ARIZONA ASSOCIATION OF CHIROPRACTIC

PERSONAL INJURY QUARTERLY

Volume 2, Issue 4

INSIDE THIS ISSUE:

Dr. Jeffrey A. Cronk, DC, JD

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The AAC Personal Injury Quarterly

2018—4th Quarter— Issue 4

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

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Injury Care with X-ray Diagnostics Can Expand the Chiropractic Profession

By Jeffrey Cronk, DC, JD

In America today, there will be over 108,000 injuries that will require over 115,000 emergency room visits and will generate over 252,000 medical visits. (1) These by the way are not visits to chiropractors or to physical therapists. These are medical doctor visits.

Auto injuries generate the most costs, followed by home injuries, then work injuries and then injuries outside of the home called public injuries. On the work injury side our employers spend and average of $42,000.00 per medically attended injury (2). Some calculators place a $50,000.00 price tag on just one back injury with the costs going over $275,000.00 if the injury goes beyond three years. (3)

Patients with chronic lower back pain can expect to spend $9000,00 to $19,000.00 a year to medically mange this condition according to the American Pain Society. (4)

Spinal ligament injuries are the number one cause of all this chronic pain and disability and these costs are at epidemic levels in the market today. Societal costs of all injuries in America is around 12,000,000,000.00 dollars a day! (5) Yes, that is 12 Billion a day. That is about the total size of the whole year of the chiropractic market in one day. Again, the biggest offenders in this injury market are the spinal soft tissue injuries. If these are just "soft tissue injuries" why are they so out of control in cost, chronic pain and disability? Now a better question is why you as a Doctor of Chiropractic so beaten up in this market or in the case of work comp in some jurisdictions not even really in the market.

How about this fact, our injury experts of yesteryear were so good, some of them even created the current injury guidelines such as the ODG guidelines used in Work Comp. If these injury experts, these injury leaders, these injury guidelines are/were so good, then why are these conditions at unsustainable levels cost and chronic pain wise? Why do top researchers like Dr. William Marris with the Biodynamics Laboratory out of Ohio State University, explain to us in his book, (The Working Back a System View), that 80-90% of all Low Back Disabilities do

not have a pathoanatomic cause identified. The doctors treating these patients are not sure what is causing the problem. That is a problem! Yes, diagnosing this condition is a problem for most doctors, but it does not have to be for us.

If the current state of our medical experts and their guidelines are so good, why are there such poor results in the market?

Now some of you reading this may be starting to think that we as a profession have solutions to this, especially in the spinal soft tissue area of spinal injuries. I am glad that you are thinking that, because we do have the solution to this problem on a very broad scale. There has never been a greater time to lead in this market because right now it appears to be led by the confused that are not even sure how to find the underlying cause of the problem in these types of injuries.

Why aren't we as a profession taking a leading role in solving these problems?

Well it is very easy to understand when you realize we do not apply our own most basic axiom, "alignment improves function" to ourselves as a profession. Where are we aligned in our procedures in this area? Certainly, we are not aligned in our injury procedures. We even have our national organizations trying to reduce the utilization of x-ray which happens to be the only imaging tool that can standardly analyze and assess for the most common cause of spinal pain which is spinal instability due to ligament damage. We tell the public how important spinal alignment is to their health and function, yet some in our ranks seem to specialize in misaligning ourselves so that we stay dysfunctional as a group.

The bottom line is this, to scale we must align our procedures and nowhere is it more evident than in the area of spinal soft tissue injuries.

A patient with a spinal soft tissue injury had ought to be able to walk into any chiropractors' office and get a standard spinal soft tissue work up. This must be like a patient walking into a dentist's office with a cavity. Pretty much any patient can go into any dental office and get almost an identical work up. By the way, how is that profession which is so aligned doing?

In our offices the patient must be able to walk in and get a standard spinal instability exam, which includes standard stress x-rays and a standard excessive motion measurement procedure. At Spinal Kinetics which is a national medical company that does spinal ligament damage assessments, we trademarked the term CRMA® Computerized Radiographic Mensuration Analysis as our term for doing this testing.

The doctor also must be able to standardly determine if the complicating factor of a disc herniation also exists with spinal instability.

Early, accurate and standard assessments of this condition by our profession would change the injury market overnight! With this we could begin to approach large industry and insurers with the understanding that we are now able to standardly knock out their number one cost, their biggest problem, the spinal soft tissue injury.

Remember everything we do should be about better early diagnostic procedures that standardly and objectively identify the problem (injury derangement) which leads to earlier and more successful interventions. This of course would lead to far less pain and far less disability. That makes you highly relevant in the market today. Aligning our procedures is the only way!

1. https://www.cdc.gov/nchs/fastats/injury.htm
2. http://www.nsc.org/Membership Site Document Library/2015 Injury Facts/NSC_ InjuryFacts2015Ed.pdf
3. http://www.accurateergonomics.com/the-cost-of-msd-injuries/
4. http://americanpainsociety.org/uploads/education/guidelines/evaluation-management-lowback-pain.pdf ❖

Dr Jeffrey A Cronk, DC, JD is the Director of Education for Spinal Kinetics and can be reached at 877-508-9729. He also the founder of the SmartInjuryDoctors™ and SmartInjuryLawyers™ program which can be found at www.smartinjuryeducation.com

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	INT BLEEDING		
LIPID PANEL********	LIPID	**BASIC PANELS**	CMCC)
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CBC (DIFF/PLT)	CBC		CMCC)
UA, COMPLETE	UA		CMCC)
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INSULIN	INSULIN		
CK, TOTAL	CK	**ADVANCED MKRS**	CMCC)
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CARDIO CRP	CRP		
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PHOSPHATE (AS PHO	Phos P		CMCC)
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Reticulocyte count	Retic ct	Bleed	
Co Enzyme Q 10	CoQ10		
IGF-1	IGF-I		
Calcium, Ionized	Calcium, Ionized		
IODINE urine test	Iodine		
Catecholamine's	Catecholamine's (Ref In AAC PI Qrtly article)		
T-3, TOTAL	T_3 tot	**THYROID**	
T-3, UPTAKE	T_3 up		
T-4, FREE	T_4 free		
T-4 (THYROXINE)	T_4 tot	Concussions/TBI	
THYROID PEROXIDE A	TPO		
TSH	TSH	Concussions/TBI	CMCC)
T-3, FREE	T3Free03	Concussions/TBI.	
T-3, REVERSE	T3Rev		
DHEA	DHEA	**HORMONES**	
CORTISOL AM	cortisol AM	Concussions/TBI	
CORTISOL PM			
VITAMIN D	Vit D		
SHBG	SHBG		
TESTOSTERONE -	..T..	Concussions/TBI	
ESTRADIOL			
PROGESTERONE			
ESTROGEN, TOTAL			
FSH	FSH	Concussions/TBI	
LH	LH	Concussions/TBI	
PREGNENOLONE			
PROLACTIN	Prl	Concussions/TBI	
PSA free & tot			CMCC)
ANA W/RFX	ANA	**INFLAM DISESE**	CMCC)
RHEUMATOID FACT	RA		CMCC)

Referenced in AAC PI Qrtly article:.

