MAY 2022

Understanding spine injuries

Can someone be hurt when the MRI is negative? Medical knowledge is a key to success in back- and-neck-injury litigation

By Tom Feher

Spine injuries are the most common type of injury we encounter as lawyers representing people who have been harmed. In part, that is because the spine is the most vulnerable part of our anatomy when subjected to trauma in motor-vehicle collisions and falls. According to the National Highway Traffic Safety Administration, car collisions occur every 60 seconds. That equates to about 5.25 million collisions across the nation on an annual basis. That figure does not necessarily include bicycle or pedestrian incidents, so that number is likely even larger.

With that fact in mind, it is critical that we have a working knowledge of the types of injuries and medical treatment available for people who suffer spine injuries. Having worked on hundreds of spine-injury cases and successfully taken dozens to trial, I will break down several key elements to successfully work up spine cases medically and legally. Whether you end up settling, litigating, going to trial, or working in collaboration with another lawyer or firm, these tips will maximize the value of all your spine cases to the benefit of your client.

Real world versus medical-legal world

In the medical-legal world, we have been conditioned to document injuries by virtue of what insurance companies, adjusters, and defense attorneys say and do. We have all heard the following from them, "Your client never complained of pain at the scene, never went to the emergency room, did not seek treatment until a week after the collision; and, if they were really hurt, they would have."

In the same breath, if your client seeks the aid of an attorney and goes to physical therapy or the chiropractor a day or two after the collision, these insurance companies, adjusters, and defense lawyers then say, "Your client went to an attorney first, the attorney orchestrated this treatment, this is all attorney-driven treatment."

Being the good listener that you all are, you know exactly what these insurance companies, adjusters, and defense attorneys are doing – they are insinuating that you and your clients are untruthful. Talk about adding insult to injury.

The reality is people get hurt all the time and the last thing on their mind is documenting the scene or their injuries. People are in shock, scared, and shaken up after a crash or fall and are just trying to make sure there is nothing readily apparent that needs emergency aid.

Think about an experience you may have had or someone close to you may have had. After a car wreck, you just want to get home or get to where you were going. It's a terrible inconvenience. In our already busy lives where many of us are stretched razor thin with family and work obligations, the last thing we need on our plate is some person running into us on the road because they were not paying attention, let alone having to make medical treatment a second job just to get back to good health.

There is a reason that our damages jury instructions, CACI 3905A have "inconvenience" as a harm. That is because it hits at the most valued thing taken from injured victims – time. Time is an underappreciated type of harm that is commonly missing from our demand letters, discovery responses, depositions, and trials. We always hear the term "pain and suffering." An overused and often poorly articulated harm. Pain and suffering is better defined as what has been "taken from someone" and here we circle back to time. At this point, you may be saying, I thought we were going to talk about the spine, not time. We are, and as you will see, this is all connected, like Dem Bones by the Delta Rhythm Boys. (Look up that reference, if you have no idea what I am talking about, and you will have heard that song before as a child.)

Throughout this discussion, I want you to keep the notion of time close by as you imagine your own lives and consider how an injury would affect you, how you would act or react, with or without the knowledge of a social-media post, listing the top 10 things to do after a car wreck. At the end of the day, we need to look beyond what satisfies insurance companies and for us to tell the true stories of our clients' lives and how they have been affected.

What does the perfect medical workup look like?

The answer is there is no such thing as a perfect medical workup. Think about this for just a moment. If you ask ten lawyers how they would evaluate a case or go about solving a problem, you will likely get several responses, some more similar or dissimilar than others.

Let's go beyond the obvious for just a moment. I began with that to give some context because most of us do have an idea of what the "perfect" or "ideal" medical workup looks like, however, not every person is the same and not every injury is identical.

Some people want to treat conservatively with massage or chiropractic care for years because they are just not comfortable being injected with steroids or undergoing spinal surgery. Does that

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mean they are not really hurt? Does that mean they are not a surgical candidate? Of course not. The reality is that most people do not want to undergo spinal surgery.

