Clinical decision making—An evidence-based approach to managing ICBC claims

At 4 p.m. one Friday afternoon, my receptionist asked me to fit in a patient who had been in a motor vehicle accident (MVA) that morning. He was at a hospital emergency room where there was a 5-hour wait.

Bob (not his real name) had been my patient for 20 years. He had called earlier, but I was fully booked and needed to leave the office on time for my son's hockey practice. My receptionist had suggested he try the local walk-in clinic or a hospital. By the time Bob got to a walk-in clinic it was 3 p.m. and the doctor had left after reaching his daily maximum.

This left me as Bob's only hope in avoiding an ER wait. I asked her to fit him in where she could and to warn him that a follow-up appointment would be necessary next week.

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The 10-minute office visit—"So much to do and so little time"

Bob reported being stopped in traffic while driving his 2007 Ford F-250 when he was rear-ended. His truck was drivable so he continued driving to work. Bob is employed by a furniture manufacturing company as a warehouse worker, and while he was able to work, his neck and shoulders stiffened through the morning.

Bob had been in two previous MVAs in the past 5 years, each resulting in injury to his neck. With the first claim, he recovered fairly easily with minimal discomfort. He was back to work after 2 days.

With the second claim, he suffered a more significant injury and was off work for 6 months. He saw a chiropractor 67 times, a physiotherapist 54 times, had 32 massage therapy visits, and later on, he saw a personal trainer 14 times.

While taking Bob's history, he described neck and shoulder pain. He also thought he may have hit his head and wondered if he passed out momentarily.

On the way to my office he had visited his lawyer, who gave him MRI requisitions with a private facility for his neck and head. Bob asked me to fill them out.

Bob had a tryout for a professional lacrosse team the following week. He requested a note to give to the team owner stating that he is unable to go to tryouts due to his injuries. He also asked for a Tylenol 3 prescription and referrals to his physiotherapist, massage therapist, and chiropractor.

The focus of my exam was to clear Bob's cervical spine, evaluate him for concussion, and rule out any other critical injuries.

I cleared Bob's spine and found no focal neurological abnormalities. I administered the Sport Concussion Assessment Tool (SCAT) to determine a concussion baseline. I warned him of the dos and don'ts of concussion care and recommended only Tylenol Extra Strength. I informed him that MRIs would be ordered if medically indicated. I gave him a note for his tryouts.

In order to have time to deal with the issues pertaining to Bob's injuries, we planned for two follow-up visits the following week. I noted numerous medical and nonmedical factors that may influence his recovery. I wanted to do what was best for Bob and recognized that I would need to actively direct his care.

As with other busy physicians, I am not as familiar as I would like to be on what therapies are best for Bob's injuries. In the past, I had allowed Bob and his therapists to decide on his therapy, activity, and return-to-work planning. So I decided to research and review the available medical-based evidence in order to develop an appropriate care plan and return-to-work strategy for Bob.

"Where is the knowledge we have lost in information?"

—T.S. Eliot

I googled Medline, which has free access through PubMed at www.pubmed.gov. Under "whiplash" there are 2391 articles and 270 review articles. The volume of information was vast. I was able to put my critical analysis skills to work. However, this took most of an hour. I picked out five relevant articles with the following results:

• Moderate evidence of benefit that

neck strengthening exercises reduce pain and improve function.[1]
- The effectiveness of massage for neck pain is uncertain.[2]

I searched the Cochrane database at www.cochrane.org/index.htm under "acute whiplash therapy." The Cochrane Collaboration has evolved to help prepare, maintain, and disseminate results of systematic reviews on health care interventions. Here are the results:
- The 2006 database for conservative whiplash treatment suggests "those who receive active treatments may have less pain and stiffness and may be able to perform more everyday activities than those who receive passive treatments. Furthermore, there is insufficient data for patients with whiplash related problems that lasted longer than six months."[3]
- The 2007 database indicates that there is "moderate evidence that acupuncture is more effective than inactive treatments for short-term pain relief."[4]

I also logged onto the Official Disability Guideline (ODG) site at www.odgtreatment.com (for physician access to the ODG web site, contact Anita Gill at 604 647-6134 or anita.gill@icbc.com for password details). The information is comprehensive, covering evidence-based recommendations for history, physical, investigations, imaging, presumptive diagnosis, management, and return-to-work timeframes. This is followed by a detailed list of treatments and evidence supporting or not supporting efficacy. Useful references are also listed. ICBC adjusters often use the ODG to gauge treatment options and the estimated recovery period for an injured claimant.

Evidence-based medical resources

Medline searches are time consuming and limited by their random selectivity. The Cochrane systematic reviews and ODG have inherent limitations and should not be utilized as absolute. They can, however, be valuable tools in clinical decision making and directing care, particularly when dealing with complex medical cases and the added pressures affecting personal injury claims.

After reviewing the information available and printing out key references, I was able to develop a reasoned approach to Bob's treatment and return-to-work planning based on best evidence. I planned to share this information with Bob and work with him toward developing a plan for a pragmatic functional recovery.

If you have any questions or observations about treatment and return-to-work planning for ICBC patients, I would like to hear from you. Please contact me at martin.ray@icbc.com, by fax at 604 943-8344 or by phone at 604 943-6999.

—Martin Ray, MD

References

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