H Stephen Injeyan, MSc, PhD, DC, Allan C Gotlib, BSc, DC and John P Crawford MSc, PhD(Path), **DC The clinical laboratory in chiropractic practice: what tests to order and why?** J Can Chiropr Assoc. 1997 Dec; 41(4): 221–230. CMCC)

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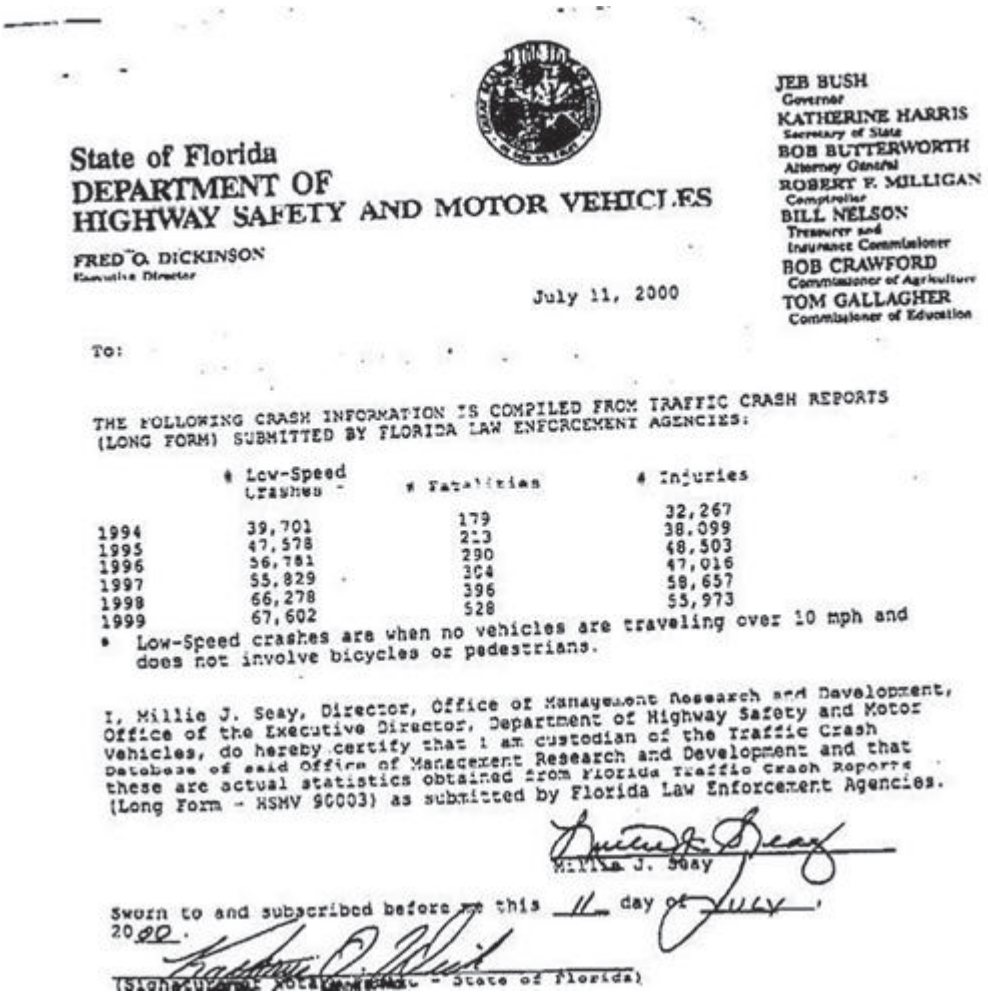

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July 11, 2000

To:

THE FOLLOWING CRASH INFORMATION IS COMPILED FROM TRAFFIC CRASH REPORTS (LONG FORM) SUBMITTED BY FLORIDA LAW ENFORCEMENT AGENCIES:

	* Low-Speed Crashes	# Fatalities	# Injuries
1994	39,701	179	32,267
1995	47,578	213	38,099
1996	56,781	290	48,503
1997	55,829	304	47,016
1998	66,278	396	58,657
1999	67,602	528	55,973

* Low-Speed crashes are when no vehicles are traveling over 10 mph and does not involve bicycles or pedestrians.

I, Millie J. Seay, Director, Office of Management Research and Development, Office of the Executive Director, Department of Highway Safety and Motor Vehicles, do hereby certify that I am custodian of the Traffic Crash Database of said Office of Management Research and Development and that these are actual statistics obtained from Florida Traffic Crash Reports (Long Form - HSMV 90003) as submitted by Florida Law Enforcement Agencies.

Millie J. Seay

Sworn to and subscribed before me this 11 day of JULY, 2000.

(Signature illegible - State of Florida)

Tragedy and Hope in Pittsburgh

by Dr. David A. Sheitelman, DC, Chiropractor
Past President, Arizona Association of Chiropractic

It is no wonder that most people do not want to get involved in anything that seems to relate to politics. This sentiment is probably based on the rhetoric and divisiveness that we have seen in the media and different outlets over the last couple of years. To compound this feeling, I was truly saddened and angered to see pundits and media types use senseless murders of 11 Jewish souls in Pittsburgh to push their own personal agendas. It makes me want to check out, stop educating myself on the political process, pull up to the sofa and finally get down to binge watching game of thrones.

Then on my morning commute a radio show gave me pause and cause for hope. In a remarkable humanitarian display, two Muslim groups have raised $210,000 for their cousins of faith. Rather than dwell on the seemingly never-ending political and military conflicts of the middle east these organizations made the world a better place by standing up for what they believe in. If the squabbling children of Isaac and Ishmael can come together surely, we as chiropractors can get over our petty chiropractic disagreements.

In fact, I would argue that politics gives us an opportunity to do what is most needed today - **We must come together speak up and stand up for our ideals**. And by our ideals, I mean our shared chiropractic ideals.

When individual chiros are in their practice, within a 5-mile radius of their office they are true superstars of health-care. Chiros are great marketers. Many are perpetually spreading the "good news" of chiropractic to their communities and thrive on doing what is right for the patient. Many chiropractors are generous to a fault. In my last four years as president of the AAC I have seen more than a few chiropractors put their patient's well-being above the well-being of their bottom line. Moreover, chiropractors are innovators and truly life-time learners that possess a keen interest in learning tools and technologies to get their patients better without the use of drugs and surgery.

It could effectively be argued that, chiropractors are the last profession that authentically sees the human frame as a self-healing, self-regulating organism that needs very little outside influence to express true health. Chiropractic brings hope to a medical model that is schizophrenically the most amazing health care and broken health-care system in the world.

The AAC believes, that as a profession we can change the hearts and minds of the people of Arizona. We believe we can build a community that honors the patient's choice in health care without bureaucratic bullying. We believe Chiropractors should be able to practice without fear of financial ruin from government agencies or corporate greed. We believe chiropractors should be treated equally in the eyes of the law and respected commensurate with our education, training and experience.

I won't sugar coat this, there are a lot of greedy people against us and it will take all of us to achieve our goals. It will take motivation, purpose, intent and action. On the flip-side, there a lot of well-meaning lawmakers that respect you and want to hear from you. Building a strong profession is a lot like building a profitable practice - It's all about your relationships.

Perhaps we can use this senseless tragedy to rededicate to our vision and bond to each other as chiropractors. Let's use this energy to become like the people of Pittsburgh – strong like Steel! ❖

Preliminary-Review of the CI [Clinical information element(s)]: Seeking an objective opinion, including supporting rational, relating to the following question(s):.

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

Cited by >100/***|>1000/**** State,Country,Univ,Dept, or Lab

1...What is/are the injury(ies) or condition(s) diagnosed and documented in the clinical records ?

Mechanism of injury as described and taught in the certificate in motor vehicle injuries(CMVI) presented by the American Academy of Motor Vehicle Injuries. Including: CRMA, alteration of mental status, ensuring a reliable airway, CDC concussion symptoms (Physical, Cognitive, Emotional and sleep elements) are some of the post-graduate higher education elements available when Dx a MVC trauma !!

Patient should be tested for prediabetes if you are overweight or have obesity *((epidemic))* and have one or more other risk factors for diabetes. (ADA)

A waist measurement of 40 inches or more for men and 35 inches or more for women is **linked to insulin resistance.** This is true even if your body mass index (BMI) falls within the normal range.

