



Dynamic Chiropractic – January 14, 2003, Vol. 21, Issue 02

CAD: Common Questions and Answers

By Arthur Croft, DC, MS, MPH, FACO

Twenty-one years: It seems like a long time, yet it also seems like only yesterday that I decided the investigation of the whiplash phenomenon (cervical acceleration/deceleration, or CAD injury) would be my life's work. It is also truly incredible how far we have come in that short history. Compare our current understanding of injury mechanisms, sources of pain and other symptoms, diagnostics and management with those of 1982, and you realize that this is one of the most rapidly advancing fields of science in health care. Of course, it is also one of the most important, since CAD trauma costs society many billions of dollars annually and holds an important distinction among its peers in the arena of public health burden: it is, in large measure, preventable.

At the suggestion of my wife, Holly, who watches me answer hundreds of e-mail postings from fellow DCs each week, I'm presenting a few of the more common questions I receive and the answers I usually give.

Q: Please advise on how to respond to the following comments from a peer reviewer:

1. According to the *Mercy Guidelines*, therapy should not exceed 12 weeks.
2. According to the Quebec Task Force, after 12 weeks of care, the patient should be sent for a multidisciplinary consultation.
3. In the reviewer's experience, care shouldn't have been provided for more than about 24 weeks at most.
4. The reviewer finds it difficult to understand how any patient could require care for 34 weeks.

A:

1. The *Mercy Guidelines*, on page xxxiv, claims that one of its purposes is to provide a *guideline*, as opposed to rigid standards by which outside agencies can judge the practice of individual practitioners. My interpretation is that the guidelines are merely a stepping-off point - not something to be used for peer review purposes. Thus, the peer reviewer has violated the spirit and intent of the very document he

cites. Secondly, and more to the point, *Mercy* did not, in any section or in any way, discuss whiplash injuries, period.

2. The Quebec Task Force stated if the patient had not returned to his or her "usual activities" (defined as either work or school) after 12 weeks, a multidisciplinary consult was called for. Temporary, total disability is an important qualifier here, since very few U.S. CAD patients are out of work for more than 12 weeks. If they are at work or school, the QTF-WAD guidelines simply do not apply.
3. Although we might be tempted to inquire as to what the reviewer's actual experience is in treating these patients, the key point is that nobody is interested in his or her unqualified judgments about probabilities in terms of likely periods of care. It is unethical to discontinue care based merely on statistics. Even if 99 of 100 individuals with a given condition would have recovered after a certain amount of time, this arithmetical fact does not justify the termination of care for the one individual who requires more care. What we are interested in is simply whether or not care was justified. The reviewer should decide the question by examining the treating doctor's clinical notes and any other relevant documents in the case. He or she might also be reminded that the *Mercy* document instructs practitioners that, ultimately, it is the patient who is the guide to care decisions.
4. The fact that the reviewer finds it difficult to understand why a person might require longer periods of care is either an indication of his or her lack of qualifications for conducting peer reviews in the first place, or evidence of the common bias shared by doctors employed by insurers. If the reviewer has never seen patients require such care, he or she probably has little practical clinical experience and is probably not familiar with relevant outcome literature. (Of course, it is incumbent upon the treating doctor to maintain good notes, so that someone reading them can make the right decisions about the appropriateness of care.)

Finally, the doctor's patient was a grade-3 CAD injury, and her treatment did, in fact, fall within the guidelines I developed years ago, which have now been adopted, recommended or endorsed by at least a dozen U.S. states and the Canadian Chiropractic Association, and are the only guidelines developed specifically for chiropractic care of CAD patients. Interestingly (or perhaps conveniently), there is no mention of these guidelines by the reviewer in the above case.

Q: I'm going to trial tomorrow on a side-impact case. [The doctor provides case details.] What papers should I read to get me ready for this trial?

