ARIZONA ASSOCIATION OF CHIROPRACTIC

PERSONAL INJURY QUARTERLY

Volume 2, Issue 3

INSIDE THIS ISSUE:

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The AAC Personal Injury Quarterly

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A special thanks to Dr. Bill Gallagher for his tireless efforts and dedication to seeing this publication through!

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Editor in Chief	Greg Muchnij, DC CMVI
Advertising Coordinator	Mark Widoff
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Authors	Jeff Woolston, Bill Gallagher, Lois Laynee, Trevor Penny, Robert L Menner
Content Strategists	Jeffery Wolston Andrew Altman

Improve the Health of Your PI Practice: Check Your Vision!

Wayne Bennett, DC, DABCO, DABCC

Based upon the assumption that you are reading this article because you are interested in improving the health of your Personal Injury practice, here is a handy "PI Practice Health Tip":

Check your vision.

Several years ago a colleague introduced me to the word "Acluitic". You will not find it in any dictionary, but I have found it to be a very useful term. "A-clue-itic". It means "in a state of being without a clue". One knows not that they know not. If you were to ask me about something like the price of fertilizer in Belgium, I would willingly respond that I am "acluitic" on the subject.

Now while I am comfortable being acluitic about many subjects, it bothers me when I learn that I have been running around with a blind spot on a topic about which I am responsible for knowing well. In my decades of working with Personal Injury cases as a treating doctor and when reviewing cases and records from other providers, I have come to the conclusion that there are some common "blind spots" in the "vision" of chiropractors when it comes to practicing in the personal injury arena. Hopefully, this article will shed some light with regard to three of them.

Avoid Subluxation Tunnel Vision

We are chiropractors. We detect and eliminate subluxation. It is the core of what we do. However, while personal injury patients very often present for care with traumatically induced subluxation, they frequently have other things wrong with them as well. They have sprains and strains and labral tears and traumatic brain injuries and perhaps a number of other issues. They have pre-existing conditions and other complications that are going to drive more complex decision-making if the patient is going to achieve the best possible outcome.

We are Doctors of Chiropractic. As physicians, especially when responsible for the coordination of care in a personal injury case, it is our responsibility to identify all of the injuries sustained by our patient in an injury event. If we don't "see" them initially, we will not examine for them, we will not diagnose them and, worst of all, the patient will probably not get treated for them.

Failing to widen our scope of inspection in treating injured patients and neglecting to embrace more than just the subluxation component is a disservice to the patient. Keeping a watchful eye on all that has happened to your patients will earn you the referrals and patient outcomes that you will deserve by keeping a wide field of vision!

And by the way, even if you are a "subluxation only" treating doctor, that's OK! But if you aspire to be the lead doctor in a personal injury case, you have the responsibility to detect all musculoskeletal components of the injury and if you aren't going to treat the "non-subluxation" components, then refer the patient for concurrent co-treatment and diagnosis.

Look Into the Past

Most commonly in the personal injury case you are dealing with the consequences of an event that occurred in a matter of a couple of hundred milliseconds. But more often than not there were events that occurred in the life of the patient in the weeks, months, years, and decades prior to the injury event that are very important to document. They will have a major impact upon the amount of care that patient will require, the kind of care they will need, the prognosis for a full return to function, and even the kind of settlement that their attorney will be able to obtain for them.

Was there prior trauma to any of the injured body parts? Was the patient active and in good health prior to the accident or were they sedentary and in poor health? What is their medication history? Are there underlying degenerative issues? Are there treatment records from previous injuries that you and the patient's attorney are going to want to review (because you know for sure that the insurance attorney will be all over them like a rat on Cheetos).

In short, history-taking in a personal injury situation should be conducted with a heightened awareness from the beginning of care (initial history). It is frustrating, embarrassing, and often unsuccessful to have to deal with important factors in the patient's health history after the fact, especially when the insurance attorney found them and you didn't! Be confident that you understand what your patient's "Pre-Injury Status" really was!

Gaze Into the Future

When we emancipate a life force rivulet by reducing subluxation our job is finished, at least for the moment. This practice approach reflects a "present time consciousness" paradigm and it works pretty well for us. But when we are treating a patient with injuries, and especially if the extent of those injuries may impact the patient's future with residual symptoms and potential future impairment and disability, it is necessary for us to look down the road of the patient's future for them as part of our job.

When we decree that the patient has reached "Maximum Medical/Chiropractic Improvement", we need to have a clear vision of what we are saying. If the patient has made a full recovery with no residual symptoms or impairment, then our job is less complicated. But if the patient's Pre-Injury Status included complicating factors that remain an issue after treatment, if there are residual symptoms from injuries sustained in the event being addressed, and especially if there is a ratable impairment present, it is the quality of our diligence and documentation skills that may make a big difference in the outcome down the road for the patient.

If we enter into every personal injury case with our eyes wide open, knowing what to look for, then we are in the best position to provide the kind of care that our patients deserve, and which will bring confident PI referrals to our practice.

I hope that you "see" what I mean!

Dr. Wayne Bennett is a Diplomate with the American Board of Chiropractic Orthopedics and the American Board of Chiropractic Consultants.

Email: drbennett@cableone.net

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T-3, UPTAKE	T_3 up		
T-4, FREE	T_4 free		
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PSA free & tot			CMCC)
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Accident Reconstruction from a Physician's Perspective (Part 2).

Greg A. Hauser, DC, FICPA, CICE

We left off discussing how most motor vehicle collisions occur in about a quarter of a second (250 milliseconds). When calculations are performed, even for collisions with relatively low Delta V's (less than 10 mph), the subsequent accelerations can be significant. This is referred to the average acceleration. To complicate this matter more, a subsection of that 250 milliseconds can be examined with calculus. This subsection is referred to as instantaneous acceleration or peak acceleration. This is where the injuries are caused.

