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Of Foxes and Hen Houses

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A few months ago, a paper appeared in the *New England Journal of Medicine*¹ that many believed would rock the foundations of how we regard whiplash injury in North America. Spin-masters were quick to post press releases to the major wire services, and ABC ran a piece on the nightly news. Who are these spin-masters, and who employs them? We can only guess, and the gist adduced from the research was widely twisted into what can only charitably be called half-truths or misconceptions.

The paper we refer to was the result of a research project designed to compare the results on claiming behavior for cervical acceleration/deceleration (CAD, a.k.a. whiplash) injuries in the Canadian province of Saskatchewan during periods in which the province was under a tort system, and after the conversion to a no-fault system. The work was funded by Saskatchewan Government Insurance (GSI), the government auto insurer.

The authors reported a decrease in claims of 43 percent for men and 15 for women, with a reduction of median claim duration from 433 days to 194 days with the change to a no-fault system. The authors concluded that "The elimination of compensation for pain and suffering is associated with a decreased incidence and improved prognosis of whiplash injury."

In this paper, the authors began by making their position clear: "An insurance system in which financial compensation is determined by the continued presence of pain and suffering provides barriers to recovery." An interesting view, but one for which they offered no support. The authors also sent questionnaires to the claimants included in the study at initial claim; six weeks; four months; eight months; and 12 months postinjury. Curiously, no data was provided with regard to what, traditionally, we as clinicians would consider outcome - that is, were the claimants actually any better off after the changeover to a no-fault system? Thus, the reader is forced to accept the authors' conclusion about improved prognosis blindly.

Readers might recall that the lead author of this report, J. David Cassidy, also authored the Quebec Task Force on Whiplash-Associated Disorders paper in 1995.² In that research, also funded by an insurance company with considerable interest in the study's results, the authors used a rather unorthodox definition of the term "recovery." In the context of the paper, recovery occurred when the claimant stopped receiving a check for time lost from work. Not surprisingly, the authors found that by one year post-injury, 97 percent of the subjects had "recovered."

What the reader did not realize was that the authors of that study actually did not investigate whether any of the 97 percent were actively being treated; were partially disabled; were partially symptomatic; or even if they had returned to work. They were just aware that the claimants were no longer receiving a check for time lost. Even if the authors had looked at actual return to work status, it has never been established in the literature that return to work can be used as a proxy for recovery status.

The curious definition of the term "recovery" becomes somewhat more clear when one realizes that the sponsoring insurance company was not responsible for medical benefits, but merely as a supplemental insurer that paid benefits for time lost from work. This and other rather glaring deficits of that paper have been described elsewhere.³ However, in the present study, the authors claim closure to recovery without providing the reader any information about the actual condition of the claimants.

The authors reported a six-month cumulative incidence of claims under tort of 417/100,000, which was reduced to 302/100,000 and 296/100,000 in the second two six-month periods after no-fault. Interestingly, a figure of 700/100,000 yearly incidence was reported in the earlier paper.² This suggests that the figures for the tort period had either decreased significantly since the earlier (1995) report, or that the data collection and reporting system in Saskatchewan for injuries had changed rather drastically.

It was also noted that a claim closure took longer under the no-fault system when claimants saw either a chiropractor or a chiropractor and a medical doctor. However, it was not possible to determine from this paper whether those who saw a chiropractor were comparable in terms of injury severity to those who did not. It was also not possible to determine whether chiropractic patients generally fared better or worse than non-chiropractically managed patients.

It is important to note that when the outcome of interest is claim closure, having a physician who will actively fight to keep a claim open for continued treatment (i.e., a DC) will increase claim closure time in comparison with a less involved physician who is more likely to acquiesce to the demands of the insurer for

rapid closure of claims. The longer claim closure time says nothing about the results of treatment. The authors also reported that retention of an attorney lengthened claim closure time, which would be expected if an attorney was involved in a case and litigation resulted.

Perhaps more importantly, it is not clear from this paper what, if any, incentives for early claim closure were provided to physicians, nor do we know all of the factors attending the implementation of no-fault, aside from the inability to sue for pain and suffering, that might cause claims to be closed earlier. It is certainly reasonable to speculate that some of these factors could also be responsible for the changes in claiming behavior. Thus, the implication that the changes are all attributable to the withdrawal of pain and suffering compensation is clearly confounded by these other factors.

If a system makes it more difficult to keep a claim open regardless of the need of the claimant, and thus disincentivizes potential claimants from even filing a claim, it can hardly be said to be a surprise when claims are closed more quickly and the number of claims decreases. Claimants under no-fault are required to go through various work hardening, rehabilitation and psychological counseling programs if they require care for more than six weeks. These requirements appear to be based on the original QTF treatment/management guidelines, which were not based on any concrete scientific research, but which resulted from a consensus of mostly non-whiplash experts within the QTF task force. Although the notion of multidisciplinary care is gaining popularity and has merit, these new programs may also be perceived as unreasonable barriers to some patients and might result in early claim closure, particularly when it is known that all of the physicians providing the multidisciplinary care are employees of the Saskatchewan Government Insurer.

We believe the ultimate purpose of an insurance system should be to make every reasonable effort to facilitate the return of patients to their original state of health. The authors of the present study seem to have been focused on claiming behavior alone, taking it as a proxy for patient recovery. This is a dangerous assumption, and it is misleading to all. With so many other changes that have accompanied the change to no-fault law in Saskatchewan, and in light of the fact that the actual patient outcomes were not described in the NEJM report, and given the dubious history of unorthodox methodologies and questionable conclusions of the QTF-WAD in the past, we are concerned. The authors of this paper may have demonstrated nothing more than this: When the foxes are given the keys to the hen house, the life expectancy of the hens (and their population) will surely decline. If the insurer is given unfettered control over claim duration/closure, outside of any reasonable countervailing influences of knowledgeable physicians or trauma researchers, it

does not come as a surprise to us that claims decrease in number and duration. All of this is fine for the insurance company's bottom line, of course, but does the patient actually benefit? This seems like a question that still remains unanswered.

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