

Writing the History

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In my last column ("[The One Strategy for Preserving the Landscape](#)," March 11 issue) I discussed ways of preserving the landscape of the practice of chiropractic. This piece was about personal injury, but many of these issues are relevant to all of practice life. I was pleasantly surprised to get so much positive email feedback to that editorial! I suppose I shouldn't be surprised after all, though, because everywhere I go I hear the same beleaguered voices crying out from the battlements of clinical practice. This editorial takes up where the last left off, and is written to encourage the downtrodden in the trenches. There really is light at the end of the tunnel (and it isn't from the train of doom). Although I don't have the space to go into the details, I'll offer some hope to those who feel like giving up. Here are some examples of common problems and their solutions.

Problem: Accident reconstructionists and biomechanists are hard to beat and almost always win over a jury. (I call us "auto crash reconstructionists" [ACRs] when I'm feeling charitable or teaching the subject; "accident revisionists" is often a more apt term.)

There is some truth to this, and here's why: Almost without exception, plaintiff attorneys haven't the remotest clue how to cross-examine. When they do, it is almost child's play to tear their testimony apart in most low-speed cases. How can that happen? Either the attorney hires another reconstructionist/biomechanist, or the DC can write an affidavit based on the ACR's report. The latter is the easiest scenario, and the DC needn't be an ACR. All that is required is knowledge of the vast catalog of subterfuge typically applied by these experts. Believe me, this is not rocket science and is easy to do.

In my experience, once the affidavit is sent, the defense often pulls the ACR expert from the case. We've written papers on this subject that have been used in several supreme courts and have now placed limits on what ACRs or biomechanists can testify to.¹⁻⁴ For example, in Maryland, a defense attorney cannot put up a photograph of the plaintiff's car to call attention to the low amount of property damage in hopes of swaying the jury toward a defense verdict unless he/she produces an expert to specifically discuss the meaning of that photograph in terms of injury risk.

Again, this shouldn't be a problem for the plaintiff who knows how to cross-examine that expert, and expert DCs can provide the blueprint for that cross-examination. The most common collage of defense-oriented literature has been carefully dissected on the basis of methodological flaws and/or common misinterpretations.^{1,2} This expository literature has resulted in a greatly diminished use of popular junk science, as exemplified by decisions of, for example, the Colorado Court of Appeals. In Arizona, ACRs and biomechanists are still allowed to opine about issues of crash parameters (speed changes, acceleration, etc.) but are generally not allowed to discuss the potential for injury. Similar devolution has occurred in New York and other states. This should be encouraging.

Although we haven't won every battle, we are generally winning the war and should continue to keep up the pressure. (As a disclaimer, I don't mean to imply that all ACRs or biomechanists are disingenuous, dishonest or unqualified. That is far from the truth. In the context of this editorial, I

am merely referring to those who distort the truth to minimize crashes.)

Once we get past the crash reconstruction issues, we find that looking at property damage has neither allowed researchers to predict injury nor long-term outcome. And, as I often tell juries, even if we did know the precise crash parameters (delta V, acceleration, etc.), we must still consider human and other physical crash factors to determine risk. Otherwise, how can we explain the crash in which one person is killed and another walks away with only scratches? Both were exposed to exactly the same vehicle delta V and acceleration; thus the reason for risk-factor analysis. This is the physician's job - your job. And I've written much on this, too.^{4,5} Here you'll find the most credible and meaningful way of assessing risk for injury and risk for poor outcome. Armed with this information, you are unstoppable.

Problem: Defense lawyers win these cases even without having to hire their own experts.

Yes, indeed that does happen. And how convenient it is for the defendant. Think of all the money they save on expert witness fees by just sending the defense lawyer into court to win these cases. The lawyer uses the old photo-of-the-plaintiff's-car-showing-only-scratches-on-the-bumper trick and implores the jury to use common sense in assessing risk. "How bad could it be, folks?" the defense attorney asks. The fact that this kind of thing happens at all, however, is an indictment of the plaintiff bar in general.

Usually, the final curtain call of this pathetic act can be achieved in the following way: Consider what's happening here; the defense attorney is asking the jury to consider the damage to the vehicles and deduce from that and their own "common sense" that the risk for injury was minimal or nonexistent, and therefore the need for care was also minimal or nonexistent. Likewise, pain and suffering would be relative nonissues. However, the jurors are not crash reconstructionists and have no way of determining the relative forces of a crash based simply on bumper or other damage (or lack thereof). Even ACRs can't do it with much precision. Jurors' "common sense" in this determination is without any scientific basis and is wholly invalid. Moreover, even if they had a valid way of determining the resulting forces from that crash, they have no knowledge of the tolerance of the various soft tissues and bone to the transfer of energy resulting from it.