The New Car Assessment Program (NCAP) was established in 1972 and the original standard for frontal collision was for a 30 MPH crash into a rigid barrier. In 1979 the standard was changed to a 35 MPH crash into a rigid barrier. This is almost a 40% increase in Kinetic Energy to crush a vehicle. What this means for us as occupants, and more importantly as providers, is the vehicles now are much more rigid. A more rigid vehicle that collides at lower speeds transfers more energy into the occupants rather than crushing the vehicle. This coupled with 4 and 8 MPH bumpers has a 2-fold effect. 1 - the instantaneous acceleration as discussed in the previous paragraph has a much greater spike (yielding more significant injuries) and 2 - the vehicles show less damage than before.

The following diagram (see facing page) and explanation represents what actually happens in a rear end collision.

"In the rear impact, the kinematic response is biphasic. As the seat back strikes the subject from the rear, it causes the curvatures of the spine to flatten. Then the pelvis and torso are accelerated forward by the forward moving seat. As this happens, the head remains momentarily at rest. This is called the head lag phase. But, as the car, car seat, pelvis, and torso continue to move forward, the neck and head are eventually pulled forward. The head may also come into contact with the head restraint, which will greatly boost the head's acceleration to the point that now the head is accelerating at a greater magnitude than that of the car or the pelvis or the torso.

When the torso is projected forward by the seat back, its velocity becomes greater than the car itself in a phenomenon we call torso overspeed. The head will be projected forward with an even greater velocity than the torso in a phenomenon we call head overspeed. And now the occupant must actively decelerate his forward moving head. At the same time, as the forward moving torso and pelvis are abruptly restrained by the seat belt and

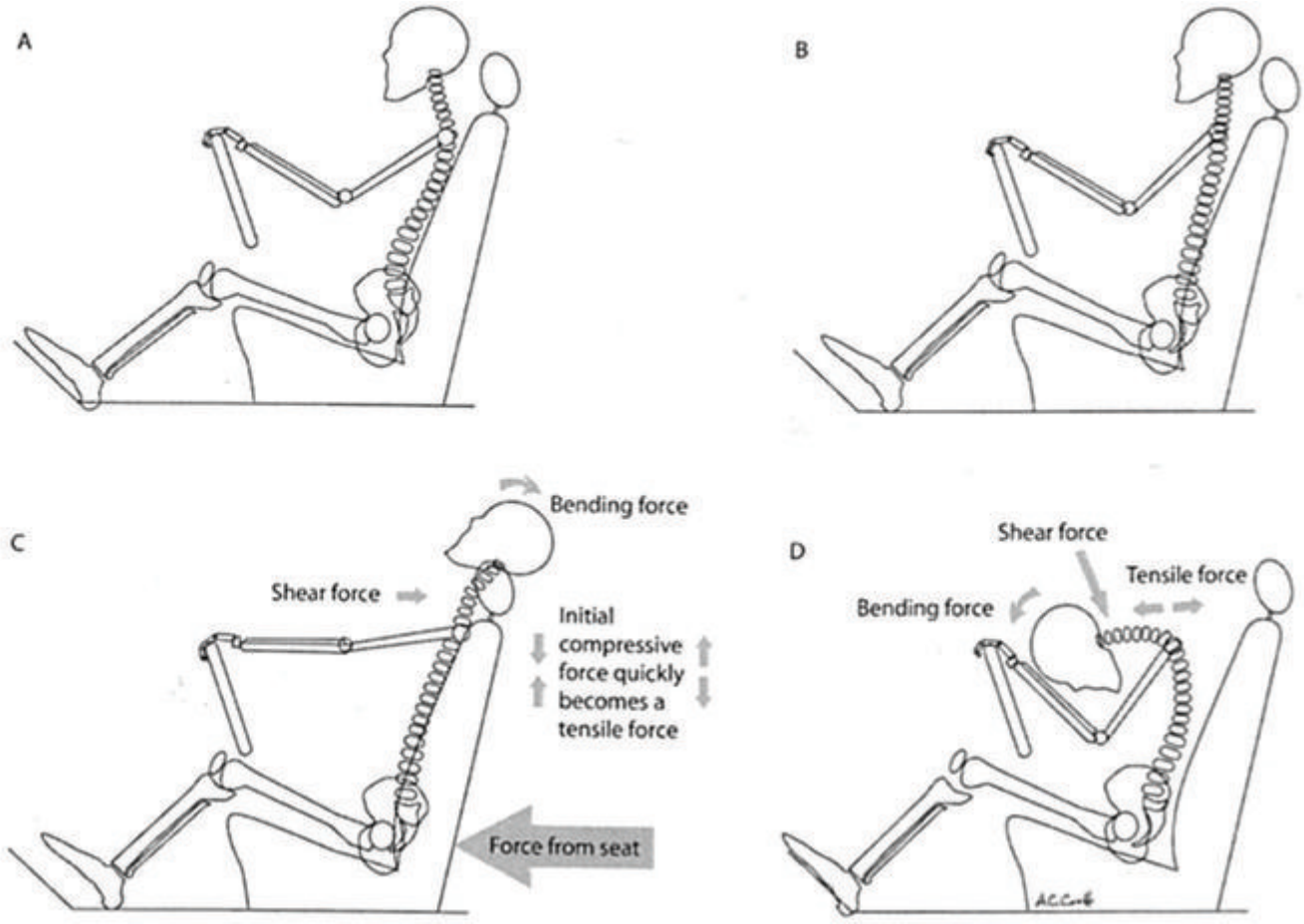

Diagram of occupant kinematics in a rear end collision.

shoulder harness, the head continues its forward excursion."1 Remember, this action takes place in under 300 milliseconds.

Because the human head weighs in the neighborhood of 8-10 pounds, a peak 4 G instantaneous acceleration now equals 32-40 lbs of horizontal force to the head and neck structures and a 10 G instantaneous acceleration now equals 80-100 lbs of horizontal force to the head and neck structures over the span of about 50 milliseconds or 5/100th of a second. To put this into perspective, if you were to slowly stretch a piece of Silly Putty it would stretch pretty far. However, if you were to take that same piece of Silly Putty and stretch it very rapidly, it would break cleanly. This is what happens to the soft tissues in a person when they are stretched too rapidly. As a matter of fact, because the brain can only process information so fast, when the occupants are asked, most times they will recall being thrust forward and they will not remember being thrust back into their seat or hitting their head on the head restraint.