- National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK),

Conditions such as obesity, insulin resistance, prediabetes and Diabetes disease will/would be determined using the elements tested in the following study guidelines and standards of care positions:

- NHLBI Obesity education Initiative >7000/****
- Insulin Resistance & *Prediabetes | NIDDK *FPG/Glu 100-126mg/dL *A1c 5.7-6.4%
- American Diabetes Association. Standards of medical care in diabetes—2017. (ADA)

Condition known as the Stress response will be/was graded by measuring Cortisol and catecholamine levels correlate with the type of surgery, the severity of injury, the Glasgow Coma Scale and.... The increased release of stress hormones results in multiple effects (metabolic, cardiovascular and immune) aimed at restoring homeostasis during stress.

- VA Critical Care Medicine and AUSTRALIA Intensive Care Research Center***

Cortisol, a steroid hormone of the glucocorticoid class, is released in response to stress. Cortisol release is associated with depression, anxiety, and other negative emotions.

- Faculty of Psychology, Beijing Normal University, Beijing, China
- Collaborative Innovation Center of Assessment toward Basic Education Quality, Beijing Normal University, Beijing, China
- College of P.E. and Sports, Beijing Normal University, Beijing, China
- Department of Psychology, University of Chinese Academy of Sciences, Beijing, China
- Key Laboratory of Behavioral Science, Institute of Psychology, Chinese Academy of Sciences, Beijing, China
- Department of Psychiatry, Massachusetts General Hospital, Harvard Medical School, Boston, MA, United States

Metabolic syndrome is a clustering of risk factors, such as central obesity, insulin resistance, dyslipidaemia, and hypertension that together culminate in the increased risk of type 2 diabetes mellitus and cardiovascular disease. As these conditions are among the leading causes of death worldwide and metabolic syndrome increases the risk of type 2 diabetes *fivefold* and cardiovascular disease *threefold.* It is of critical importance that a precise definition is agreed upon by all interested parties.

- School Pharmacy and Pharmaceutical Sciences, Trinity Biomedical Sciences Institute, Trinity College Dublin, Dublin, Ireland /cited 349 >100/***

According to the National Cholesterol Education Program (NCEP) Adult Treatment Panel III (ATP III) definition, metabolic syndrome is present if three or more of the following five criteria are met: waist circumference over 40 inches (men) or 35 inches (women), blood pressure over 130/85 mmHg, fasting triglyceride (TG) level over 150 mg/dl, fasting high-density lipoprotein (HDL) cholesterol level less than 40 mg/dl (men) or 50 mg/dl (women) and fasting blood sugar over 100 mg/dl.

- Cardiovascular Research Center, Massachusetts General Hospital cited by 623 >100/***

2...Is the treatment consistent with the injury(ies) or condition(s) diagnosed and documented in the clinical records ?

Doctor awarded Advanced certificate of Competency and Certificate of Completion from Spine Research Institute of San Diego and will/would be using Croft guidelines when providing treatment frequency and duration documented in the Clinical information.

3...What is the etiology of the diagnosed injury(ies) or condition(s) ?

****Causation of injury also documented*

1) X-rays taken to identify subluxations ..etc Industry guidelines

2) CRMA was performed for technical review…(ligament instability)..etc AAMVI AZCE****
3) CT better for imaging acute hemorrhage (bleed or fractures) AAMVI AZCE****
4) The preferred T3 closed MRI - Chiari malformations(CM) congenital v. traumatic AAMVI AZCE****
5) Tonsilar invaginations acute vs congenital. Found in brain stem injury in whiplash on upright MRI in 23.3% of cases. Common to have severely **rotated** upper cervical. F>M / >Celtic descent AAMVI AZCE**** Mechanism of Injury
6) Symptoms and Diagnosis of the Chiari Malformations AAMVI AZCE****
7) Stages of mTBI (Acute, Sub-acute, Chronic) AAMVI AZCE****
8) Pure deceleration forces can produce diffuse axonal injury (DAI) many times complaints of dizziness. Nerve cells die causing inflammation. Diagnosis of DAI classified into grades. AAMVI AZCE****
9) Diffusion tensor imaging (DTI) will be especially helpful in cases involving high velocity change injury, such as high speed car accidents in which the injury is suspected to be Diffused Axonal Injury (DAI) AAMVI AZCE****
10) Injury to Pituitary or pituitary dysfunction requires evaluation. /Sella turcica (AACE –Clinical review)
11) Thyroid dysfunction can be made and survival associated with higher values…
12) The Glasgow Coma Scale (GCS) is the primary selection criterion for inclusion in most TBI clinical trials … KY Univ. of Kentucky and Workshop Scientific Team and Advisory Panel Members-Collabrators(31)***, and should/must be used in clinical documentation especially when providing quality clinical information which may be needed in litigation standard of evidence process.
13) Questionnaires presented in the AZCE**** American Academy of Motor Vehicle Injuries were reasonable and Necessary when documenting the MVC injury(ies) or condition(s) to support a research based clinical diagnosis's. (RBCD)

4…Are the type, intensity, frequency, and duration of the provided treatment/services/products *consistent* with the severity of the documented injury(ies) or condition(s) ?

Verifying of over 100 unique data elements (UDEs) listed in the clinical documentation with research guidelines and additional specializes diagnostic dynamic tools and technical reviews of injury(ies) or condition(s) to provide the best and safest treatment outcome.

Itemize-List all forms…including questionnaires..[Titles or name]...Provided in clinical information to ensure that all unique data elements (UDEs) for both the limited dataset and the deidentified information are addressed in CI communications.

(Transparency and using ICD language are needed for proper transfer of CI documentation elements. MVC injury(ies) or condition(s) are overlooked or under evaluated in the current American prescription industry epidemic (APIE)) an unsupervised data exploratory analysis.

….Emergency departments(ED) which have been described as a "natural laboratory for the study of error"….

- (NY Columbia U/ TX U of Texas/ New York-Presbyterian Hospital)

The "Incidence rates for deaths directly attributable to medical care gone awry haven't been recognized in any standardized method for collecting national statistics " says Martin Makary, M.D., M.P.H. professor of surgery at the Johns Hopkins University School of Medicine and an authority on health reform. "

- The current opiod epidemic *must be considered as a probable cause of undervaluation of injury(ies) and condition(s) in* the push to sell addictive drug pathways as a primary treatment plan. Advertising pills/tx is increasing $$$$$ at un-monitored levels and no other options are disclosed about other professions/physicians in the industry. Chiropractic physicians clearly provide non-addicted and safer treatments plans.
- All Tx options must be disclosed for the epidemic to be held in check and agreed upon by all interested parties.
- DEA licensed/certified physicians in the medical Associations should be referring to chiropractors who can provide the safest most effective treatment (non-opiod tx) for MVC injury(ies) or condition(s).

5…What is the patient's prognosis ?

This is when your standardization and/or collective intelligence of Clinical information (CI) is needed to determine if additional care is needed, and having the CI already documented relating to the ability to establish future treatment as reasonable and necessity. Many doctors outside our scope of practice have been trained in evaluating future care recommendations (called a medical validation). These validations may/should be utilized to ensure that the most beneficial and least addictive treatment choice is a made available in the clinical information.

Clue… Continued chiropractic care is often recommended temporarily because it is the safest NON-Addictive pathway for pain injury(ies) or condition(s). With current reimbursement strategies chiropractic care may/will require a medical validation to *properly* ***disclose*** non-pharma/drug recommendations which are currently reimbursed unfairly even when the opiod epidemic is a imminent danger to public.

(Continued on Page 10)

(Continued from Page 9)

When pain medications are needed temporally, we can utilize the NMD's and MD's who have additional training and are able to provide a medical validation and keep the public safe from the opiod epidemic / American prescription industry epidemic (APIE).

6…Has the condition reached pre-injury status ?