Just read the long list of risks associated with spinal surgery and it will have most people running out of the doctor's office. Surgery is scary. The risk and fear of surgery is part of the harm people go through in these cases and an integral part of their story we shouldn't easily dismiss, especially with our clients who choose to avoid this option at all costs. We must sensitize ourselves to what people endure when faced with an injury, life limitations, and risky treatment options like surgery by continually placing ourselves in their shoes. The "Golden Rule" should always apply when you are representing your client because that is how you empathize with their story.

As many of us have observed in our practice, a medical workup that is considered sound is one where there are no "gaps" in treatment and a client moves through conservative treatment to pain management to surgery seamlessly. Is that a reality? Sometimes. While medicine is very much a science, it is also an art, and it is constantly evolving in both realms. Hence the phrase, the "practice of medicine" and not of those we represent and those who are medically treated, surprisingly, the "practice of law." Given that both law and medicine unequivocally involve an ongoing practice, it is incumbent upon us all to practice with integrity and with the client's best interest in mind.

Never stop learning the medicine

Now that we have gotten our ethics MCLE out of the way, let's dig into some medicine. Most often, after a car crash or fall, the initial treatment for a spine injury will be conservative. That may include, rest, ice, medication, chiropractic care, physical therapy, stretching, at-home exercises, etc.

If your client is at the emergency room, it's exceedingly rare for a CT or MRI of the spine to be taken and as a result, very rare for an acute disc herniation to be identified. At best, X-rays will be taken, which do not show injuries to discs, nerves, muscles, or ligaments.

More importantly, acute disc herniations are not a one-size-fits-all phenomenon. Some doctors hired by insurance companies will say someone must have an immediate onset of terrible pain after a traumatic event to have an acute disc herniation. That may be true if the disc herniation sufficiently impinges or irritates a nerve root at that particular moment.

But even under that scenario, everyone's body reacts to nerve irritation or impingement differently – some may have numbness or pain or weakness or tingling or any combination thereof. For others, the inflammatory process brought on by trauma may take hours or days to develop. Even more, a disc may be traumatically compromised and over time worsen to the point of irritating a nerve, resulting in a later onset of radicular symptoms.

If someone is experiencing neck or back pain and they have radicular symptoms, it is a good idea to get an MRI. MRIs are the best tool we have at this point; however, they are not perfect. This still raises the question: What are we looking for in an ideal world?

We are looking for a clinical correlation, which is consistency between a patient's history, their symptoms, their exam findings, and their imaging as a basis for treatment moving forward. Here is one example. Someone is involved in a car collision; they have a sudden onset of neck pain that is moderate or severe; they have pain or numbness going down their right arm and into their index finger, and they have a cervical MRI demonstrating a disc protrusion or extrusion with moderate to severe foraminal stenosis impinging the C7 nerve root.

If you are not familiar with the dermatomal patterns, I would Google it and study it. You'd be surprised to know that some defense medical experts have been caught in court not knowing this on cross-examination and it was a lot of fun for me, not so much for them. In short, a dermatome is an area of skin in which sensory nerves derive from a single spinal nerve root. Each nerve root in our spine has a dermatome that can be affected by a disc herniation or stenosis. Stenosis is a fancy word for "narrowing" and it can result in the spinal canal or foramin (the areas where the nerve root exists). It is important to note, there may be overlap of affected dermatomes in a patient because multiple nerves are irritated.

Even if someone has the medical profile in the above example, they still may not be a surgical candidate if their symptoms resolve with non-surgical therapy. People have had acute disc herniations that have self-absorbed over time. Conversely, someone who does not have this profile may still be a candidate for spinal surgery, radiofrequency ablations, or even a spinal-cord stimulator. More on that later. This is where it is important to recognize there is no cookie-cutter approach to a medical workup for an injured person.

