>
> However, **causation and damages are materially weaker than the liability picture**. The presentation was genuinely atypical, and on the records provided the patient appears to have recovered without long-term sequelae. Before committing to a full expert review, I would want the three items listed under "What's Missing" below — particularly the post-operative course. If those come back unremarkable, this is a case with a defect but limited value.
>
> **Recommendation:** proceed to records supplementation, not yet to full expert workup.

Key Findings

1. **No documented reassessment after treatment.** The patient received IV fluids and analgesia over approximately three hours. The physician note contains a single abdominal exam, timed to arrival. There is no documented repeat abdominal examination prior to discharge. Reassessment of an undifferentiated abdominal pain after analgesia is a basic expectation in emergency practice, and its absence is the strongest single finding in this record.
2. **Nursing and physician documentation conflict at discharge.** The nursing flowsheet records pain of 8/10 at the time of discharge. The physician note states symptoms were "improved." Nothing in the chart reconciles the two. This kind of internal contradiction is the sort of thing that becomes disproportionately significant later, because it undercuts the discharge decision on its own terms.
3. **An abnormal laboratory value is not addressed in the medical decision-making.** The white blood cell count was mildly elevated. The MDM section does not mention it, does not explain why it was considered non-contributory, and does not document any reasoning about it. An abnormal result that goes unaddressed in the reasoning is materially different from one that is considered and dismissed with a stated rationale.
4. **Right lower quadrant tenderness appears in the nursing assessment but not the physician exam.** The triage nursing note documents tenderness in the right lower quadrant. The physician's documented exam describes diffuse tenderness without localization. Appendicitis does not appear in the documented differential at any point.
5. **Return precautions are generic.** Discharge instructions are a standard gastroenteritis template. There is no documentation of condition-specific return precautions or of a discussed diagnostic uncertainty, which is the customary way of managing an undifferentiated abdominal pain discharged without imaging.

Where the Case Is Weaker Than It First Appears

I would be doing you a disservice to present only the findings above.

- **The presentation genuinely pointed away from appendicitis.** The documented history includes several episodes of diarrhea, which is more consistent with a gastrointestinal illness and is a recognized reason clinicians move appendicitis

down a differential. A defense expert will make this point, and it is a fair one. The failure here is better characterized as inadequate reassessment and documentation than as an obviously missed diagnosis.

- **The causation question is not answered by these records.** The interval between discharge and the return visit is approximately three days. Whether earlier diagnosis would have prevented perforation, or merely moved it earlier in time, is a question that requires the operative findings interpreted alongside the post-operative course. The operative report describes perforation with abscess, but perforation timing cannot be reliably established from it alone.
- **Damages appear limited on the available record.** The patient underwent laparoscopic appendectomy with washout and, on the records provided, had an uncomplicated post-operative course. Absent extended hospitalization, reoperation, or documented long-term complication, the value of this matter may not justify the cost of a full expert workup and a testifying expert.

What's Missing From the Record

Three items would materially change my assessment, in order of importance:

1. **Complete post-operative and follow-up records**, including any readmission, wound complication, or subsequent surgical intervention. This is the single item most likely to change the value of the case.
2. **The ED audit trail for the index visit.** The timing of chart access and order entry would establish whether the documented single examination reflects what actually occurred, or whether a reassessment took place and simply was not charted. Those are very different cases.
3. **The actual discharge instruction document as provided to the patient**, rather than the template reference in the chart, along with any patient-signed acknowledgment.

If You Proceed

A full record review would develop the reassessment failure into a documented standard-of-care analysis, address the diarrhea point directly rather than leaving it to the defense, and give you a defensible position on the timing of perforation. I would estimate that work at four to six hours once the supplemental records are in hand. Half of this screening fee is credited toward it if engaged within sixty days.

If the post-operative records show an uncomplicated recovery, my honest recommendation would be to decline the matter rather than develop it further.

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