Tricky question…

If a body part(s) is impaired or residual condition(s) are NOT identified when this question is answered, then future care may/would be denied with pre-injury status question…..Also used …Has patient reached MMI ?

Better question…

Which part(s) of the body have reached static MMI, and will there be any additional treatment recommendations for future care for any body part(s) ?

7…Is the current treatment plan appropriate for, and consistent with, the severity of the injury(ies) or condition(s) ?

Current treatment plan was clinically documented with related research clinical information being interpreted/identified/collected and listed to ensure a transparent and efficient mechanism for communicating all findings (ex +,-, normal… observed hypo/hyper functions, No observed dysfunction… high, low, optimal etc..) relating to the MVC and concussion findings identified, including functional and dynamic testing processes supported by related research.

Grossly intact is not an acceptable term when identifying cranial nerve **injury(ies) or condition(s).** Findings often observed with the concussion/TBI condition(s). The physician(s) should documenting injuries(ies) and condition(s) as the research supports. All CN elements must be identified through dynamic clinical testing techniques verified and supported in related research.

8…Is there plan appropriate for identifying exam(s) element(s) for MVC trauma related injury(ies) or condition(s) ?

With proper related clinical information used to document the MVC **injury(ies) or condition(s).** We as a profession can rise above the current opiod standard of care limited examination which is financially bankrupting our healthcare industry. We cannot bailout the healthcare industries opiod abusers by addiction recovery centers reimbursing the probable cause or suppliers of the epidemic. The pharmaceutical companies and medical licensed distributors who over sold these opiod substances should not be financially rewarded for prior bad actions leading to the American prescription industry epidemic (APIE) and contributing to a leading cause of death.

A plan is indeed needed to undo the lack of documenting fundamental elements for identifying known established injury(ies) or condition(s) and agree on what elements are related and should be addressed and documented to be eligible and considered an expert level physician exam. We cannot allow the suppression of documentation supported by research to be considered a non-expert level encounter when the evidence is provided.

> You cannot escape the responsibility of tomorrow by evading it today
>
> ❖ Abraham Lincoln

9…What is/are your diagnosis(es) of the patients injury, disease, or disorder ?

Join

The AAMVI, become certified (CMVI) to gain a higher level of Clinical information relating to MVC trauma injury(ies) or condition(s).

PRINCIPLE 1L. DIAGNOSTIC PROCEDURES The doctor of chiropractic shall recommend and use only those diagnostic and analytical procedures, laboratory and imaging techniques allowable by applicable state and/or provincial law that are in the best interests of the patient, will assist in the patient's diagnosis/analysis and care, and are necessary for the well-being of the patient. Furthermore, a doctor of chiropractic shall recognize his/her responsibility in advising patients of diagnostic/analytic findings and any attendant recommendations therefrom.

International Chiropractors Association / **ICA Code of Professional Ethics / These canons of professional ethics are based upon fundamental principles of moral and professional behavior and recommended for all doctors of chiropractic and chiropractic assistants.**

References available upon request…

Zürich

Bill Gallagher, DC, CMVI

In order to excel at personal injury the first step is tIn October, I had the distinct honor of serving as Chair of the 7th International Conference and Exhibition on Pain Research and Management in Zürich, Switzerland. There are several factors that made this honor so special.

About five months ago, Nelson Hendler, MD was the first doctor invited to speak at this conference. He has done considerable research at Johns Hopkins on pain and failure to diagnose. This includes three studies showing that between 40 and 80% of patients involved in litigation are misdiagnosed and half of those require a surgical procedure.

Upon accepting the invitation, he advised the organizers that if I was available to speak they should grab me because, "he is the best chiropractic speaker." While even I could debate that there are better speakers, there was no way I could pass up an invitation such as this.

A month prior to the conference. I was asked if I would be available to be the keynote speaker, a position to which I quickly answered, "yes". A week later, I was asked if I would be able to present on both days of the conference and eventually to provide the closing remarks.

When I met with Dr. Hendler in Zürich my first question was, "What did you tell them that led them to ask me to co-chair the conference with you?" He was puzzled at the question and told me that he had not spoken about me with them and anything they were asking me to do was based entirely on my own credentials.

What made my appearance at this conference even more notable is the fact that I was the only chiropractor in attendance. Outside of a few researchers, it was a room full of surgeons, anesthesiologists, and pain specialist. I made it clear that as a chiropractor there are things I can do for the patient that they could not do. I also assured them that when I reach a point where I can no longer help a patient I am glad to be able refer to specialists who can.

Despite the nine-hour jet lag I was able to present on "Understanding the mechanism of injury: A means to a better diagnosis" and on the second day, "Failure to diagnose concussion/TBI due to a lack of understanding the mechanism of injury".

Besides being able to open them up to a better understanding of what to look for in an injured patient, I also had the opportunity to let them know what our profession was capable of. With only one psychologist in the conference who had ever been to a chiropractor, it was an eye opener for the rest of the attendees.

Of the thirteen speakers at the conference, all of whom received polite applause after their presentations, my presentations were greeted with the loudest and longest applause. Clearly, I had impressed this room full of surgeons (a little more personality that I added likely helped there too.) More than that they got to see that it is possible for an MD to learn from a DC.

Despite the divergent approaches to pain management between chiropractic and pain specialists, the surgeons were impressed by learning how much they were missing in their own patient care.

The remarks I heard during the breaks ranged from; "I never thought to look for that", "I had no idea how those injuries occurred" on up to "You have at least one very embarrassed MD in the audience because I have never done that part of the examination."

I learned from them too. One doctor had discovered a way to cross the blood-brain barrier by transplanting a piece of the omentum. He believed that this would have saved John McCain's life as it would have allowed the chemo to reach his tumor. Another discovered a better analgesic by simply moving a hydroxyl molecule to a different position.

A video presentation by my colleague Lois Laney on her Dynamic Functional Cranial Nerve Assessment Tool® was also received with great enthusiasm. The MDs who were previously only looking for cortical lesions on MRIs seemed to have forgotten how many other structures in the brain can be injured.

As the chair of the conference I also had the honor of making the closing remarks in which I stated, "We need to work together. We need your research. We need your new pharmacology. We need your innovations in surgical procedures. But you all need to know that not every patient suffers from a deficiency of medication." ❖

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.

Legislative Consideration of Minimum Limits Vehicle Liability Insurance

by Barry M. Aarons lobbyist for the Arizona Association of Chiropractic

A battle has raged in the last few regular Arizona legislative sessions over proposed increases in minimum liability rates for auto insurance. Originally set over forty years ago, Arizona's rates are at the bottom of the national average. Arizona's rates, set by statute at $15,000 for bodily injury for one person and $30,000 for two or more persons, have been way overdue for revision. Realistically those levels are hardly in line with the corresponding inflationary trajectory of the past 40 years and are no longer a reasonable reflection of economic reality.

In the past two years legislation was introduced by Republican Senator Kate Brophy McGee of Phoenix with the support of the trial lawyers to increase those rates to $25,000 and $50,000 respectively. But strong opposition from the insurance industry have usually led to the proposal stalling before it was able to pass.

Insurance companies have contended that the proposed changes would increase premiums which would fall disproportionately and heavily on the lowest class of insurance customers. That has affected both Republicans and Democrats alike. Especially of concern was the possibility that increased rates could go into effect during the 2018 election cycle.

Nevertheless, in the 2018 session significant progress was made. Throughout the session negotiations occurred that would soften insurance company objections. And ultimately, the insurance companies agreed to stand down from their objections with inclusion of some additional provisions.

Included in those provisions were requirements that a named insured's policy declaration page to be sent to the named insured's and stipulates that the policy declaration page is valid for, extends to and covers all persons insured under the policy; a requirement that the offer of uninsured or underinsured motorist coverage limits to a named insured or applicant to be made at the time of application; and, a stipulation that an insurer does not need to make a new offer of uninsured or underinsured motorist coverage if there is a change to the statutory minimum liability limits for bodily injury or death.