Knowing this information can help ferret out details of mechanism of injury when taking a patient history during an examination, even if the patient cannot recall because "everything happened so suddenly", or worse yet if they sustained a traumatic brain injury. It is not uncommon for a patient to be deposed and state they do not recall hitting their head on the restraint. This can and will be used against your patient to "take away" the mechanism of injury. If the mechanism of injury does not exist (the collision did not cause the injuries) than the injuries you treated must be caused from another source, and the other party is no longer financially responsible. Careful investigation of the collision and clinical correlation can be critical.

In Part 3 we will discuss risk factors and human factors that can increase the likelihood of injury in these types of collisions.

[1] Arthur Croft, *Whiplash and Mild Traumatic Brain Injuries*, Spine Research Institute of San Diego Press 2009.

***Review: … of Cranial Nerves and Subluxations provided in the article listed with a graphic display of Cranial Nerves and Subluxation codes for assessment of diaphragm and breathing dysfunction affecting vertebra and postural components… .**

By Robert L Menner DC, BsPT, DABFP, CCWP, DABFM, CMVI

"Anatomic connections of the diaphragm: influence of respiration on the body system" Cited by 63

1. Rehabilitation Cardiology Institute of Hospitalization and Care with Scientific Address, S Maria Nascente Don Carlo Gnocchi Foundation
2. EdiAcademy, Milano, Italy

The article explains the scientific reasons for the diaphragm muscle being an important crossroads for information involving the entire body. The diaphragm muscle extends from the *trigeminal system* to the pelvic floor, passing from the thoracic diaphragm to the floor of the mouth. Like many structures in the human body, the diaphragm muscle has more than one function, and has links throughout the body, and provides the network necessary for breathing. To assess and treat this muscle effectively, it is necessary to be aware of its anatomic, fascial, and neurologic complexity in the control of breathing.

- The *phrenic nerve* innervates the diaphragm, and runs from the roots of X C3 to C5…and according to some authors, the pathway of the phrenic nerve involves the entire brachial plexus and the entire cervical plexus X (C1–T1)… The Phrenic motor units not only control breathing but also have other functions that are not specifically breathing actions, such as deglutition, vocalization, and the expulsion of waste-containing substances for the expectoration of the airways…

It is easier to transmit an electrical impulse to a precise point rather than send a metabolic message to a single neuron. For this reason, it is possible to verify a symptomatology that is different from a mere breathing disorder, such as brachialgia, ie, pain in the shoulder… Along its pathway, the phrenic nerve anastomoses (coming together /uniting) to the subclavian nerve, which innervates the *subclavian muscle, specifically, the first rib and the clavicle X (C5–C6)…Therefore, if there is a phrenic disorder, it is possible to contract the subclavius muscle, raising the first rib and reproducing a thoracic outlet syndrome, with the relevant symptomatology;…for instance, pressure on X C8–T1 can cause problems in the little finger… The scalene muscles, which are innervated by the cervical and brachial plexuses, are equally important….
There is a close link between the diaphragm and the thoracic outlet.

This means that diaphragmatic dysfunction produces symptoms that are observable in the region of the cervical base, in the floor of the mouth, and in the dura, as well as in the eyes.

It is important to proceed in order; now we review in detail the connections of the *vagus nerve, thereby clearly explaining the connections. The medial longitudinal fasciculus is an association of nerve fibers that connect the mesencephalon and most of the cranial nerves, including the *trigeminal nerve, and the cranial nerves that innervate the *eye (ie, II, III, IV, the first division of V, and VI), the tongue *(the hypoglossal nerve, XII), and the cervical base X (C1–C3)…. Therefore, the medial longitudinal fasciculus is an important connecting pathway, the margins of which go from the mesencephalon-diencephalon to the lumbar spinal cord (L4) and further, at least according to some sources… This pathway is essential to understand the relationship between sight and posture.

The spinal trigeminal nucleus, which is connected to the vagus, is the destination of the trigeminal fibers from Gasser's ganglion…It should be noted that there is a close relationship between the diaphragm, the buccal diaphragm, and the dura mater…

The nuchal ligament, innervated by X C2, is also connected directly to the dura mater…,and the trapezius muscle is part of the thoracolumbar fascia and possesses innervation which is close to the vagus nerve…With regard to symptoms, we can hypothesize that the phrenic nerve can affect the spinal trigeminal ganglia, which will stimulate the last two branches of the trigeminal nerve, reaching the periodontal ligaments through the alveolar nerves, and that the result will be dental pain. The same pathway may lead to pain in the temporomandibular joint and the ear through the ganglion of Gasser.

Another link is through the transverse cervical nerve, which is a branch of the cervical plexus X (C2–C3), in direct contact with the mandibular branch of the trigeminal nerve….

Carrying on our analysis of the vagal nerve, this nerve is firmly connected with the hypoglossal nerve, which is closely related to the trigeminal system… The hypoglossal nerve, which is a somatic efferent nerve, along its path is in contact with X C1–C2 (namely, the suboccipital muscles), by their efferents… The floor of the mouth is linked to the trigeminal system by afferent fibers… The connection between the diaphragm and the floor of the mouth is easily recognized in the event of poor swallowing or sleep apnea, or again in the event of diaphragmatic dysfunction…

Injury to CN trauma –ex MVC

- I olfactory
- II optic
  - Tract & pathways
  - Visual cortex
- III oculomotor
- IV trochlear
- V trigeminal
- VI abducent
- VII facial

VIII acoustic

- IX GLOSSOPHYRENGEAL
- X VAGUS
- XII HYPOGLOSSAL

Subluxation

Thoracic

S23.110	T1-T2
S23.120	T2-T3
S23.122	T3-T4
S23.130	T4-T5
S23.132	T5-T6
S23.140	T6-T7
S23.142	T7-T8
S23.150	T8-T9
S23.152	T9-T10
S23.160	T10-T11
S23.162	T11-T12
S23.170	T12-L1

