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Back Talk

The Expert Witness (Part One - of Two Segments)

When you think of being an expert witness, a number of things may come to mind. As the jury watches, you might imagine being grilled by the defense attorney, enduring such humiliation as being called a "choiropractor," being told you are not a "real" doctor, and having accusations abound about your "mail-in" education to obtain a degree, and not being able to prescribe medication, etc. Maybe you have nightmares about having to go to court to testify. Well, if your only thoughts about being an expert witness deals with your appearance in court, let me assure you that this is a very small part of the role. The vast majority of your responsibilities occur way before you take the stand.

What you do or don't do on day one is vital to prepare you for your appearance in court. The beginning is the history. This includes your thorough investigation of what occurred. If it is an auto accident, you must find out such things as 1) how the accident occurred 2) road conditions 3) if the patient was the driver or the passenger 4) if he/she was aware of the impending impact 5) what he/she was doing just prior (looking down to text, turning to speak with another passenger, etc. 6) head and body position 7) headrest position 8) if the seat back broke 9) extent of damage to the vehicle.

History must also include treatment following the accident, what was diagnosed, what procedures were performed, and what recommendations were made. You should also note any problems of activities of daily living. Any questions that you may have should be clarified at this time.

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Past health history is vital and should include prior symptoms and treatment. This should include prior injuries, as well as surgery, particularly if the injured region had prior procedures. Obtaining past records can be enlightening, as the patient may forget or intentionally not disclose previous problems. Don't be naive to believe that he/she is being totally accurate with you.

You should find out every symptom that the patient has and determine if it occurred as a result of the accident, pre-existed the accident and is the same, or pre-existed the accident and is worse. When a patient has prior symptoms that worsened, I find it best to use the *Visual Analogue Pain Scale* to determine what the pain levels were prior to and following the accident. Also, you should learn what type of work the patient performs and note if any time loss resulted from the injury.

The second step is a thorough examination of the injured area. Range of motion, orthopedic testing and palpation should be noted. Range of motion should be obtained with dual inclinometry, as this is the gold standard. Palpation includes not only looking for restrictions but spasm as well. Two things that justify injury in an insurance adjustor's mind are range of motion loss and spasm/hypertonicity, as these cannot be duplicated with patient intent. Another objective finding that cannot be easily duplicated is the presence of bruises or adhesions, particularly when they correlate with the mechanism of injury. I find that x-rays are vital, as they show not only possible injury, but also

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indicate pre-existing factors *(degenerative disc or joint disease, spondylolisthesis, ankylosing spondilits, etc.)* that may play into complicating the injury and retarding process.

Once the history and examination are completed, the doctor needs to come to a definitive diagnosis. If possible, address every symptom with a diagnosis. Although it may seem illogical, bruises and abrasions carry more weight for justification of treatment than do strains/sprains and should be noted. A statement of causation needs to be included which correlates the patient's symptoms with the mechanism of injury and need only to state that in all medical probability, a relationship exists.

If the patient was undergoing medical treatment prior to the accident, whether it be non-accident or accident related, the insurance adjustor will expect the doctor to give an apportionment of responsibility to each. Apportionment typically occurs when the patient is undergoing care for one accident and then has another before he is discharged from the first. I commonly apportion more to the second accident than the first, as a re-injury to already weakened tissues is typically more severe. I might state that a personal injury attorney that I respect told me that he recommends that a doctor not apportion the injuries, but state that one accident is the major or substantial cause.

If time loss or work modifications are necessary, these are addressed on a regular basis. Although a doctor may be inclined to return a patient to work as soon as possible, it is better to keep the patient off work or on modified restrictions longer to avoid the risk of re-injury once he/she returns to regular work. I have found it helpful to release a patient back to work part-time first. Also, I usually release him/her back to regular work midweek when there are only a few days left before the weekend when he/she may rest. This is particularly helpful to minimize fatigue and either avoid re-injury or having to take the patient back off of work again because he/she cannot continue to do his/her duties.

The next step is a treatment plan. If symptoms or conditions appear that are not within your field of expertise, i.e. post-concussive syndrome, TMJ, etc., an immediate referral is in order while the trail is hot. With regard to chiropractic, I typically figure out a treatment plan for 30 days. At the end of that timeframe, an updated exam will be performed to determine if the patient needs additional treatment. If additional care is warranted, then another examination with assessment will be performed in 30 days. It is helpful to note not only the patient's symptoms, but also have him/her estimate the percentage of recovery that has been attained, assuming that pre-accident was 100% and post-accident 0%. If his/her opinion is either much higher or lower than what you think, it may give you additional information that the patient is either minimizing or exaggerating their recovery.

Each exam should address activities of daily living and whether the patient is not able to perform certain ADLs or has to modify their lifestyle. As long as improvement is noted every 30 days, care is warranted. If the patient plateaus, the doctor must make a determination for further testing, referral for a second opinion (concurrent care or transfer of care), or determination that the patient has attained maximum medical improvement (MMI).

The typical case should be wrapped up in 3-6 months. Complications may retard progress. This can include pre-existing problems, lifestyle issues or stress. If the patient is progressing slower than desired, a second opinion from an MD is recommended. When I worked as an associate, I was taught that sharing the responsibility with another doctor is a wise thing. Make sure that when you make the referral, you are giving the doctor the reason for the referral (second opinion, transfer of care, etc.) Since MDs are typically gatekeepers, they will commonly recommend additional testing, physical therapy, ore a surgical consultation. Additionally, they will typically state their opinion about continuing chiropractic care. Make sure ahead of time that the MD does not have a negative opinion of our profession and has a basic understanding that it is not the same as PT. Once the patient comes to the end of treatment, one of three things must be decided 1) The patient has attained pre-accident status 2) The patient has a soft tissue residual that will cause recurring symptoms and necessitate future treatment 3) The patient has a permanent impairment.

If there is a soft tissue residual, you should give an opinion as to addi-

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tional dollar amount of care that will be necessary. Regarding permanent impairment, it is the doctor's responsibility to make that determination according to AMA Guidelines to the Evaluation of Permanent Impairment. Since these guidelines are regularly updated, be sure to use the most recent edition. Probably the most common permanent impairment that a DC will use is the non-surgical disc herniation. Please understand that a doctor determines impairment, but not disability. Disability is typically determined by the legal system.

At this point, the majority of your responsibility regarding being an expert witness has been accomplished, and, if you have done procedures according to what has been described, you will be well-positioned to testify. In the next article, I will address that situation.

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