But perhaps most importantly the provisions would have a delayed effective date applicable to automobile liability or motor vehicle liability policies issued, reinstated or renewed on or after July 1, 2019. That date would have precluded any increases in premiums from going into effect during the election cycle and would have allowed the insurers that time to adapt their actuarial considerations.

Unfortunately, despite the bills passing with bi-partisan support in the final days of the session Governor Ducey vetoed the bill. In his veto message he articulated his reasons saying, "I am open to the idea of revising our minimum liability. However, I am concerned about the unintended consequences including increased premium costs for individuals who rely on affordable plans." The vote in the legislature was interesting in that it found Republicans and Democrats on both sides of the issue.

The fact that the two sides were able to come to an agreed upon compromise suggests that the opportunity for passage in the coming session may improve. Furthermore, the fact that 2019 won't be an election year could enable a different result from the Governor. What considerations he would require in order to sign a bill are unknown at this time. What is important though is that the two sides continue their cooperative efforts.

Whether Senator Brophy McGee will again be willing to move the bill forward or if there is another member who may want to sponsor the measure is not known at this time. It is reasonable to expect that the proposal will likely be introduced again when the Legislature convenes in regular session this January. ❖

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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Did the American Medical Association Gift the Chiropractic Profession It's Unifying Principle?

Jeff Woolston, DC, CMVI

Dr. Jeff Cronk, JD. DC. is the Director of Education for Spinal Kinetics, the nation's leader in excessive motion testing to determine the location and severity of spinal ligament injuries. If you aren't familiar with Dr. Cronk and his work you should listen to how he believes Chiropractic can establish itself as the spinal experts to the public and unify us as a profession. Dr. Cronk was kind enough to share his experiences and his vision for chiropractic.

Dr. Cronk how did you get started in ligament work?

It started in the mid 90's. I found that I always liked injury work, but I never really understood how significant injury work was. I challenged myself at that time to be able to correct spines in the top 2% of anyone in the world. I hooked up with Dr. Burl Pettibon, and it became apparent how significant ligament injuries were to the misalignments that I was treating every single day.

A lot of practitioners today will say they don't necessarily have an injury practice, but they say they treat headaches, neck pain back pain, shoulder pain, radicular pain, pain going down the legs and arms. Those are all indicators of spinal instability or a ligament injury.

When I started to learn how to realign the spine, I found I better understood ligaments. The more I understood the ligament injuries the more I understood any kind of patient I was working with. I liked that challenge. So, the injury work and the spinal alignment work I was doing dove-tailed right into it. I met Harold McCoy, of Spinal Logic Diagnostics, that's when I realized that you could determine the location and severity of a ligament injury. For me that pretty much changed everything. It changed everything because I could identify what the actual injury was in the patient that I was treating.

The main thing I realized at that moment was that it is very easy to determine the severity and location of a spinal ligament injury. It was a "game changer."

What is the most common thing you run into in the market place with doctors today?

Doctors are treating patients for spinal injuries and don't know where the injury is nor the severity. Now that is not just a chiropractic problem but a general health care problem. The MD's today admit that 90% of the time these patients don't have a precise diagnosis. The problem with the other professions: doctors of physical therapy are not there yet; doctors of osteopathy are not there yet. Doctors of chiropractic could be there but the problem in our profession is we don't have standardized procedures to determine the severity and location of a spinal ligament injury each and every time. So, there is not an alignment of procedures in our profession. An even bigger issue I see is significant ligament injuries, although very common, aren't being standardly diagnosed.

How can we as chiropractors make this the standard of care? The problem or weakness I see in our profession is if you were to go to 10 different chiropractors you will get 10 different methodologies and approaches. I didn't get this information in chiropractic school. The first time I saw you through the lecture series with AAMVI I was blown away. I remember we went to the break and I had fellow doctors from LACC, Logan, Palmer and I'm from Sherman and we were all wide eyed and excited. We had never heard anyone succinctly explain chiropractic and we were all in unison that this was the scientific validation our profession could agree on. Even the American Medical Association was confirming it.

The answer to the constant argument of whether a subluxation even exists or not became clearer to me as you described it. If we agreed, a spinal subluxation in medicine is the same as in chiropractic. If we stayed in our lane and owned this, this would give us that standardization we are searching for.

Correct there is no difference between a spinal subluxation and a spinal instability. They are essentially the same thing. They are 2 different ways to say the same thing. Whether you are more comfortable saying a subluxation or spinal instability, it doesn't matter. They are both misalignments, either in position or in motion; in the case of spinal instability, a misalignment in motion. If you have misalignment in position you actually have a misalignment in motion. Misalignment of motion causes a motor, sensory or pain problem at that level. That's a clinical entity.

As soon as you remove the motor, sensory or pain problem at that level you've removed technically

the spinal instability, or you have rendered the subluxation to just a misalignment. The thing chiropractors have struggled with the hardest I think is not understanding their own terminology. The thought you must correct a misalignment by realigning it is ideal, and I will be the first to tell you that. However in order to take a spinal subluxation, a clinical entity and remove it, you must remove the motor, sensory, or pain problem associated with it.
Once you have removed the clinical expression you've rendered it into excessive motion or a misalignment, and not an active spinal instability or a spinal subluxation. We have to really understand and get behind our language. We must stop allowing those that don't understand the language, to actually say, "well that language isn't good, therefore we can't use it, therefore let's throw it out".

Dr. Cronk I learned a lot from your online program www.smartinjurydoctors.com . I think it is incredibly thorough with staff training, doctor training, deposition mastery, and marketing. After I completed your program I greatly appreciated the certainty it gave me to deliver in the personal injury realm. Dr. Cronk can you please explain how confusion within our profession and the confusion of others can sabotage our certainty?

Confusion is contagious. It is very easy to get confused if you are around others that are confused, and so what we want to do especially in the injury market is to have certainty. First of all there are 108,000 Americans that are injured every single day. Huge numbers. If we take a look at 2013, the total injury market was $890 billion industry. Auto was the largest as far as payouts, work comp was next, then home injuries and public injuries.
One of the things that is interesting to me is that doctors of chiropractic will say I specialize in auto injuries. Basically what you are saying is that you specialize in the ability to manage an auto insurance claim. The injuries are the same, so if I burn my finger in a car in an accident then that's called an auto injury. If I burn my finger at work, it's called a work injury. If I burn it at home, it's called a home injury. But it's the same burn. So if I injure my neck at work or I injure my neck in an auto collision, or at home they are the same injuries. They are the exact same injuries, only where they occurred is different. That's the thing that is different.
Today the largest opportunity in the market is 9 out of 10 of patients don't have a precise diagnosis. Medicine readily admits this. This is where chiropractic can gain ground as a profession as it is the smallest in the market right now. We are about a $14 billion industry, physical therapy is about $28 billion, and medical services for back and neck conditions as of 2013 were $253 billion. Now a lot of doctors will think that $253 billion is not what they treat. I want to tell you that $253 billion is right in our wheelhouse. It is exactly what we treat. Now there are incidents of surgical procedures that patients didn't respond to treatment, but often they never had chiropractic. Many surgical guidelines require a 3-6 month conservative treatment failure, before they get a pre-authorized surgery.
As a provider in today's marketplace, if you understand injuries, you understand the basics of everything that walks into your office. Because it's injuries that create the misalignments that cause the clinical situations we deal with every day. The thing that causes acute problems also causes chronic problems. The more you understand the acute side of it the more you understand the chronic side of it. There is a huge market that is actually waiting for us to align our procedures.

What do you mean that chiropractic has to align our procedures?