M51.24 isplacement -other IVD

Lumbar

S33.110	L1-L2
S33.120	L2-L3
S33.130	L3-L4
S33.140	L4-L5

Cervical

Disc displacement

M50.20 other cervical disc
X M50.21 C2-3 / C3-4
X M50.22 C4-5 / C5-6 / C6-7
X M50.23 C7-T1

Disc disorder w/ radiculopathy

X M50.11 C2-3 / C3-4
X M50.12 C4-5 / C5-6 / C6-7
X M50.13 C7-T1

OTHERS

M26.60 TMJ disorder unspecified

Thoracic Outlet Syndrome
Facets pain

Dr Robert Menner • 602-577-2720

The hypoglossal nerve receives a multitude of presynaptic impulses from the phrenic nerve and intercostal muscles... In regular respiration, the genioglossus and other muscles of the floor of the mouth, such as the hypoglossus, are electrically involved in coordination with the diaphragm, immediately before contraction of the diaphragm itself...Of all the muscles that dilate the pharynx, the genioglossus is the greatest, and is regarded as an accessory respiratory muscle...Involvement of this muscle prevents the muscles of the mouth from closing the superior respiratory tract during inhalation... The genioglossus moves during the respiratory cycle, ie, posteriorly during expiration and anteriorly during inspiration... This action guarantees correct ventilation.

The greater the inhalation phase in terms of rhythm, the greater the electrical response of these contractile areas in the mouth... This means that signals from the peripheral neurons combine with orders from the central nervous system.... As has been recently demonstrated, this carefully coordinated relationship can be disrupted by a range of respiratory problems, causing problems with chewing, swallowing, and breathing.... Moreover, it should be noted that the pleura, innervated by the phrenic nerve, sends type C fibers to the tongue, indicating another close relationship between the diaphragm muscle and the buccal diaphragm...

Another neurologic connection with the diaphragm is represented by the orthosympathetic plexus of the greater splanchnic nerves, by the lesser and minimum splanchnic nerves. They pass the diaphragm in the crural region... According to recent anatomic dissection studies, the celiac ganglion originates in T4-T5-T9, whereas the superior mesenteric plexus derives from T10-T11-T12... .Finally, there is the inferior mesenteric plexus, which is composed of minimum splanchnic nerves, also known as the renal plexus or renal nerve. This plexus is related to L1–L2...

The celiac ganglion, like other splanchnic branches, may vary in length, shape, size and location, but is not discussed in this paper. The splanchnic nerve system is essential in order to control the orthosympathetic visceral system.11 This suggests that, in the event of a diaphragmatic problem, whether a spasm or an atrophic lesion, the pathways of the orthosympathetic systems will be negatively affected in both the upward and downward directions. This means, on the one hand, that visceral activity will be affected, and on the other, that the metamers related to innervation of the three plexuses will suffer from pain in the vertebral facets and related tissues, and the muscle area of the affected metameric zone... Further, the visceral afferents are connected to Lissauer's tract (ie, the dorsolateral fasciculus or tract), which belongs to the trigeminal system... Therefore, a diaphragmatic disorder affecting the viscera innervated by the splanchnic system will result in pain even in distal areas...

Fascial and connective links between the diaphragm and the pelvic floor, and the rest of the body. First, the abdominal muscles are related to the costal, lumbar, and pubic iliac regions of the body, ie, rectus abdominis, the internal and external oblique muscles, pyramidalis, cremaster, transversus abdominis, great psoas, quadratus lumborum, sacrospinalis, and transversus spinalis (where the multifidus spinae is distinguishable)... Moving now to the fascial links, it is important to consider that the fascia is rich in corpuscles (ie, Golgi's, Pacini's, and Ruffini's corpuscles), which have proprioceptive properties and provide significant peripheral information, as well as having a probable nociceptive function... Further, the fascial tissue possesses fibers capable of contracting, probably causing spasms, followed by dysfunction and pain...

The semispinalis muscles of the neck are mainly activated at the X C2 level; however, when anomalous tensions are registered, the muscular stress will burden... Obviously, the phrenic nerve and any connections with this region may be negatively affected. Cervical pain can have diaphragmatic causes, and has repercussions for the neck through the thoracolumbar fascia. This is a bidirectional process, and this fascial bridge may explain pain related to the sacroiliac joint in the event of dysfunction between the diaphragm and the pelvic floor.

The lateral raphe, ie, the fourth part of the fascial system that affects the diaphragm, originates at the twelfth rib and goes to the iliac crest, and is interesting with reference to the functionality of the respiratory diaphragm... In fact, the quadratus lumborum associated with the diaphragm is mainly connected to L2, and this contact is supported by the lateral raphe... The diaphragm acts mainly on L2 in order to stabilize the lumbar column and to control the resulting forces properly...

Conclusion:...The diaphragm muscle not only plays a role in respiration but also has many roles affecting the health of the body. It is important for posture, for proper organ function, and for the pelvis and floor of the mouth. It is important for the cervical spine and trigeminal system, as well as for the thoracic outlet. It is also of vital importance in the vascular and lymphatic systems. The diaphragm muscle should not be seen as a segment but as part of a body system

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1. Bruno Bordoni and Emiliano Zanier **Anatomic connections of the diaphragm: influence of respiration on the body system** J Multidiscip Healthc 2013; 6: 281–291.

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OTHERS

M26.60 TMJ disorder unspecified

Thoracic Outlet Syndrome
Facets pain

Subluxation Based PI Practice

Bill Gallagher, DC, CMVI

One of the first principles that I teach with the American Academy of Motor Vehicle Injuries is that personal injury is not healthcare. Personal injury is injury care.

In order to excel at personal injury the first step is to be able to diagnose all of the injuries caused by a motor vehicle collision. Only then can you know what to address. Only then, when properly documented will the insurance company know what to pay for.

While it may appear that this pushes us over into the medical model of treating disease it is equally important to understand that a personal-injury practice should be a subluxation-based practice.

In a medical practice, the objective is to treat injuries. Unfortunately, since most medical doctors are so specialized they tend to see only the one injury that they are trained to address, most injuries go undiagnosed and untreated. Once identified in a medical practice, a particular injury can be addressed by surgery, physical therapy, or prescriptions to support the patient's medication deficiency.