A: [A similar question would be: "Is there any research on children riding in the back of a trailer that blows off the road at night, lands in a ditch, and leaves the child with tremors and alopecia?" I'm tempted to respond, "Yes, there are several dozen papers on this very mechanism of injury, but, unfortunately, they're all in Russian."]

OK, here's the deal:

1. Since every case has subtle and not-so-subtle differences, and since there are dozens of side-impact-related papers, I wouldn't know where to point you without knowing more details of the crash and the subject's injuries. (And, of course, I don't have time to read all of the records.) Moreover, what are the key issues in the case? These can also affect which literature you cite.
2. Even if I could send you a dozen references to papers I thought would be helpful, you wouldn't have time to digest them before trial tomorrow. (Incidentally, copyright law prohibits us from providing papers, anyway. These should be obtained through school libraries or via Internet sources such as PubMed.

The big message here is, **plan ahead**. There are books, tapes, computer programs, formal training programs, and lots more that can help you develop your skill in personal injury cases. But nobody can get you "up-to-speed" on this complicated issue overnight. Sorry - there are no shortcuts. (The sad part is that the doctor will probably give a poor showing in trial and the plaintiff will likely end up with little or nothing. This will only reinforce the notion of the plaintiff attorney, that low-speed cases - in which DCs are treating or testifying - are not worth taking on. Everybody will be unhappy, and the blame falls largely on the DC.)

Q: We got a letter from the insurance company saying it did not believe my patient suffered any injuries because there was so little damage to her car and, therefore, they were not going to cover her care at my office. What should I do?

A:

1. Let's be perfectly clear on one thing: What they tell you they believe and what they actually believe are not always the same. Case in point: the insurance companies know only too well that low-speed crashes, in which there is little or no property damage, are the very ones where they see the highest bills and often the greatest proportion of long-term complaints. It is their business to know these things.

Historically, the first companies to make use of the probability and risk theories developed by the great 18th-century French family of mathematicians, the Bernoullis, were insurers. Insurance companies don't gamble on risk - they invest wisely, based on known boundaries. Therefore, attempts at educating claims reviewers are not likely to bear fruit.

The truth is, the insurance industry's practice of dissimulation (e.g., **no crash - no cash**) saves it literally billions of dollars each year. Consider the facts: Each year, there are three million new CAD injuries in the U.S. (my research). The average cost to insurers is more than \$8,000 per case (according to the Insurance Research Council). That's more than \$24 billion each year (a fact confirmed independently by an agency of the U.S. Government), a liability shared among the auto insurers. Also consider that research shows that between 50 and 60 percent are associated with minimal or no property damage (not counting paint scuffs, etc.). And suppose insurers could successfully intimidate just half of those with no property damage into forgoing medical or chiropractic care and legal representation. They might potentially save themselves more than \$6 billion annually: not exactly a trivial sum.

Sadly, most attorneys have now been successfully inculcated by this most egregious of canards. If they won't represent these patients, many times the patient is unwilling to incur large medical bills. I can assure you that in the back rooms and boardrooms of insurance companies everywhere, this is the biggest joke of all times. **It is probably the most successful hoodwinking in the history of modern business.** And, technically, although it is entirely disingenuous, it's perfectly legal. (The way to make a big change in this area is to educate attorneys, but that is a subject unto itself.)

What should you do? First, ask yourself why such a deception could be so successful. The answer is that it is intuitively logical: it makes sense that in a very-low-speed crash there will be no damage and no injury will result, and that in very-high-speed crashes, there will be a lot of damage and few will walk away unscathed. Therefore, it is intuitively easy to deduce that with increasing damage there will be increasing risk for injury and the injuries will be progressively more severe. This is logical, but not exactly true, and defense experts can almost always sell this yarn to jurors unless there is an expert on the other side to offer a more compelling and accurate explanation to disabuse the myth.