Defense medical expert song and dance

Here is something to always keep in mind. Regardless of the treatment your client undergoes, whether pain management or surgery, the medical experts hired by the insurance company or defense firm will often say that the only reasonable and necessary treatment following the trauma was an initial course of conservative treatment for two to three months. Every now and then, they may say an orthopedic exam, MRI or an injection was reasonable and necessary and related to the trauma.

This comes directly out of their playbook and many of these defense experts have a template in their reports for this language. Collect enough DME reports and you will see the identical boilerplate language. I don't say this to be cynical; I say this because it's the reality. The point is to expect this and not let it get in the way of making sure your client gets the best medical care they need.

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Another boilerplate opinion we hear from DME experts is that your client suffered no acute injury, and the condition they underwent treatment for is related to degeneration. This opinion is misleading medicine. First, acute disc herniations are not necessarily going to be identified in an MRI. Second, trauma-related signs or symptoms that would be identifiably related to a disc herniation may have resolved by the time a patient undergoes an MRI. Lastly, almost every single person has some degree of degeneration in their spine in their twenties but that doesn't mean they have a herniation or symptoms.

Can someone be hurt when the MRI is negative?

Let's assume your client has terrible back or neck pain following a crash but their MRI is negative. In other words, there are no disc herniations or stenosis. That doesn't mean they don't have a permanent debilitating injury. There is always the possibility that the MRI did not pick up the structural damage to the disc or nerve irritation. A more likely reason may be damage to the facet joints, which can be incredibly painful. Damage to the facet joint can be identified by a pain-management doctor through diagnostic medial branch blocks. If the patient obtains relief, then they may very likely be a candidate for radiofrequency ablations also known as rhizotomies. This procedure cauterizes the nerves in the facets. For many patients, those nerves grow back and require ongoing intervention.

Spine surgery is trauma

If you do have clients who undergo spinal surgery, keep in mind, surgery is ultimately trauma to the spine. Any time a patient undergoes a foraminotomy or laminectomy bone is being removed from the spinal structure, which poses a risk of destabilizing and weakening the spine. Whenever a patient undergoes a fusion, you are inevitably taking away movement from one segment of the spine, which means the segments above or below the fused level must compensate for the lack of movement.

Think of this as a trade-off. It's not even a fair trade. To get some quality of life back, the person must ultimately sacrifice the structure of their spine. This doesn't even take into consideration the fact there is no guarantee of relief from symptoms on the long road to recovery. I have seen clients undergo this incredibly difficult recovery process which can last a year or more after a lumbar-spinal fusion.

That alone is something I would dread going through. It is imperative that you and your clients document and produce evidence about the decision to undergo surgery and the journey to recovery. This is ultimately part of your damages presentation. I think about the fear and uncertainty of the recovery process. Not knowing if or when you will get better. The challenges one will face day in and day out to get their body back into functioning shape.

Again, this is all covered under CACI 3905A. Note, you are not bound by the items listed in CACI 3905A. You can add any type of harm per the jury instruction use notes that fits your case. Family members and friends are amazing resources, and they can testify in deposition and trial about the circumstances surrounding your client's treatment, their decision to undergo surgery, and their road to recovery. Treating doctors can go into detail about discussing the risks of surgery and the informed decision your client made to undergo the procedure because they desired to get back some quality of life.

There are situations where spine surgery fails and a client may have a permanent nerve injury. In those situations, your client may be a candidate for a spinal-cord stimulator, which can be used to treat chronic nerve pain as well as failed back-surgery syndrome. The technology for spinal cord-stimulators continues to improve and can be an alternative to the trauma of multiple spine surgeries. Keep in mind that for any spinal-cord stimulator procedure your client must be psychologically cleared and go through a successful trial period with a temporary implant before they undergo the permanent implant.

With all these procedures listed above, clients invariably will need future treatment. Often, I will see a case with a future surgery recommendation, however, there are no spine surgeon follow-ups, no medications, no imaging studies, or physical therapy delineated for a client's future care. Make it a point to discuss with your treating doctors and retained experts all the future care needs for your client.

We all know our clients are counting on us and I know all of you will do your very best to get your clients the fair and just results they deserve.

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