Addressing the injuries as separate entities and the body as a collection of static problems falls far short of the chiropractic vitalistic goal of addressing the cause of the problem as it affects the whole body.

Things to consider:

1. injury versus subluxation
2. ortho/neural examination versus chiropractic analysis
3. treating the injury as a static entity versus correcting the subluxation to facilitate healing

Injury v. subluxation

I shake my head anytime I am asked by an attorney to examine their client who has been through a year or more of treatment by medical doctors without chiropractic care. The current protocol of evidenced base/functional medicine begins with the most conservative, least invasive care. On that basis alone chiropractic should be the starting point for any PI case.

Arthur Croft long ago estimated that 45% of all chronic neck pain is likely due to a prior whiplash type injury. A multitude of studies since then places that figure at the low and of the spectrum.

When I first spoke with continuing Ed departments at chiropractic colleges the question was, "What is so special about your program?" The first time the question was posed my response was, "we are teaching doctors how to diagnose, docu . . . " Before I could say document the defensive response was we have an excellent diagnosis program here." I agreed and replied, "So did I. I was taught in how to diagnose heart disease, diabetes, cancer, anything I needed to get out of my office right away but they never discussed trauma."

Without going into the criteria and definitions of a subluxation, it will be a simple enough to understand that they do not occur by spontaneous generation. In fact, it is most likely that such a structural misalignment that is causing nerve interference is due to a trauma or at the very least micro trauma.

Given this perspective and allowing for the possibility of exceptions, subluxations are a result of injuries and injuries will have a subluxation at their core.

Ortho neural exam v. chiropractic analysis

There are two problems with an ortho/neural exam. First, this examination should be directed by a complete history which unfortunately, few practitioners have the time in to address. Second, having taught the subject and having reread the books, the IME doctors I have observed rarely perform these tests correctly and at best will perform a cursory examination.

As such, an examination based on a weak history, that fails to direct the doctor to all of the injuries, is further weakened by unreliable testing. On the other hand, any chiropractor in a subluxation-based practice knows how to adjust and has a chiropractic analysis that provides far greater information as to where the problem lies and how to address it.

Treating the injury v. correcting the subluxation

Since most motor vehicle crashes produce sprain/strain injuries then for the most part treatment of motor vehicle injuries is a soft tissue issue. The medical model is that a strain should heal in six weeks, most often on its own. Insurance companies will use this assumption to deny payment past two months. Sadly, that medical model tends to overlook the sprain injuries.

As a chiropractor, it is important to understand the limitations of what you can do and knowing at what point a referral is indicated. At the same time is equally important for our medical colleagues to understand the limitations of their training and scopes of practice to see the importance of referring to a chiropractor prior to attempting more invasive therapies.

Most of the pain centers with which I have worked here in Arizona understand this principle.

Personal injury pain centers owned and operated by chiropractors have an MD or a DO on staff to address the more serious injuries when needed. Likewise, most medically based pain centers have chiropractors on staff to provide that first line of treatment.

Bottom line; a personal injury case does require a greater degree of diagnosing, testing and documentation along with referral to the specialist best equipped to address what goes beyond your scope of practice. All of that should be in conjunction with chiropractic adjustments.

Scottsdale chiropractor, Bill Gallagher is the founder of the American Academy of Motor Vehicle Injures. He can be reached at drbillgallagher@yahoo.com or 480-664-6644.

REFERRALS WANTED!

ERIC W. SCHMIDT

Attorney Eric W. Schmidt is a seasoned litigator who has dedicated over 14 years to practicing exclusively in the area of personal injury law and insurance claims. Over the course of his career, he has gained experience practicing in both California and Arizona, and was the founding Partner of two law firms.

A graduate of San Diego State University and Western State College of Law, Attorney Schmidt has served as the lead trial lawyer in over 20 Maricopa County jury trials, and has participated in more than 200 mediations and arbitrations, the majority of which resulted in significant results for his clients. Eric Schmidt will provide competent legal representation to Phoenix and Arizona residents, and to those who are injured in California.

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Wayne Bennett ~ AAC Chiropractor of the Year

Jeff Woolston, DC, CMVI

If you spend any time with Wayne Bennett, you realize that he is a man of action and a man that loves to fight for a cause.

This years' AAC Chiropractor of the Year is honored for just those reasons. Wayne led the fight to get chiropractic included in Arizona's Medicaid program AHCCCS. Even though the AAC was successful in getting the bill passed, the Governor pulled the plug on funding, thus killing it.

Wayne is not easily deterred. In fact, he was honored to be recognized although he felt as though he hadn't earned it yet. He said, "I almost wanted to say to the guys you know what, I appreciate it, but let me get this job done, then give it to me."

You see, Dr. Wayne Bennett is a native Arizonan and prides himself on what he calls his western man value system. He comes from a strong lineage of railroad men and renaissance men that forged his strong convictions. Wayne said, "You don't really measure yourself through external recognition but you kind of measure yourself by who you see in the mirror in the morning."

I asked Wayne if he was a cowboy. He quickly said that that was an earned distinction he could not claim, although he acknowledged the western man/cowboy mentality shaped his approach to life. Like a cowboy Wayne stated "You ride for the brand. Every ranch has a brand so you ride for that brand, which means you do whatever it takes to get the job done."

For the last 25 years, "the brand" for Wayne has been chiropractic. In fact, Wayne got involved with the AAC even before he was out of chiropractic school. He moved back to Prescott after he graduated from Palmer West in 1992. He had a very good group of old timer chiropractors that were really good leaders, good men, and good mentors. They had little gatherings and groups locally that led to him getting involved with the state association.

"I have always been involved in whatever I was doing because that is how I was raised." Said Wayne. "You just show up and say what needs to be done. I'm not really all that good to have around if there is not something worth fighting for. My wife, Mary will tell you this for sure. My wife is good at organization and logistics. Which is probably why we are a good team."

"My strengths are not in that area. In fact if things are not happening, I have a tendency of stirring things up. So I have to watch myself in that sense. If there is a fight going on or something that needs to be done then that's when I'm good. I'm one of those sick guys that will run towards a fight or a fire not away from it." Wayne added, "I think there is something rewarding in the simple act of doing it. Even when you are not successful, if you have done it in an honorable way than your life is enriched because of that."

