Dr Laura Jensen joins ICBC as new medical community liaison

When I told a colleague that I had recently accepted the position of medical community liaison for ICBC, he asked me why I had "crossed the floor." His response certainly gave me food for thought. "Crossing the floor" implies antagonism and betrayal. Is that really the case?

I applied for the position because it seemed to offer an interesting opportunity. In our current environment of time pressures, excessive paperwork, high expectations, and doctor shortages, most practitioners are struggling to provide quality time and service to their patients, their families, and themselves within the constraints of College's guidelines, billing parameters, confidentiality/privacy concerns, and a 24-hour day. As a semi-retired general practitioner with an interest in musculoskeletal medicine, I thought I would be able to use my experience and knowledge to help physicians and ICBC personnel work together for patient care and public safety in a way that does not increase, and hopefully might even lessen, the burden on physicians. Idealistic perhaps, but that is my overall goal. Not "crossing the floor" to the other side but attempting to shorten the distance between two groups.

The most frequent interaction between ICBC and physicians involves a patient with a whiplash-type injury who visits his or her family doctor. So, let us begin there.

A patient's first visit after a car crash

When a patient arrives at the office with a whiplash-type injury from a car crash, the medical office assistant and physician should note that the reason for the visit is an injury sustained in a motor vehicle accident. It is important to code visits as MVA-related for billing purposes because these visits do not use general MSP funding.

Many offices start collecting this information by having the MOA provide the patient with a questionnaire at the beginning of the first visit. Typically, the questionnaire collects information on the MVA itself, as well as injuries sustained and symptomatology. This means that by the time the patient sees the doctor, many facts are already documented and a significant amount of time has been saved, thus freeing the physician to elaborate on the data before examining the patient.

Why are the facts of the crash noteworthy? The direction and force of impact, position of the patient at the time of impact, seatbelt use, position of the headrest, anticipation of the collision, and bracing can all play a role in the injuries sustained and their related recovery.

So what actually happens in the typical rear-ender?

When a vehicle is struck from behind, the force of the collision pushes the vehicle forward and the occupant's torso is struck by the seatback. This pushes the body forward and causes some straightening of the spine, which elevates the head and results in axial loading as well as extension or hyperextension of the cervical spine.

As the seatback pushes forward, the headrest is forced into the back of the skull. If the headrest is properly adjusted with the top of the headrest above eye level, it will limit the amount of extension of the cervical spine. If the headrest isn't properly adjusted, or if there is significant elevation of the body, the neck may hyperextend, which can result in more severe injuries.

Within milliseconds, the neck rebounds forward and the head catapults into a chin-on-chest position. The torso is held in check by the three-point seatbelt and the head movement is unchecked unless an airbag is deployed.

If the head is turned at the time of the collision or if other rotational forces are experienced, shearing forces are brought into play and can modify the injuries sustained. This is why it is important to ask patients what they were looking at or doing at the time of impact.

Other questions to ask

Onset and timing of pain is important. Generally, pain that begins the morning after the MVA is milder than and not as long-lasting as pain that begins immediately after the collision. It is also important to note pre-existing and coexisting relevant conditions that may pertain to injuries sustained and subsequent recovery.

There is considerable information to collect from a patient following an MVA. Much of the information we have discussed can be obtained in a questionnaire provided to a patient by your MOA before you have even walked into the examining room. If you currently use a questionnaire and are willing to share it in order to develop a prototype, I would appreciate receiving a copy at Laura.Jensen@ICBC.com or via fax at 604 647-6148. Additionally, if you have any questions

Continued on page 27

nurse came and saw me and called the hospital doctor, who was there very quickly, and who in turn called an internist, who was there equally quickly. After an examination I was sent for a contrast scan as an embolus was suspected, but it turned out to be pneumonia, for which treatment was started. The ventolin inhaler gave almost immediate relief. Such was my 2007 Christmas. The rest of my care was no great shakes either, but I survived and am now fully recovered.

Two things became apparent to me. First, there is a general lack of spirit in this hospital; there is no empathy that I could detect. It is sad to see what was once one of the best hospitals in the valley slide to this level. Second, the emergency docs have been instructed to do all the tests they deem required before calling a specialist. This not only results in unnecessary testing, thus increasing costs, but it also is a major factor in the long wait times in the emergency. If a specialist comes in to the case when the diagnosis has been made, why does he get the big consultation fee? Should he not do the investigation? This would expedite care in the emergency, result in fewer tests, and very likely in better care.

Thus my tale of woe.

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Continued from page 25

or comments regarding the treatment of MVA patients or other ICBC-related topics, please let me know.

—L.A. Jensen, MD
ICBC Medical Community Liaison

The opinions expressed in this article are those of the author and do not necessarily represent the position of the Insurance Corporation of British Columbia.

New preferred life insurance rates

The BCMA Term Life Insurance plan has introduced lower rates for nonsmokers and two new underwriting classes—Preferred and Elite. Members and their spouses who practise a healthy lifestyle are rewarded with lower premiums.

To be eligible for the Preferred or Elite class, you must be in very good health and lead a low-risk lifestyle, and your term life insurance coverage must be a minimum of $250 000. Through the normal medical underwriting process, other factors will also be examined, including:

- Tobacco use
- Physical build
- Cholesterol level
- Blood pressure
- Recreational activities
- Driving record
- Personal and family medical history

As an example, the accompanying tables illustrate the cost savings between the new and the standard rate classes for women and men, age 40.

Underwriting class	Annual premium for a female, age 40 for coverage of:		
	$200 000	$250 000	$500 000
Elite	Not available	$110	$220
Preferred	Not available	$115	$230
Standard nonsmoker	$96	$120	$240
Standard smoker	$192	$240	$480

Underwriting class	Annual premium for a male, age 40 for coverage of:		
	$200 000	$250 000	$500 000
Elite	Not available	$130	$260
Preferred	Not available	$140	$280
Standard nonsmoker	$128	$160	$320
Standard smoker	$264	$330	$660

To find out more about the new underwriting rate classes or to request an application, contact the BCMA Insurance Department.

—Sandie Braid, CEBS, BCMA Insurance

Pulsimeter continued on page 28