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Managing Motor-Vehicle Trauma: A 2011 Status Report, Part 1

By Arthur Croft, DC, MS, MPH, FACO

"It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair, we had everything before us, we had nothing before us." -- Charles Dickens, *A Tale of Two Cities*

Written in the mid-19th century, the subject of this classic tale was the French revolution, which transpired over a turbulent decade: 1789-1799. Rush ahead some 150 years and the novel's introductory paragraph hauntingly describes the state of art in the treatment and management of motor vehicle trauma.

For us, the outlook is much rosier than it was for Robespierre and his confederates. In fact, in many ways, these truly are the best of times. Here is the 2011 state of affairs for chiropractic in the management of motor vehicle crash (MVC) trauma from my perspective.

The issues I hear of most of the time that seem to concern chiropractors in the context of personal injury are (a) reimbursement (including the fear of post-payment audits); (b) difficulties with third-party insurers; (c) attorneys who either won't represent patients or who lack zeal in their management of the cases, or fail to grasp the value of the chiropractor as an important source of expertise; (d) criticisms concerning a lack of evidence supporting the efficacy of chiropractic intervention; (e) criticism concerning the risk for stroke with cervical manipulation; and (f) the concern that chiropractors are limited in their scope concerning the kind of testimony they can offer (which is linked to the item concerning attorneys). Let's visit each of these issues in turn.

Reimbursement and Third-Party Issues

Perhaps the *worst of times* was in the mid-1990s when auto insurers began to redefine their industry as exemplified by the so-called Three Ds of Allstate: delay, deny and defend. And, in fairness to Allstate, these tactics have become fairly universal, but Allstate's doctrinaire policy was laid bare during a landmark trial.

If a long delay in reimbursement does not discourage a claimant, then an insurer will typically transition into the denial phase. The extent to which this is carried out is anything but subtle. Defendants are coached to change their stories, even if it completely reverses their at-scene statements to police.

It ushered in what might be viewed as the *age of foolishness* with the auto crash reconstructionist (ACR) and the biomechanist. If the claimant were stubborn and wanted their day in court, the final phase was to defend. The ACR and biomechanist, in concert with a defense medical examiner (DME), played an important part here as well. Belief and incredulity were the currency of the courtroom.

For several years, these expert teams were highly successful in inculcating the plaintiff bar and dissuading claims. But like any revolution that is flawed from the adamant up and suppresses the reasonable treatment of the public, its weaknesses were destined to be exploited.

While there have been a few high-profile post-payment audits, these have been few and far between and the clinics that have been singled out, for the most part, are the clinics that have rather egregiously abused the system. Honest and conscientious practitioners have virtually zero to fear from this kind of action.

The *best of times* occur when we realize that the auto insurance industry has toyed with no-fault payer systems and, to a large extent, has decided it likes the tort system best. Some states and Canadian provinces have gone back and forth, but in either case, and with a few exceptions, the reimbursement exceeds all other reimbursement systems. This relative status quo contrasts with the boa constrictor-like grip of the general health care industry. Even when liens are held, there are ways in many states to gain control of the reimbursement process in ways never imagined by many practitioners.

Moreover, the medicolegal side of this practice is both exhilarating and rewarding, and offers an alternative earning mode to that of simply ending one's career with the same constant bending, stooping, pushing and pulling maneuvers that make chiropractic one of the top professions for disability claims.

The treatment guidelines authored back in the 1990s have now been placed on the government's National Guidelines Clearinghouse under the ICA's related guidelines, and now many auto insurers are acceding to the guidelines and holding DCs to that standard. Many states have also adopted them and, until such time that a superior guideline is adopted, they provide a common starting point for practitioners and payers.

Attorney Issues

During the so-called *worst of times,* we saw a mass exodus of plaintiff attorneys. Some would call that the *best of times,* and in some ways it was. Many who left were the ones whose work ethic came from the Mainard G. Krebbs school of thought. In any case, thinning of the herd is often an natural evolution. Many of my students have participated in some very remarkable cases in the past couple of decades. Those cases garner the expected attention of the local bar, but, in general, it remains the work of the individual to make changes on a local level.