I asked Wayne how do we motivate more chiropractors to get involved with the AAC?

Wayne simply stated, "My presumption is everyone should be involved if they are really going to be a truly integrated person. We hear a lot about self-actualization and fulfillment. You don't achieve self-actualization in a vacuum by yourself on an island. That happens when you interact with humanity. There is a sense of responsibility and duty, and a sense of service, if this is not part of your makeup then it's not part of your makeup, and you're not going to have as good a life in its absence."

"When I feel like there is something that calls to me and needs to be done, typically that's when I step up, and in our profession that's like every week. We have been kicked around and mistreated and disrespected in a lot of ways, I feel like we deserve better."

Wayne's calling of late is getting chiropractic in to AHCCCS. He says, "I didn't go hunting trouble with AHCCCS, it came to me." When he was president of the state association in 2004, it was an issue than, the AAC made a run at it, and almost got inclusion then.

"What is not to like about the argument? It's a strong argument. The only reason you wouldn't include chiropractic into AHCCCS is for financial or political reasons."

"When the opioid situation developed we already had all this evidence that we had been accumulating on the management of chronic pain. It seemed like the timing was right and I was hopeful the state association would recognize that as well. I am pleased to see that we have a good core of leaders in our group that I am actually impressed with."

"I think this is an opportunity whose time has come. I think we need to be successful at it and use every resource to make that happen, because there is over a million people that need our help."

"The cost to maintain a person in chronic pain on opioids costs the state, on average around $32-33,000 a year, and it doesn't even work. It's not even managing it. Those statistics in the cold light of truth are just appalling."

Wayne laments, "We didn't get the bill passed. The opportunity we are presented with now is to significantly move forward and set a whole new baseline in terms of engagement of chiropractic services in the management of chronic pain. Because the first thing we need to understand is we are not treating acute pain; we are managing chronic pain. The benchmarks and measures of success and the benchmarks of determining medical necessity when managing chronic pain is very different than that of treating acute pain."

"We can move chiropractic to a whole new level through this AHCCCS program if we are able to:

A. Be able to use our full scope of practice, and be reimbursed for our full scope of practice because we need to use our full scope of practice to be effective.

B. Make the medical necessity model for managing chronic pain understood to the extent that we don't measure the number of visits and treatment dosage by the same benchmarks."

"I really hope that this year when we come back we can do what they have done in Virginia and/or Missouri. In those states, the medical necessity basic benefits packages have a non-preauthorized 20 visit minimum of care available, if chronic pain management is documented. We would move our profession into a position being able to accept AHCCCS patients. We are talking about over a million patients in our state who have chronic pain with no pre-authorization, with a 20 visit minimum, and at full scope of practice. And we would be able to step into an environment that could really make a meaningful measureable impact, at a time where there is a real crisis and it's under the microscope of the health care environment. So, I see it as a magnificent opportunity."

We talked about a recent national story on opioids that 72,000 people died of overdose in 2017. Wayne was quick to point out 40% of those deaths came from heroine. "That's the sad results from the current Governor's guidelines of turning the opioid crisis over to the pharmaceutical people to come up with the solution to the problem. And low and behold, the solution we have is a brand new drug and new ways to use drugs for patients who already have a drug problem."

"There is no mention whatsoever in the governor's opioid game plan of non-pharmacological management, and that's a significant oversight. We need to address that because if we don't, we are going to see more of what we are already seeing. I have patients coming to me already who are saying they are cutting back on their opioids but they are not being given anything to replace it with. What they should be replacing it with is non-pharmacological care, such as chiropractic, physical therapy, massage and acupuncture."

"By removing the supply of opioids, without dealing with the driving addictive pain issue, that is going to drive people out the bottom. They are addicted and they can't get access to the meds, so

(Continued on Page 16)

(Continued from Page 15)

what do they do? They go to the street and they take heroine. And I believe if we watch these statistics carefully, until we address this problem, we are going to see that mortality rate go up."

I asked Wayne how does the inclusion of chiropractic into AHCCCS help our profession and society as a whole?

"What I would like this to be about, is that we would get the ear and attention of more fellow chiropractors to increase their awareness, so that they really understand that we are offered a wonderful opportunity to advance our profession forward, to help a whole bunch more people, and become a meaningful player in a solution to a real problem that our culture has."

"Talk about cultural authority and cultural validity, what better way to achieve cultural validity and authority than to step in and contribute to the resolution to a problem in a big way. I believe we have an opportunity to do that, but we need better awareness by our provider brotherhood and sisterhood. If they can get behind this and contribute we can really do this. We are going to need resources; we are going to need time, treasure, and talent. I sure would like to see when we come back around this next legislative session to have more of that available to us."

So rise up fellow Arizona chiropractors! The brand that can take us to new heights starting with inclusion in AHCCCS this year, is the AAC. Get involved. Look around. Do what needs to be done.

In closing Wayne shared a favorite quote from western author Louie L'Amour, "You can't stop a man who knows he's right and just keeps a coming"

That's right Arizona, the AAC chiropractor of the year, Dr. Wayne Bennett, won't back down until this fight is won!

Dr. Jeff Woolston is a delegate with the AAC and practices in North Scottsdale with his wife Dr. Larissa Woolston.

PAIN MANAGEMENT 101 – PART THREE

By Trever Penny, DC, MUA CICE

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Our company throws professional mixers every year. Regular attendees include personal injury attorneys, medical doctors, pharmacy reps, chiropractors, physical therapists, diagnostic imaging consultants and even orthopedic surgeons. Our marketing personnel will introduce you, creating new business relationships.

We Focus On Personal Injury:

Personal injury was the impetus for the founding of West Valley Pain Solutions. All pain procedures are performed in an office setting, eliminating the facility charge from the bill. Since our over head is lower; policy limits and low settlements aren't a problem, and we always wait for payment. Our service adds value to the case allowing more money to be available for all parties at settlement time. We will never be the reason a case can't settle. Even though our pain management bills are lower than other pain management companies, we still negotiate our final settlement fees.

