Shifting toward health

Surely there are primary care physicians who enjoy dealing with the Insurance Corporation of British Columbia (ICBC)—I just haven't met any of them. I am pretty confident that the family physicians in my community don't look forward to this part of their practice. Listening to patients' complaints and recording soft tissue tenderness with painful reduced spinal range of motion isn't that onerous, so why do we all hate it? It has something to do with the looming shadow of secondary gain involved in these visits, as they become more about compensation than health and wellness. Even the best-intentioned patients can get caught up in the whole claim process. Compounding this is involvement by lawyers and other health professionals. Patients painstakingly list all their symptoms and disabilities while relating what their physiotherapist, chiropractor, and massage therapist are telling them. They often relay requests from their lawyer about investigations, treatment, and required frequency of visits. Redirecting them to focusing on health by getting active is an uphill battle.

As of 1 April 2019, new ICBC regulations have come in to effect for treating patients who have been in motor vehicle accidents. This new model aims to reduce ICBC's litigation costs while increasing patient care. A cap of $5500 has been put on payouts for pain and suffering for minor injuries. More choices in types of treatment will be available, including kinesiology, acupuncture, massage therapy, and counseling. In addition, the overall allowance for medical care and recovery expenses has doubled to $300 000. Doctors of BC was significantly involved as a key stakeholder to help raise issues and inform the new process and I appreciate all of the work that went in to this process.

Previously, when a patient was seen post-accident, a history and physical were recorded and a treatment program was designed. The patient was then seen in follow-up as needed. ICBC would send a request for records along with a patient consent at their discretion. If a patient had legal representation, ICBC was only entitled to a CL-19 form summarizing the patient's history, findings, treatment, and disability.

Under the new care-based model, physicians are asked to collect consent from patients to proactively send either a standard medical report if there is no work loss or an extended medical report if the patient is unable to work, study, or train. Based on this report, ICBC will decide whether the patient has suffered a minor or major injury. An independent dispute resolution process will take place through the Civil Resolution Tribunal if patients are unhappy with their injury designation. If a patient refuses to give consent, physicians are expected to collect their information but not send in the initial medical report. However, ICBC believes they are entitled to the patient's information and expect to receive it once requested; in their opinion, the Insurance Vehicle Act overrides the Personal Information Protection Act. If a minor injury lasts more than 12 months or if concussion symptoms and accident-related mental health issues are present after 4 months, it becomes a major injury, no longer subject to a financial cap.

Through my experience in dealing with ICBC patients for over 20 years, I would agree that ICBC costs are excessive, mostly due to the litigation process. Retaining legal counsel leads to more investigations, treatments, and consultations—all of which cost money. In addition, one-third of settlements go directly to the lawyers. I hope that the new regulations will lead to a reduction in costs and improved patient outcomes, but I remain a little skeptical. I am suspicious that after seeking legal counsel a significant number of patients will surprisingly have concussion symptoms and mental health issues after 4 months or remain symptomatic from their soft tissue injury a year later.

I'm interested to see how all of this plays out, but in the meantime I will continue to do my best to shift patients' focus away from financial compensation and toward health, where it belongs.

—DRR

Listen up, Doc

"Good morning, Ms S. What brings you in today?"

As I ask the question I see that she is clutching a tax credit disability form and there is a vitamin B12 vial sitting on the counter. Before she can answer, I say, "I see you have a form for me to fill out," and I gesture for her to hand it to me.

"Yes, I've been wanting to bring it in for some time but wasn't sure if I was eligible," she says. I'm signing on to my EMR as she speaks. I start flipping through the form and agree that she is not eligible for the credit. I then proceed to address that she needs her vitamin B12 injection. After giving her the injection I am ready to wrap up the appointment. As is my routine, I ask, "Is there anything else I can do for you today?" and I get up to take her BP as she starts speaking. "Actually . . . I've been having trouble with my memory," she says and starts to cry. I ditch my efforts at the BP, sit down facing her, put my hand on her arm, and I wait. She looks at me and starts to talk. It is quite apparent that she is very worried about her forgetfulness. She is embarrassed, sad, and scared. I continue to listen and then we formulate a plan for how we can further investigate her symptoms. She is thankful, and through tears she gives me a hug as she leaves.

According to a recent study in the *Journal of Internal Medicine* by Naykky Singh Ospina and colleagues,[1] on average, physicians give patients 11 seconds to explain their reasons for a visit before interrupting. It was also determined that primary care physicians allowed more time for patients to list their concerns than specialists. The authors concluded that, "Failure to elicit the patient's agenda reduces the chance that clinicians will orient the priorities of a clinical encounter toward specific aspects that matter to each patient."

I reflected on my visit with Ms S and other patients and realized that my idea of a successful encounter was usually one during which I had completed my agenda for the visit, not always the patient's agenda. If Ms S hadn't broken down I may not have been able to help her with her real concerns that day.

Being present and *being mindful* are phrases that I relate to the act of being a good listener. But I find that these skills have to be practised regularly to be naturally occurring during a patient visit.

A paper by Mary Shannon, "Please hear what I'm not saying: The art of listening in the clinical encounter,"[2] summarizes that "the simple yet complex art of listening is, in and of itself, a clinical intervention, for the healing that comes from being listened to is often greater than any cure. Listening constitutes the very heart and soul of the clinical encounter."

William Osler, often called the father of modern medicine, advised students: "Just listen to your patient, he is telling you the diagnosis."

A review of reports by the Joint Commission, a not-for-profit organization that performs accreditation of health care organizations, found that communication failure rather than physicians' knowledge or technical skills was the root of more than 70% of serious adverse health outcomes in hospitals.[3]

Why are physicians being touted as being poor listeners? I remember receiving what I thought was adequate training on how to communicate with the patient during my family medicine residency at the University of Saskatchewan. We were also taught how to direct the communication so that the encounter could be efficient and productive for both the patient and the physician. I believe that we

try to do the best in the time we have. The waiting room full of patients, the EMR waiting to receive its data, the tasks waiting to be reviewed at the end of the day, the patients expecting to be called back about their urgent concerns, our partners with supper on the table, our kids waiting for us to show up at their soccer game, and the financial burdens that we have created for ourselves are just some of the reasons we may feel the need to encourage the patient's visit to run along faster than is considered adequate.

I did a small-scale trial of better listening in my clinic a few weeks ago. What I discovered was that if I let the patient speak uninterrupted after my initial inquisition of what brought them in, it took most patients less than 10 seconds to relay their concerns. Of course there was further discussion after that, but being present and really listening to the patient at the onset of the visit sets the tone for the rest of the discussion. I know that most patients are mindful and respectful of my time and I think they deserve the same.

"Most people do not listen with the intent to understand; they listen with the intent to reply" – Stephen R. Covey. The message is clear; we need to start listening with the intent to listen—to our patients, our peers, our families, our friends, and ourselves. Physician burnout is starting to be more recognized and health authorities and physician groups are starting to take real steps to address this important topic. I'll save that discussion for another day. For now, in the words of TV psychiatrist Dr Frasier Crane, "I'm listening. . . ." **—JC**

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References

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