Well let's talk injury. In order to injure a human body, you must derange it. With a dog bite there is a particular look and derangement of the tissue but if you get burned the tissue deranges differently. If you get a gunshot wound it doesn't look like a dog bite or a burn. Any time you injure a body part there is a derangement that occurs. We have to listen to ourselves. If we say we are the specialist in the spine but come out and say a client has a cervical sprain, well that was great 30 years ago. The problem is this language falls short with what we now know and can document today.
If the medical doctor says the patient hurt his leg, we ask what diagnosis did they give? What if the doctor said a lower extremity sprain? Now the chiropractic profession would laugh at that, saying that is not very specific. Wondering did he sprain his hip, knee, ankle, or foot? What did he sprain? Yet we say we are the highest professional doctors for the spine in the world today and we still say the patient sprained his neck. How is that different than someone with a leg injury saying they sprained their leg?
We don't recognize that the spine is a very intricate organ and give it it's due. The next logical questions for the doctor are, Ok the guy sprained his neck good, where? And how bad is it? What ligaments?
Today we have the largest opportunity because our primary tool for ligament assessment is x-ray. That's static digital, which equates to great x-rays.

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That's the tool that picks up excessive motion. What gets me so excited is these x-rays are bio-imaging markers. These bio-imaging markers are inherent to the injury. Inherent which means inseparable. Inherent in a fracture is a bone that's misaligned. You can't have a fracture without misaligning a bone. You can't have a significant sprain of a joint without it altering the motion pattern in the joint. They are inherent. It is impossible to have it. You can't say someone has a serious sprain at C5/C6 but has no excessive motion. That's like saying a guy has a femur fracture but there is no fracture identified on x-ray. It's just that simple.

If a doctor is going to determine the severity and location of a ligament injury there are only 2 derangement findings. Excessive motion and disc herniation with excessive motion generally more problematic of a condition than the disc herniation. You have 220 specialized ligaments in the spine and you have 23 discs. So the MRI is good for the 23 discs, but it's not good for the other 198 ligaments.

It doesn't tell us anything about them. So, we as a profession must become experts in that especially since that's the tissue that holds our spine together and spines are what we say we are specialist in. If we don't address the basic thing that allows alignment or misalignment to occur than what are we addressing?

So as chiropractors we need to be experts in spinal ligament injuries?

Yes and often there are questions that come up. Right now, in order to assess a spinal ligament injury, you have to have an excessive motion study. The reason why I started my first company, National Injury Diagnostics and then merged it into a medical company called Spinal Kinetics in which I am the director of education, is because I know excessive motion testing needs to be a standardized test. So I set out to make it a standardized test for doctors of chiropractic, doctors of physical therapy, doctors of osteopathy, medical doctors or anyone that wants to be a specialist in these ligament injuries.

Whoever wants to lead in ligament assessments, has to be able to lead with excessive motion testing. There is no other way to test this and that is the reason we set up Spinal Kinetics. What makes Spinal Kinetics unique today is that it is done by board certified radiologist. We are the only real national company. We would like to have more companies in the market with us. We also have quality control protocols at Spinal Kinetics that can't be duplicated in provider's clinics.

A Doctor of Chiropractic will look and say I'm going to buy my own software and do this myself. I am going to tell you right now there is a lot to the software and a lot to the technology. I've been doing this along time. I'm always going to make the recommendation that you use an unbiased third party to do this procedure. What makes spinal kinetics unique is that every single test is seen by 2 licensed providers. If there is a ratable finding or an abnormal finding then it is re-reviewed always and often by a third licensed provider. We have the highest quality control in the market today and nobody even comes close to us, and that matters especially in a medical legal situation.

How does the AMA Guides play into this?

In 1994-95 I read the Guides for the first time. I read chapter 15 and I realized, oh my gosh, the medical profession for the longest time, since 1993 has been validating the chiropractic subluxation model. They had actually established that if you had a significant spinal instability or spinal subluxation it came with a 25% whole person impairment. So as soon as I read that I immediately realized that wow this condition is being validated by the medical profession at a very high level. I could never understand why chiropractors didn't know more about it or why they didn't use it. The AMA Guides is the Kelly Blue Book for the body. It actually is the consensus document that says if you damage your car this is how much it is reduced in value. If you damage your body this is how much it is reduced in function and that reduction in function is called, a whole body impairment rating.

I like that! That is a great way to describe the AMA's Guide to Permanent Impairment, comparing it to Kelly Blue Book.

What is in the future for Smart Injury Doctors?

One of the things we are doing in 2019 is we will introduce Smart Injury Help. It will be the largest injury website in the country based on one premise, showing the public that doctor can get results with their injuries. It will be like Health Grades for injury providers. What it is designed to do is to give local people immediate access to good injury providers for their injury type. One of the biggest problems that patients have when surveyed is they don't know where to go. Often with spinal injuries they waste valuable time going to the wrong doctor such as their GP that may take 3-4 weeks to get into. I have nothing against GP's, but they are generally highly undertrained to handle these types of injuries. Then after they finally get into the GP they are then getting sent out to a specialist. What they don't realize is

they are seriously increasing their risk of never fully recovering because of not starting the care they need early enough. We see that in work comp cases as well. Delay in reporting a claim adds 3% a day to the cost. It's becoming more and more known in the market that you have to get to the injury and start applying treatment that is effective for it as early as possible in order to get the best result.

That sounds exciting and certainly is a missing piece in the personal injury/health market. What can we do individually and as a profession to take this to the next level? I would recommend your program.

Yes, the Smart Injury Doctors program was the first online program that is dedicated toward demystifying ligament injuries. Making it so the doctor really understands how to diagnose those conditions and better manage the patient. If you are a doctor that understands how to diagnose those conditions you are a rare doctor in the market today. We also help to train the staff so the staff understands and is aligned with what you are doing and this can really leverage injury referrals. Today any doctor that is able to produce great results with this condition, should be able to easily come out of obscurity in their market and attract a lot of injury referrals. We help to align your product and then align your message so that you can go to patient groups, attorneys or medical doctors and promote your services.

Attorneys are coming to us more and more across the country as they are understanding the pitfalls that are associated with the over reliance on the MRI studies or the lack of finding thereof. I actually wrote a report on this and anyone can go to www.smartinjuryradiology.com and download a free report the "3 biggest pitfalls of MRI and spinal ligament diagnosis".

Doctors are starting to go to attorneys to educate them on the pitfalls of MRI. This is good but I knew that attorneys needed more and that is why I developed the first Spinal Ligament Injury online training program for attorneys called the SmartInjuryLawyers™ at www.smartinjurylawyers.com . The attorneys are now getting educated on these injuries and of course the first thing that they need coming out of this course are doctors that can diagnose, treat and document this condition.

Look, MRI's are a great tool and I work with and talk to radiologist's every week. MRI is a great tool for a disc but there are only 23 discs and there is a lot more spinal ligaments than 23. It's good for 10% of the ligamentous structure of the spine it doesn't tell you anything about the other 90%. That sounds weird because people get so enamored with the MRI and they lose site, of their main tools and don't think their tools are as good.

9 out of 10 doctors don't even know this condition exists let alone how to diagnose it. If you don't know what is there how can you get good at treating it? Our profession can take this to another level if we can align with it. I always thought it was so funny because our profession's basic axiom is "alignment improves function". That's the basis of our profession but we are one of the most misaligned professions there is. If our thing is in order for function to be stellar, we must have perfect alignment, then we have to follow our own philosophy, our own axiom. And if we don't, then don't complain that we are losing in the market quite dramatically. But doctors, we don't have to lose at all as there is a huge market to gain and that is what I intend to help us do!

Dr. Jeff Woolston practices in Scottsdale. He has completed the AAMVI certification and is a delegate for the Arizona Association of Chiropractic.

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.