There are strategically very successful ways of doing this; but I don't advocate or condone the kinds of gimmicks or shortcuts suggested by some. Indeed, the way to make lasting inroads with the kinds of attorneys who will diligently advocate for your patient and treat you with respect is perseverance, hard work, and the consistent demonstration of specialized knowledge and skill; more the Horacio Alger school of thought.

These days, I teach doctors to take a more active role in the process of legal action. Doctors should never view themselves as advocates, but they can certainly assist by writing declarations or affidavits, which can then be attached to motions *in limine.* They can also aid in the development of cross-examination strategies of opposing experts.

Lack of Evidence-Based Support

The worst of times: I have heard hundreds of versions of the popular mantra in the past 25 years that implies chiropractic lacks experimental support. *The best of times* is now, when the irony has become palpable. In studies that honestly squared off medicine, chiropractic, and acupuncture for the management of chronic spinal pain, chiropractic came out the unambiguous victor,[1] even after a long-term follow-up.[2] This same kind of thing has been reported in numerous studies of the effectiveness of chiropractic and medicine in workers' compensation claims, which I have discussed in my previous columns.

With few exceptions, for the types of musculoskeletal conditions most often treated, chiropractic has been shown to be more effective, less expensive and less frequently associated with long-term disability than conventional medicine. In a recent paper published in the *Journal of Rheumatology*, the Cervical Overview Group conducted a large-scale meta-analysis of existing literature concerning the management of mechanical neck disorders, including radiculopathy.[3] The categories of evidence ranged from *strong*

evidence, to *moderate evidence*, to *limited evidence*, to *evidence of no benefit*. The only regimes that managed to make it into the highest level of evidence were [combined] stretching/strengthening exercise and mobilization/manipulation. Medical interventions failed to make the cut. Meanwhile, many have been questioning the wisdom of various applications of more invasive medical procedures, particularly when a trial of manipulation has not been instituted.

The medical profession is clearly looking out for the welfare of its patients and guarding the public health when it expresses strong concerns over the risk of serious injury, stroke or even death from spinal manipulation of the cervical region. This same level of concern should be shared by chiropractors for their patients and for the public health, in my view, even at the risk of upsetting a few sacred cows.

Medicine is an example. There is no question that many lives are saved with antibiotics,[4] and other drugs effectively control the effects of diabetes, heart disease, gout and hundreds of other conditions. In other cases, however, evidence of the efficacy or even safety of drugs remains unknown. Drug trials frequently focus on younger adults who may be fully representative of all potential users of the medicine. It's well known that older adults require lower doses because their liver function is diminished, yet one recent study showed that most physicians typically do not alter doses among aged patients.

In 1998, a rather extraordinary paper published in *JAMA* estimated that in 1994, approximately 106,000 Americans died as a result of adverse drug reactions (ADR)[5] - reactions to prescribed drugs. The FDA instituted a watchdog program called MedWatch as a result. With this increased scrutiny, the number of recognized fatal ADR has grown, as has the actual incidence.[6] It can be estimated from the changes reported that the number of deaths each year due to ADR are more than 275,000 in the U.S., making ADR (depending on how one scores it) the sixth to fourth leading cause of death in America today.

Somewhat counterintuitively, in 1997, the FDA relaxed direct-to-consumer advertising (DTCA) regulations to allow television advertising of patent medication. Today, only New Zealand and the U.S. allow DTCA of prescription drugs.[7] Many physician groups strongly denounce this practice. But with managed care biting the heels of practitioners, there is less time to spend with patients and this is likely to increase the incidence of ADR.

If you are thinking that none of this really concerns you, consider the drugs that top the charts. For death, the top two are oxycodone and fentanyl; two drugs that many patients with chronic musculoskeletal pain take. One of the largest sources of hospital admissions for ADR is gastrointestinal bleeding due to NSAIDS.

Acetaminophen, which television commercials constantly assure American viewers is "trusted by more hospitals," is number five on the list of fatal ADR.

Part 2 of this article appears in the Feb. 12 issue (along with complete references for both parts) and continues Dr. Croft's look at the state of MVC trauma management in 2011.

Click here for more information about Arthur Croft, DC, MS, MPH, FACO.

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