

THE "PI" ATTORNEY UPDATE

BRINGING YOU THE LATEST RESEARCH IN THE AREA PERSONAL INJURY LAW & CHIROPRACTIC

A Free Publication of East Gate Chiropractic & Wellness

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THINGS TO KNOW WHEN QUESTIONING A DEFENSE ACCIDENT RE-CONSTRUCTION EXPERT

One of the more challenging jobs of the PI attorney is attempting to prove injury in low impact accidents. Compounding the problem at trial is that many of these collisions appeared to be non-injury crashes until a few hours or on occasion days after the police have left

It is not uncommon for the accident either to be not investigated, or investigated only superficially. **This is especially true in collisions where the property damage is minor.** Additionally many times the only information available is the statements of the parties involved and the medical data.

Reliance on vehicle damage alone to determine the severity of a collision is invalid. Discounting injuries based on lack of vehicle damage is not supported by either the laws of physics or the empirical data available.

Even with repair estimates it is difficult to ascertain anything less than a minimum impact speed. If damage is visible, a reasonable minimum is a 10 m.p.h. impact speed. If damage extends beyond the bumper, 15 m.p.h. is a reasonable minimum impact speed. It is rare to have an impact speed as high as 20 m.p.h. with no damage. **However, the absence of visible damage in a poor photograph is not the same as there being no damage.**

Another source of information that can be used, and is often overlooked, is frame or unibody damage. **This is often the first damage that is visible in a rear impact and is captured in the repair estimates only a fraction of the time.** It can be inferred through physical inspection of the vehicle and proven with inexpensive laser measurements. **It is usually not visible in photographs taken by insurance companies.**

Every year the IIHS, an insurance industry funded group, runs numerous crash tests of vehicles into barriers at low speed. The IIHS then publishes

the results as an indication of how much damage a vehicle will incur in a low speed collision. Usually these tests are run at 5 m.p.h. into walls or poles. Many times a reconstructionist for the defense will attempt to compare the damage in a vehicle-to-vehicle collision with the damage in an IIHS test.

Based upon the principle of conservation of energy, this will grossly underestimate the actual collision speed. IIHS barrier test data does not reflect the performance of actual bumpers in vehicle-to-vehicle collisions. **The data only provides information on how bumpers will perform when running into walls.** It is worth noting that the IIHS implies that the reason they run barrier tests is to ascertain the performance of bumpers in vehicle-to-vehicle collision. Their web site^{ix} has the following statement;

Bumpers should protect car bodies from damage in low-speed collisions, the kind that frequently occur in congested urban traffic. But many don't. The Institute assesses performance using the costs of repairing vehicle damage in a series of four crash tests at 5 mph -- front-and-rear-into-flat-barrier, front-into-angle barrier, and rear-into-pole.

IIHS does not test bumpers under conditions that match their implied goal. Their data does not establish the actual performance of bumpers in vehicle-to-vehicle collisions. **The data collected by the IIHS has no relevance in determining the impact speed in a vehicle-to-vehicle collision, although it is commonly used in litigation in support of the insurance companies that fund the IIHS.**

A misconception often propagated is that if a vehicle has a 2.5 m.p.h. bumper and the bumper is not damaged, the impact speed was under 2.5 m.p.h. **This is a misapplication of the bumper standards.** The standard establishes the conditions under which bumpers cannot be damaged. **It does not establish the standard under which a bumper must be damaged.**

It is worth noting that the design of modern bumpers often prevents the direct observation of bumper damage without physical removal of the bumper.

Other errors (tricks) that are often seen include the use of bumper isolators and photographs to determine speeds and ignoring foam core bumper damage. Isolators are often used to assert a maximum impact speed. **However, they only have some applicability in determining minimum impact speeds.**

A study reported in the LA Times¹, shows that cars are sustaining more than just bumper damage in 3

mph collisions. Grills, hoods and tenders are also sustaining damage. You can now use this study to cross-examine defense "experts." These experts opine about the force of impact and speed of the vehicles based solely on the amount of damage. Well, if an Infiniti sustains \$5,200 in a 6 mph collision, how fast was the collision if there is \$2,500 in damage? Slower? Faster? You don't know because there are many more factors that come in to play. Two other points to keep in mind: Most cars do not have steel reinforced bumpers like they did 10 years ago. And with more cars, the bumper is being designed into the body of the vehicle so there is no bumper.

In your next MIST case, make sure you ask the defense expert about this report. My guess: he has never heard of it! (*more on MIST next month*)

1. Vartabedian, , Ralph Flimsy bumpers in low-speed crashes can result in costly repairs Los Angeles Times November 7, 2007

THE ATTORNEY AND CHIROPRACTOR

The truth is that most MIST patients end up at a chiropractor. And when they do, the chiropractor has all kinds of standard forms to fill out, just like when the patient goes to an MD. The one big difference: **the chiropractor always asks who the attorney is on the file.** And they usually get this information right next to some very good information about the accident. The downside: the form can become problematic. If you send in a form that lists you as the attorney, the adjuster will immediately conclude, rightly or wrongly, that either you referred the client to the chiropractor or the chiropractor referred the client to you. Under either situation, the case may now have less settlement value.