1. How many pairs of cranial nerves originate in the brainstem?
   A. 12
   B. 10
   C. 6
   D. 5

2. Which of these is NOT a brainstem structure?
   A. amygdala
   B. medulla
   C. mid-brain
   D. pons

3. Which of these is a purely motor cranial nerve?
   A. Facial
   B. Glossopharyngeal
   C. Hypoglossal
   D. Oculomotor

4. Nerves conveying which sensory input do NOT connect in the thalamus before projecting to the cerebral cortex?
   A. hearing
   B. olfaction
   C. vision
   D. vibration

5. Concerning the examinee's eyes during testing of Cranial Nerves I, V and VII through XII, which of these options is correct?
   A. Both eyes should be open.
   B. Only the ipsilateral eye should be closed.
   C. Only the contralateral eye should be closed.
   D. Both eyes should be closed.

6. Which Cranial Nerve innervates the ability to keep one's eyes closed against the examiners attempt to open them?
   A. Oculomotor
   B. Trochlear
   C. Trigeminal
   D. Facial

7. Which Cranial Nerve innervates the platysma muscle?
   A. Glossopharyngeal
   B. Spinal Accessory
   C. Trigeminal
   D. Facial

8. Which Cranial Nerve innervates the sternocleidomastoid muscle?
   A. Glossopharyngeal
   B. Spinal Accessory
   C. Trigeminal
   D. Facial

9. Which of these Cranial Nerves is NOT involved with the act of swallowing?
   A. Glossopharyngeal
   B. Hypoglossal
   C. Trigeminal
   D. Vagus

10. Which Cranial Nerve provides the majority of visceral sensory input to the brain?
    A. Vagus
    B. Trigeminal
    C. Spinal Accessory
    D. Vestibulocochlear

Dr. Kollasch is a Phoenix native and practices in Scottsdale. He worked with the National Board of Chiropractic Examiners for 20 years and is its former Executive Vice President.

You may contact him at (480) 948-6020 or martin.kollasch@gmail.com.

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

IN MEMORIAM

It is with deep sadness that the members of the Arizona Association of Chiropractic announce the passing of Dr. Jim Badge on Saturday November 7, 2018.

Our friend Jim served as President of the Arizona Association of Chiropractic in the mid 90's and continued his affiliation with and support of the AAC throughout his professional career.

He served the chiropractic community with great dignity as a member and Chairman of the Arizona Board of Chiropractic Examiners for literally decades. His wise counsel and advice served chiropractic physicians from around the country from his service on the National Association of State Boards' of Chiropractic Examiners.

He was respected by politicians in Arizona from both political parties and was called on by them frequently to serve his Phoenix and Arizona communities.

Jim was a devoted husband to his beloved Deborah, a committed family man and a faithful participating servant of God.

But most of all, to those of us who knew him well, he was simply a great and trusted friend.

As the poet said, some people walk into your life, make footprints on your heart and you are never the same.

God speed Jim Badge. ❖

The Arizona Court System-A Brief Review

by David M. Morrison, Attorney

Most doctors, even those very familiar with personal injury, have little or no exposure to the Arizona Court system. Some are even intimidated by the thought of going to court and having to testify. This article will attempt to make you more aware of what occurs when one of your patients gets involved in a litigated matter and more comfortable when you are called to participate in the "system".

First, let me mention staying away from litigation is preferred. Any favorably settled matter is a good result. However, for those matters that cannot be settled, the choices vary as to the best venue to litigate.

There are several courts to choose from when considering which one to file a lawsuit.

There is Small Claims Court, Justice Court, Superior Court, the Court of Appeals and the Supreme Court. These are all Arizona based courts and not Federal courts. This article will NOT be discussing Federal Court nor Federal Law.

SMALL CLAIMS COURT

Small claims court will rarely be part of your practice. It is a court of limited jurisdiction. This means there is a ceiling or limit on the total amount you can sue for.

This amount is $3,500. In addition, attorneys are not allowed in small claims court (unless they are representing themselves of course). If a doctor chooses to file a suit in small claims court, it is usually to collect an outstanding balance on an account. In those types of cases, all you really need to prove is that you provided the services and the patient agreed to pay for the service. Due to the limited amount you can sue for, you have to evaluate if it is worth your time to proceed with this type of suit.

JUSTICE COURT

Justice court is also a court of limited jurisdiction, but its limits are $10,000. In my personal injury practice, I sometimes use this tool to file smaller cases. I will explain this strategy later in this article. The rules for proving an injury case are the same as Superior court in terms of having to prove fault, causation and damages. Plaintiff's attorneys still have to put on evidence, take depositions and argue to a Judge or a jury, but it is a simpler, more streamlined process. The awards in these cases are usually final. Those are the benefits. The downside to Justice Court is the $10,000 limit. Your patient will never get an award in excess of $10.000.

SUPERIOR COURT

Superior Court will be the location of the majority of any litigated matter involving your practice. This is a court of unlimited jurisdiction, meaning no caps on awards.

However, due to congestion at this level of court, an Arbitration requirement has been set up for cases that have a value of less than $50,000. This is not a limit and an Arbitrator can award more than $50,000, but that is rare.

Arbitrators for these cases are picked at random, for a pool of all licensed attorneys in the county where the suit was filed and many times those attorneys have no background in personal injury. Basically, it's the luck of the draw. Having said that, it still is a good system as arbitration will average six to eight months to get to conclusion.

Now for the downside. In Superior Court,

EITHER side can appeal an arbitration decision and request a jury trial. This trial is a de novo or completely new trial. None of what was decided at the arbitration has any value at the jury trial. You cannot even mention the arbitration to the jury. Thus, a patient having gone through an arbitration could be forced to do it all again. The bigger problem is that a jury trial will take six months to a year to schedule. So your patient may have to wait over eighteen months to two years before getting a final result in their case. This translates to you having to wait a similar amount of time to get paid if you are on a lien.

The rules for proving a case are the same as mentioned above. Your patient must prove fault, causation and damages. The evidentiary rules are the same. However, while Justice Court may be more informal, Superior Court is very formal. Chances are you will be called to testify, as the providing physician, either at deposition or trial or both. Superior court cases are a lot more expensive to put on and this translates to less money for your patient and for you.

I also should discuss what happens when an arbitration gets appealed. There is a pretty severe penalty involved against the appealing party. If your patient is the one appealing, there may be some pretty strong arguments against doing so. The penalty is that the appealing party must do 23% better than the arbitration award to avoid being penalized. If the appealing party does not beat that number, the appealing party must pay the attorney's fees of the other side. This is severe.

To give you an example, I was involved in a case where the award to my client was $12,000. Because the insurance company was the party that appealed and because my client's jury award beat the penalty clause, the insurance company ended up paying my attorney's fees. This was over and above the $12,000 award. The net result was a very good outcome for my client. Nice, but very rare. However, you can see how the penalty can end up being quite severe.

TERMINOLOGY

FAULT

Fault quite simply means whodunit. Who caused the accident? Typically, you are not involved in that discussion. However, on second look you are. How did you document the facts of the accident in your notes? How does your intake sheet, filled out by the patient describe the accident? Sometimes, a patient's description can make or break a case. What the patient tells you and what you document also is important. If the documentation says a "45 miles per hour" rear end accident and the police report has both parties telling the officer they were going five miles per hour, this affects the credibility of your patient as an accurate teller of the facts. This may also affect how you describe mechanism of injury and affect your credibility when your opinions have been based on inaccurate facts.

CAUSATION

Once fault is decided, causation answers the question of "did the accident cause injury?". This is the area of your expertise. What was the mechanism of injury and how did it affect your patient. Most of the time, this is the contested issue. If there is enough money at stake, the insurance company will hire an "expert" to either examine your patient or conduct a records review. These are supposed to be "independent medical exams", but they are far from independent. Most insurance company experts will be orthopedists, although some will be chiropractors. I still maintain that you, as treating physician, have the tactical advantage to issue an opinion on causation. However, if your documentation and/or testimony is weak, all advantages are lost.