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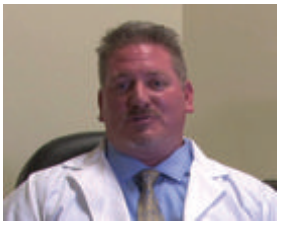

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PERSONAL INJURY QUARTERLY Quiz

by Martin Kollasch, D.C.

Test your knowledge of some basic personal injury topics covered during the American Academy of Motor Vehicle Injuries' curriculum by answering the following questions. There is only one correct answer.

Match the pain descriptor with the most likely tissue generating the type of pain. (Each descriptor has only one answer but, the answers [A, B, C, D] may be used more than once or not at all.)

Pain Descriptor	Tissue of origin
1. Throbbing pain	A. Bone
2. Cramping pain	B. Nerve
3. Deep dull pain	C. Muscle
4. Shock-like pain	D. Vasculature

5. A patient's cervical range of motion (ROM) is significantly restricted and painful during active ROM, passive ROM is nearly normal and nearly pain free, yet isometric contraction produces pain. Which of the following tissues is, or are, most likely injured?
   A. Ligaments only
   B. Nerves only
   C. Muscles only
   D. Muscles and ligaments

6. Consider the doctor's instructions to a patient during testing of reflexes and dermatomes. The patient should be instructed to _____.
   A. keep both eyes open
   B. close both eyes
   C. cover or close just the ipsilateral eye
   D. cover or close just the contralateral eye

7. Hypotonicity and or weakness of a sternocleidomastoid muscle suggests a lesion to which cranial nerve?
   A. Glossopharyngeal (CN IX)
   B. Vagus (CN X)
   C. Spinal accessory (CN XI)
   D. Hypoglossal (CN XII)

8. Which of these is the most likely cause of vascular injuries to the neck during a motor vehicle crash?
   A. Tearing during hyperflexion
   B. Tearing during hyperextension
   C. Direct contact with an airbag
   D. Direct contact with a shoulder harness

9. Which combination of symptoms is consistent with a compression injury to the C6 nerve root?

	Numbness of:	Weakness of:	Diminished DTR of:
A.	Back of neck	Shoulder shrug	Triceps
B.	Lateral shoulder	Arm abduction past 90 degrees	Biceps
C.	Tip of thumb	Wrist extension	Brachioradialis
D.	Ring finger	Finger flexion	Triceps

10. Which of the following statements best characterizes daily chiropractic care of a whiplash patient during the first week following a motor vehicle crash? It is _____.
    A. the standard of care when supported by exam findings
    B. excessive and could be grounds for disciplinary action
    C. contrary to research but justifiable in some rare cases
    D. justifiable only if the patient requests it without prompting

Dr. Kollasch is a Phoenix native and practices in Scottsdale. He also worked with the National Board of Chiropractic Examiners for nearly 20 years. You may contact him at (480) 948-6020 or martin.kollasch@gmail.com.

Answers: 1 – D; 2 – C; 3 – A; 4 – B; 5 – C; 6 – B; 7 – C; 8 – D; 9 – C; 10 – A.

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Concussion Recovery Center

Bill Gallagher & Lois Laynee

For all the injuries that doctors fail to diagnose in a personal injury case, the one most commonly missed is concussion. Misconceptions abound around this condition ranging from believing that there needs to be a the loss of consciousness to make the diagnosis to the thinking that you can just shake it off and get back out there.

So first, we must address the myths. The definition of concussion centers around an alteration of consciousness following a trauma. There does not need to be a loss of consciousness to make this diagnosis. There does not need to be direct impact of the head to have this condition. It is not necessary to have a diminished Glasgow Coma Scale score in order to make this diagnosis. In fact, most people who suffer a concussion in a motor vehicle collision will have a Glasgow total score of 15/15.

It is highly unlikely that you could damage structures in the cervical spine without causing injury to the brain and its associated structures. For a clinician who understands the mechanism of injury, diagnosing concussions is a no-brainer.

Given sufficient force to damaged ligaments, muscles, discs, and even bones in the cervical spine a coup contra-coup injury is to be expected. This motion of the brain inside the cranium will cause impact as the brain bounces front to back or side to side.

This rapid motion of the brain can also cause trauma to the cranial nerves as they pass through fossa and foramina in the base of the skull. Traction on these nerves across the bony surfaces are likely to cause diminished functioning at the very least. This can measured with a proper cranial nerve exam to document the injuries.

Two other injuries that are commonly found are first, cerebellar tonsillar ectopic, which can cause severe headaches and a multitude of other symptoms has been found in 23.3% of whiplash cases. Also commonly seen especially with female patients is trauma to the pituitary gland, which controls hormones. While few doctors will pose the question, it is common for a woman to have menstrual problems after a collision.

With the opening of the Concussion Recovery Center, here in the Valley we can now provide you with the testing to validate the diagnosis along with treatment to support that. Some of this testing can even be administered in the attorney's office.

We offer a four stage testing protocol that begins with the Rivermead Post-Concussion Symptoms Questionnaire. This one page survey addresses sixteen areas of concern can be administered in your office after a crash. It comes with scales from 0 to 4 and if your client circles threes or fours that is a clear indication of a concussion. With positive findings on this questionnaire, we can arrange for your client to do a cloud-based, neuropsychological assessment. This takes about 30 minutes and includes a battery of tests to observe brain functions that are the established standards in the field of concussions.

The next step when this battery of tests indicates the patient has suffered a concussion is to actually perform a cranial nerve exam. Unfortunately, very few doctors do these test and many have told me they stopped doing it because they never really found any positives. The Dynamic Functional Cranial Nerve Examination developed by Lois Laynee checks all twelve pairs of cranial nerves and each of their functions. If your client has suffered a concussion in a collision this examination will find the injuries.

The final step when indicated is more sensitive electro-diagnoses and radiology. This includes the QEEG which reads beyond a standard EEG and can assist us in mapping areas of the brain that are no longer functioning properly.