In a court of law, jurors are given instructions. They are instructed to base their decisions on evidence presented - not intuition, common sense, or *a priori* knowledge. In fact, in the scenario I've just described, the defense attorney also is not an expert in crash reconstruction, nor did he likely perform any specific calculations, tests or experiments with the car(s) in question to determine the crash velocity or other parameters. Nor is the attorney likely to be an expert on the tolerance of human tissues. Yet by asking the jury to make a decision (based on deductive reasoning) about these forces and injury risks by observing photographic evidence of involved vehicles, he is acting as his own expert. And by encouraging members of the jury to use common sense (rather than factual evidence or expert witness testimony) he is asking them to violate jury instructions, which are sacrosanct. At this point, the plaintiff attorney should intercede and firmly request a directed verdict as to causation and medical necessity, since the defense offered no expert testimony to counter plaintiff's expert testimony. In a directed verdict, the judge will rule on causation and medical necessity - these issues will not be put to the jury and no longer be argued by defense. The only question left for the jury will be of pain and suffering.

Problem: Experts testify that the doctor's treatment was excessive or unnecessary.

While such allegations are sometimes true, this is a virtual *sine qua non* of peer reviewers who act as experts for the defense. They are fond of citing the *Mercy Guidelines* in support of their conclusions. I have written on this subject as well (see *Of Gridlines and Guidelines*, which can be

found at <http://www.chiroweb.com/archives/16/09/01.html>). And arbitrators or jurors often have no way of determining who has the preponderance of evidence on this point: the erudite-sounding defense expert or the treating doctor.

Once again, the cross-examination of the expert is child's play. Did he examine the patient? If so, did the examination take place during the time the patient was actually receiving active care? Did the expert see and rely on all of the medical records (radiographs, hospital records, etc.)? How about the crashed vehicles? A copy of the *Mercy Guidelines* is also handy during the cross-examination. Is the expert aware that in the first few pages, there is a clear statement to the effect that these guidelines are not to be used for peer review purposes? The expert should then be handed the guidelines and asked to find the section, which deals with reasonableness and necessity of care for whiplash injuries. That will likely be a challenge - because no such section exists!

Peer reviewers often extrapolate from a section derived from a single study on industrial injuries to the low back; both anatomically and pathomechanically quite separate and distinct from the type of neck injury occurring in whiplash. Such extrapolations, in fact, are scientifically unsupported. If the expert argues that such extrapolations are fair, he or she is only digging a deeper pit to fall into. Moreover, from an epidemiological standpoint, it is further inappropriate to extrapolate population-based statistics (the population in this case consisting of a rather small number of industrial low-back-injured workers) to an individual.

Suppose that the mean recovery period for condition X is 12 weeks. Does this justify cutting care for those persons who fall on the wrong side of the population mean based only on chronology? Of course not. Nowhere in medicine is this considered an ethical method of management. Imagine, for example, the cardiac patient in the ICU recovering from a myocardial infarction (MI), who is still gravely ill, being sent home to fend for himself because he's been in the ICU 2.5 days beyond the statistical mean for MI patients.

Again, it's important to consider risk factors and, most importantly, whether treatment provides the patient with sufficient continued relief and/or recovery from injury to prevent labor-disabling impairment. (By the way, the authors of the *Mercy guidelines* mention that ongoing care is justified on this basis of need. Comprehensive SOAP notes will settle this question of reasonableness more conclusively than any statistic can.)

We have developed our own whiplash treatment guidelines (published in *DC* in the Nov. 19, 2001 issue). Several states have now adopted them and we expect that eventually they will be widely adopted throughout the U.S. and Canada. They establish the current practice standards of DCs in the U.S. and Canada. They can also be used, as they have been in Oklahoma, to set standards for peer review. This prevents renegade reviews based on arbitrary treatment numbers or duration.

Finally, I can assure you that it is the plaintiff who has the major evidentiary weapons when it comes to personal injury cases. I'd like to share them all, but there are literally thousands of compelling and powerful papers to call on. They are your shield and buckler; your ammunition. Remember that the courts eschew junk science and let good science in. In the past 50 years or so, more than that many papers have described outcome studies in whiplash cases.^{4,5} None of them showed that the majority of whiplash victims recover in 6-12 weeks. Quite to the contrary, on average, about 35 to 50 percent of those injured have long-term symptoms, while seven to 10 percent suffer permanent disability.

Parting Thoughts

Having only touched on a few subjects here, I hope I have nevertheless offered some

encouragement to those feeling beset. There really is a gradual devolution of the defense battle works in this arena, so take heart and keep the faith. Dissimulation and lies won't work forever. Eventually, we will all come to the same conclusion: Whiplash is a serious public health burden that requires some degree of reasonable care, and its prevention is a worthy goal for crashworthiness researchers and automotive engineers. Remember, as in any war - metaphorical or otherwise - it is the winners who write the history.

References

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