DAMAGES

Damages are the amount that "will fairly and adequately compensate the Plaintiff for the injuries and inconvenience suffered" by the accident. You are also important in this process. This is not just because you can establish mechanism of injury. Your notes should be detailed as to the activities of daily living and should document any disability suffered by your patient.

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You should also include notes concerning loss of earnings. Some of you merely document the initial time off work and nothing about continuing problems and/or limitations. Your documentation as to light duty or limitations on lifting or activities could aid in the recovery awarded to your patient. This evidence is often missing from notes.

MORE DISCUSSION

As far as strategy, I recommend to my clients they file in Justice Court, if they do not expect to recover more than $10,000. This is because we will likely conclude their case within six months of filing and because there is rarely an appeal from Justice Court. Even if it's a close call, it is better due to the finality of the decision.

You should also note there are times I will recommend a client skip the arbitration process. This is for cases that have a higher value. This allows them to skip the arbitration process and any penalties if they have to appeal. The downside is that juries, in Maricopa County, tend to be conservative. It also costs a lot more to go straight to a jury trial as experts have to appear to establish causation and damages. Typically, these experts get paid for their time in court. This increases the cost of choosing Superior Court and skipping the arbitration process.

COURT OF APPEALS/SUPREME COURT

Arizona also has a Court of Appeals and a Supreme Court. You cannot directly file with these courts, unless you meet certain exceptions. The Court of Appeals is for matters appealed from Superior Court. The Supreme Court is for matters appealed from the Court of Appeals. There are exceptions to these rules, but they are not discussed here.

SUMMARY

This article only covers a very basic discussion of the Arizona court system. There are also considerations concerning Mediation, High/Low agreements and other strategies for getting a case resolved without litigation. These will be discussed in a future article.

You should also be aware of that different counties have different limits they impose before requiring arbitration. As mentioned above, Maricopa County has a $50,000 threshold. Yavapai County has a $65,000 threshold. You should make yourself aware of the threshold in the county you practice.

Hopefully, this article answered some questions you might have had about litigation and will help you answer questions you might get from your patients. Should you or your patients have questions and would like to discuss any aspect of litigating a personal injury case, I would be happy to respond to those questions. My contact information is below.

BIO

I have been an Arizona licensed attorney for over thirty seven years. I have represented the Arizona Association of Chiropractic for over twenty seven years. I have been a member of the National Association of Chiropractic Attorneys since 1993 and its Secretary since 1995. I am a past president of the Arizona Association of Health Care Lawyers. I have an active Personal Injury practice and have litigated over 400 arbitrations and twenty jury trials. I also represent Medical Professionals in matters involving their licensing Boards (I have experience with the Arizona Board of Chiropractic Examiners, The Arizona Mental Health Board and the Physical Therapy Board, to list a few). I can be reached at 602-277-6996 or Dave@Morrisonlawaz.com. ❖

Loss of Consciousness; the Myth of Concussions

by Bill Gallagher & Lois Laynee

One of the more common myths about concussions is the need for there to be a loss of consciousness in order to make the diagnosis. There are two problems with this assumption.

First is how we define loss of consciousness, something that so far is ill-defined. The common assumption is a loss of consciousness is the same as passing out or blacking out. It is not unusual for your patient to have suffered this total loss of consciousness and even to have been delivered to the ER in such a state.

The ICD 10 codes for concussion take into account the amount of time of loss of consciousness which can be measured by a witness or paramedic but is a poor test posed to a patient. If there is a total loss of consciousness the only estimate of the length of that loss that the patient could provide would be information that had already been provided to them.

One of those codes, S06.0X1A is a concussion without loss of consciousness

The patient in this condition would have a Glascow Coma Scale total of less than 15. By its name of COMA scale this is a good measurement for someone who is unconscious. The problem with Glascow is that it is not necessary to be unconscious in order to suffer a concussion.

From the CDC, by definition a concussion involves an alteration of consciousness, not a loss of consciousness. As such when you pose the question, "did you lose consciousness," a response of "I don't know" is a clear indication of an alteration of consciousness or a loss of consciousness.

Lois Laynee teaches Cranial Nerve Exam for the AAMVI. Her research has led to development of the Dynamic Functional Cranial Nerve Examination that is taught as part of the AAMVI Certificate. She can be reached at loislaynee@restoringbreathing.com

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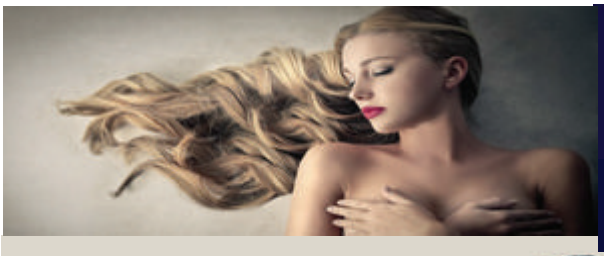

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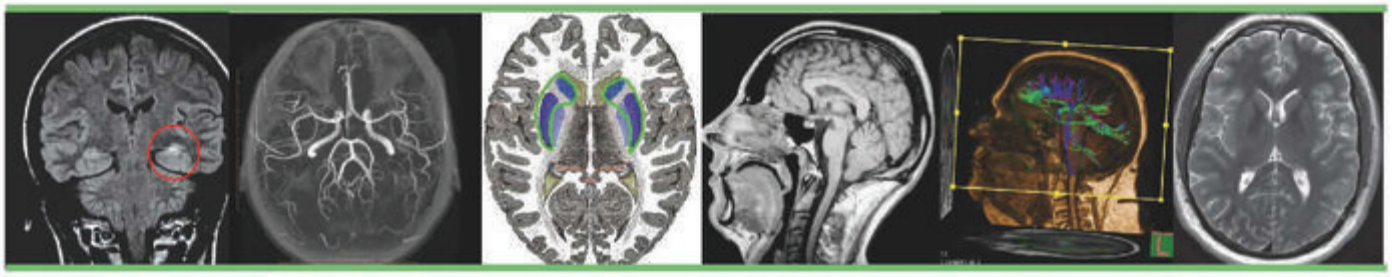

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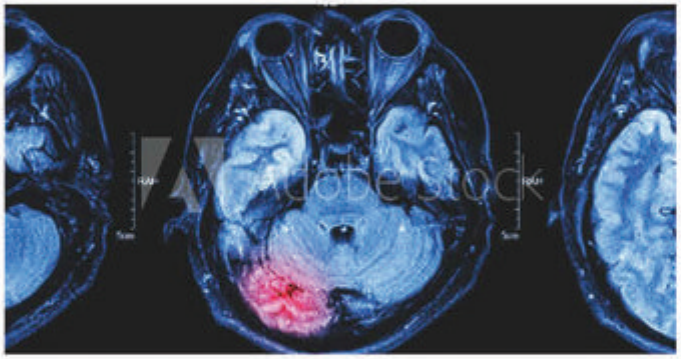

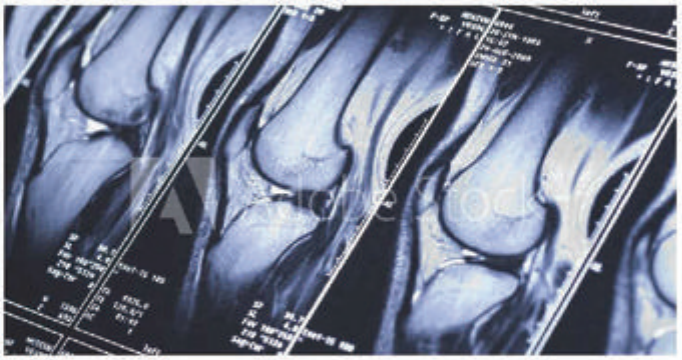

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