The solution: ask the chiropractors to put the attorneys information in a separate spot or on a separate form. This will allow you to send in the intake form without worrying about the adjusters faulty conclusions. Although even this form in most cases may become discoverable

CHIROPRACTIC "SUBLUXATION" LEADS TO \$105,000 AWARD

The case focused solely on the injuries to a 45-year-old male resulting from a "T-Bone" type automobile collision. The primary factual issue was whether the patient had sustained an exacerbation of pre-existing, asymptomatic degenerative disc disease in the cervical spine as a direct and proximate result of the collision.

Following the collision, the patient was transported by ambulance to the hospital where cervical spine films were taken and interpreted as "normal." The radiologist indicated in his report that there appeared, "mild degenerative disk narrowing at C5-C6 and C6-C7." This is a very common finding. Films of the chest showed fractures of four ribs with minimal displacement.

The patient was discharged from the hospital with a clinical diagnosis of left rib fractures and pulmonary contusion. No mention was made in any record as to any injury to the spine.

Within a week, the patient was seen by an internist who kept the patient under observation for the next eight weeks, then discharged him. No treatment was rendered with regard to the cervical or thoracic spine. Medical records made no mention of any complaints by the patient about to neck or back pain. After being discharged, the patient did not receive treatment from anyone for six months.

The patient was told by the internist that he had reached maximum medical improvement; further, that any "discomfort" that he might occasionally feel would subside in time. **Eight months after the collision, the patient entered the care of a chiropractor complaining of neck and back pain, bilateral numbness in his arms and headaches.**

The patient explained that he could no longer tolerate the pain, which by that time had become disabling. The chiropractor treated him for about one year, during which time the patient showed good results, however the plaintiff's attorney realized that, in order to prove the pain his client suffered was caused by the accident, opinion testimony had to be persuasive, supported by a broad foundation of empirical evidence. The defendants called an orthopaedic surgeon who had conducted a medical examination of the patient shortly before trial, his testimony was that the patient had sustained merely a "transitory aggravation" of pre-existing degenerative disc disease and, due to the eight-month lag in treatment, no chiropractic treatment was reasonable or necessary.

The surgeon placed heavy emphasis on the fact that no nerve root compression was apparent. The **opinion of the treating chiropractor, however, was that the patient had sustained a permanent exacerbation of pre-existing cervical degenerative disc disease as a result of the automobile collision,** arguing that the exacerbation not only made the pre-existing condition symptomatic, it had also accelerated the degenerative process.

Proving this latter point was pivotal to the case because it took the judges out of the realm of deciding the case solely on the word of one doctor over the word of another as to the presence of pain. By proving the presence of the subluxation complex and measuring the changes of that condition in objective terms, the focus would be away from a qualitative and somewhat argumentative evaluation and more toward a quantitative, objective analysis.

Evidence that the collision had "made active" the patient's pre-existing disc disease logically fit the

Vertebral Subluxation Complex Model described by Lantz.¹

Static and video fluoroscopic film and precise inclinometric readings established kinesiopathology. Neuropathology and myopathology was graphically depicted and proven by surface electromyographic findings and neuromotor deficits and demonstrated permanent impairment at maximum clinical improvement with the results of computerized muscle testing.

After introducing into evidence all prior medical, employment and military records and all plain and videofluoroscopic films, the chiropractor testified that he had reviewed all medical records and had viewed all films, in particular the plain films taken on the night of the collision.

He then testified that he concurred with the findings of the radiologist, showing the panel what the affected area looked like by pointing on the films to the disc space narrowing at C5-C6 and C6-C7.

The patient's prior medical records had no reference to spine pain or problems. The treating chiropractor testified that he had reviewed these records, and then compared his initial observations and impressions of the patient's demeanor and apparent attitudes, noting that the patient consistently minimized his complaints of pain and discomfort. The doctor had obtained a history and noted that it was consistent with past medical records.

The doctor then testified as to the results elicited by the Oswestry pain questionnaire and compared the responses with the clinical examinations that he performed on the patient. He gave detailed testimony on the results of specific tests he performed on the patient throughout the course of the patient's care.

Of crucial importance was the results of various outcome assessments. Detailed testimony recorded that the doctor followed the standards set forth in the *AMA Guides to the Evaluation of Permanent Impairment* and conducted each range of motion test three times, utilizing a fluid-filled inclinometer. He showed the judges what such a device looked like and demonstrated its use. The patient's ranges of motion were stated in specific numerical values followed by a line of questions pertaining to the significance of the findings. This was in sharp contrast with the testimony of the orthopedist, who also stated that he had obtained range of motion findings but failed to utilize either an inclinometer or goniometer. He testified that his years of experience gave him the benefit of a "critical eye."

Through a series of questions by plaintiffs counsel, the treating chiropractor related the results of his clinical examination and results of range of motion tests and computerized muscle testing with plain and videofluoroscopic films. He identified the specific anatomical structures which were affected in the collision.