2. Second, learn why there is no correlation between property damage and injury potential in low-speed crashes. Study the mechanics, occupant kinematics and injury mechanisms. Learn why elastic collisions, in

which there is little or no property damage, injure subjects by transferring energy, and how damage collisions can mitigate some of that energy transfer. The calculus of this argument does not require...well - calculus! Learn what studies and statistics to cite; then write your rebuttal letter to the insurer. If there is an attorney on the case, send him/her a copy as well. Doing that sets you above about 89 percent of the rest of the DCs in the country, frankly, and the insurers will immediately know that you are one of the 11 percent to be reckoned with. After all, they also know this literature. In the future, you're less likely to get this patronizing type of letter from that agent. (Of course, it will have no effect on the way he or she treats all the other DCs in town, but that's their problem.)

Parting Comments

In the example of the treating DC beset by the peer reviewer's derisive comments, I would add this: **You should always rebut these reports if you disagree with findings or conclusions.** The same holds true for IME reports. Without any form of checks and balance, reviewers and IME doctors tend to venture further into the empty space of their fertile imaginations as time goes by, developing creative theories and statistics known only to themselves. They cite non-existent guidelines, ignore existing guidelines - or incorrectly cite them as in the above example. They are counting on the fact that most doctors have not read these documents and will not challenge their *unique* interpretations. Emboldened by their success, they typically become increasingly abusive with time.

When you rebut their reports, you put the insurer and defense attorney on notice that the reviewer might not be a reliable witness, should the case go to arbitration or court. This alone could seriously erode the defense's strategy. When you create this document, of course, it also serves as a blueprint for the future cross-examination of this person by plaintiff's counsel, and the defense realizes this.

Putting insurers on notice that they are knowingly basing their policy decisions on non-existing literature or guidelines, or misinterpretations of guidelines, can have further ramifications in terms of bad faith claims. Once they are put on notice of the error of their ways, it will become much more difficult for them to simply shift the blame onto their "expert" panel of physicians who they trusted to correctly use and interpret existing guidelines and scientific literature.

There are other potential sanctions. For example, a few medical societies have now adopted rules governing the behavior of physicians offering expert testimony. Traditionally, experts have been indemnified against charges of perjury by simply stating, "It is my opinion," but this can be put to the test. Knowingly perjuring

oneself might result in loss of a license in some jurisdictions. Are there rules in your society or associations that have been violated? Find out.

Send a copy of the rebuttal to the reviewer; the insurer who hired the reviewer; the defense attorney (if there is one), to the patient; and to the patient's attorney (if there is one). A well-written rebuttal, constructed carefully and unemotionally, and which avoids *ad hominem* attacks, will have a predictable effect. The reviewer will often be mortified. After all, when you're wrong, you're wrong. The defense firm doesn't want to hire "experts" who can be easily impeached on cross-examination by plaintiff's counsel. Chances are, they will look for a more skilled or careful expert. In the meantime, it is likely the reviewer or IME doctor will go back and look again at the documents he or she is quoting (and those that should have been quoted) and, in future reports, exercise a bit more restraint.

Patients injured in whiplash trauma are best treated by a comprehensive management scheme that includes activities of daily living advice, exercise, orthotic supports and nutritional management, as well as spinal care and physical therapy modalities. The concatenation of the medical with the legal is a simple fact of life. The two facets cannot be desegregated and physicians desiring to be successful in this area of health care must master both sides. It is an adversarial business, of course, and it is tempting to use war as a metaphor. Each side is always devising new tactics and weapons. Battles are won and lost before the smoke clears and a victor emerges. To that end, I end with a quote from Sun Tsu, whose writings from before the time of Christ are still taught at all of the major military institutions: *Every matter in war requires prior knowledge.*

Arthur Croft, DC, MS, MPH, FACO, FACFE
Director, Spine Research Institute of San Diego
San Diego, California
drcroft@srisd.com

Click [here](#) for more information about Arthur Croft, DC, MS, MPH, FACO.



Page printed from:

http://www.chiroweb.com/mpacms/dc/article.php?id=8973&no_paginate=true&p_friendly=true&no_b=true