With a personal injury case, diagnosing all of the injuries is paramount. Our testing clearly supports that diagnosis. The protocol for addressing the concussion at the Concussion Recovery Center focuses on retraining the cranial nerves to function properly. The treatment program that follows is designed to retrain each of these nerves and each of their functions allowing us to demonstrate improvement or permanence on follow-up examinations.

Lois Laynee teaches concussions and cranial nerves for the American Academy of Motor Vehicle Injuries. She can be reached at 480-664-6644.

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Sept 29-30 MOD V: Documentation for Motor Vehicle Injuries
Dec 1-2 MOD III: Outcomes Assessment Tools for Motor Vehicle Injuries

LA
April 7-8 MOD II: Medical Legal Issues for Motor Vehicle Injuries
May 5-6 MOD IV: Radiology for Motor Vehicle Injuries
Sep 22-23 MOD VI: Spinal Examination for Motor Vehicle Injuries
Oct 27-28 MOD X: Whole Person Permanent Impairment Rating for Motor Vehicle Injuries

San Diego
Jul 28-29 MOD VII: Extremity Examination for Motor Vehicle Injuries
Oct 13-14 MOD I: Spinal Ligament Injury in Motor Vehicle Injuries

Chicago 2018 Schedule
Jun 16-17 MOD X: Whole Person Permanent Impairment Rating for Motor Vehicle Injuries
Aug 18-19 MOD IV: Radiology for Motor Vehicle Injuries

Davenport 2018 Schedule
Sept 15-16 MOD III: Outcomes Assessment Tools for Motor Vehicle Injuries
Oct 6-7 MOD I: Spinal Ligament Injury for Motor Vehicle Injuries
Nov 3-4 MOD V: Documentation for Motor Vehicle Injuries
Dec 8-9 MOD IV: Radiology for Motor Vehicle Injuries

Phoenix 2018 Schedule
Jan 20-21 MOD III: Outcomes Assessment Tools for Motor Vehicle Injuries
Feb 24-25 MOD II: Medical Legal Issues in Motor Vehicle Injuries
Mar 24-25 MOD VI: Spinal Exam for Motor Vehicle Injuries
April 21-22 MOD IV: Radiology for Motor Vehicle Injuries
June 9-10 MOD V: Documentation for Motor Vehicle Injuries
July 14-15 MOD I: Spinal Ligament Injury in Motor Vehicle Injuries
Aug 11-12 MOD VII: Extremity Examination for Motor Vehicle Injuries
Sept 8-9 MOD VIII: Case Management for Motor Vehicle Injuries
Oct 20-21 MOD IX: Concussions and Cranial Nerve Exam for Motor Vehicle Injuries
Nov 10-11 MOD X: Whole Person Permanent Impairment Rating for Motor Vehicle Injuries

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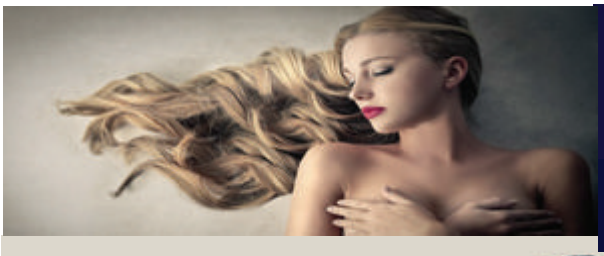

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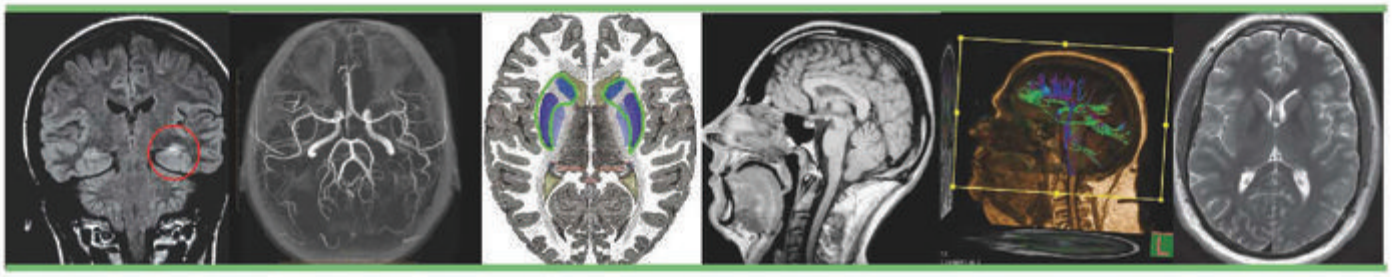

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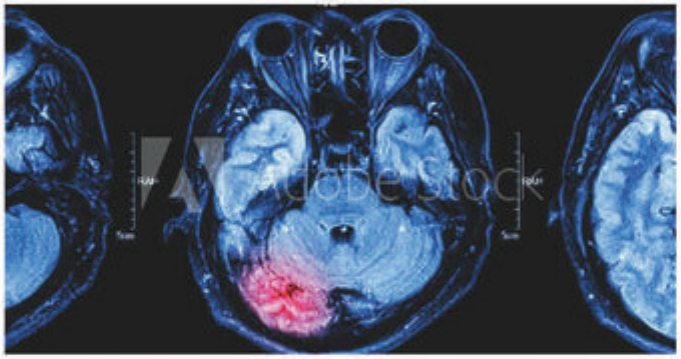

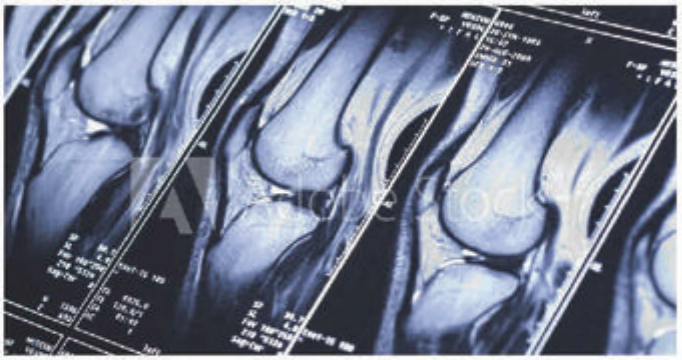

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