He described the various forces which came to bear upon the patient's spine during the collision all the while pointing to a model of the human spine and anatomical charts of the body.

The doctor then compared the plain film obtained on the night of the accident with the first film he took of the patient's cervical spine eight months later showing an identical loss of cervical lordosis. Of significance was the report of a radiologist interpreting the videofluoroscopy which indicated sclerotic changes which were not apparent in the plain films taken on the night of

The most remarkable aspect of this case was the lack of emphasis placed upon pain. Focusing merely on the issue of pain -- a subjective reaction which is difficult to prove or disprove -- creates little more than a guessing contest for the judges, who are often misled by irrelevant factors rather than the merits of the case.

While pain was a very significant factor in this case, this case did not focus merely on pain. It focused upon a clear demonstration and explanation in biomechanical terms of exactly how the patient's pre-existing condition was affected by the collision.

A fundamental principal of persuasion was adopted throughout the presentation of evidence:

(1) People will believe only that which they can understand.

(2) In order for it to be understood, it must be seen.

(3) Seeing is believing.

It became apparent that the patient had suffered a permanent insult which was considered by all to be painful and the award of \$105,000 was made by an unanimous panel.

(1) Charles A. Lantz, *ICA International Review of Chiropractic*, Sept/Oct 1989.

The case was Bret J. MacDermott, D.C., of Des Moines, Wash. Zoro can be contacted at 2150 112th Ave. NE, Bellevue, WA 98004, 206-637-3048

THE QUESTION OF PALLIATIVE TREATMENT

If your client has been treating with a chiropractor for six months or more, defense counsel will point out in examining the doctor that despite thousands of dollars worth of treatment, the patient is still not better. Normally chiropractors handle these questions by stating that their treatment allows a patient to stay at a certain plateau and not get worse. A better approach is to have the chiropractor discuss how these treatments enable clients to continue work and try to function normally without becoming dependent on pain medication. The theme here is that a natural way of dealing with pain is preferable to masking it with chemicals. This is a theme that a jury will accept.

CHIROPRACTIC "ONLY PROVEN EFFECTIVE TREATMENT" FOR CHRONIC WHIPLASH

A study published in the *Journal of Orthopaedic Medicine*¹ not only points out the superiority of chiropractic care for chronic whiplash patients, but also examines which chronic whiplash patients respond best to chiropractic care. The authors begin the paper by explaining that:

"Conventional treatment of patients with whiplash symptoms is disappointing.

"A retrospective study by Woodward et al., demonstrated that chiropractic treatment benefited 26 of 28 patients suffering from chronic whiplash syndrome."²

The question was not whether chiropractic was beneficial for acute whiplash patients, but to determine "which patients with chronic whiplash will benefit from chiropractic treatment."

The authors interviewed "100 consecutive chiropractic referrals for chronic whiplash symptoms," seven of which were "lost to follow up." They were able to divide the remaining 93 patients into three symptom groups:

Group 1: patients with "neck pain radiating in a 'coat hanger' distribution, associated with restricted range of neck movement but with no neurological deficit";

Group 2: patients with "neurological symptoms, signs or both in association with neck pain and a restricted range of neck movement";

Group 3: patients who described "severe neck pain but all of whom has a full range of motion and no neurological symptoms or signs distributed over specific myotomes or dermatomes." These patients also "described an unusual complex of symptoms," including "blackouts, visual disturbances, nausea, vomiting and chest pain, along with a nondermatomal distribution of pain."

The patients underwent an average of 19.3 adjustments over the course of 4.1 months (mean). The patients were then surveyed and their improvement reported as follows:

Group 1

24% - Asymptomatic
24% - Improved by Two Symptom Grades
24% - Improved by One Symptom Grade
28% - No Improvement

Group 2

38% - Asymptomatic
43% Improved by Two Symptom Grades
0% - Asymptomatic

Group 3

9% Improved by Two Symptom Grades
18% Improved by One Symptom Grade
64% No Improvement

9% Got Worse

In their discussion, the authors made these observations: "Woodward, et al.,² found improvement in chronic symptoms in 26 of 28 patients (93%) following chiropractic treatment. Our results confirm the efficacy of chiropractic, with 69 of our 93 patients (74%) improving following treatment.

The Woodward study suggests that such a group of nonresponders does exist, represented by group 3. The defining characteristics of patients in this group were the full range of neck movement in association with neck pain, bizarre symptoms, female sex and ongoing litigation. The mean age of the group at 29.5 (16-43) was lower than that of the other two groups (mean 36.8, range 18-65).

The results from this study provide further evidence that chiropractic is an effective treatment for chronic whiplash symptoms. However, our identification of a group of patients who fail to respond to such treatment, highlights the need for a careful history and physical examination before commencing treatment.

1. Khan S, Cook J, Gargan M, Bannister G. A symptomatic classification of whiplash injury and the implications for treatment. *Journal of Orthopaedic Medicine* 1999;21(1):22-25.

2. Woodward MN, Cook JCH, Gargan MF, Bannister GC. Chiropractic treatment of chronic whiplash injuries. *Injury* 1996;27:643-645

About Leonard F. Vernon, DC

photo