(Part 1 – Diagnosis)

1. The adoption by medical professionals of a standardised approach to the examination of soft-tissue ('whiplash') injuries will bring more consistency to medical reporting and diagnosis.

Irish College of General Practitioners – Moderately Agree. Providing the adoption is a standardised approach is developed through a well-established process of education for examining clinicians, it may bring more consistency.

Irish Association of Emergency Medicine – Agree. Many clinicians are asked to offer opinions regarding patients suffering trauma. The result is opinions based on varying level of expertise. Patients suffering trauma, particularly road trauma, commonly first seek medical care at Emergency Departments (EDs). The Consultants in Emergency Medicine that run / supervise EDs see large numbers of these patients and are therefore the medical experts that see, treat and rehabilitate patients with 'Whiplash Associated Disorder' on a daily basis. Consultants in Emergency Medicine are familiar with and already use the format and scoring systems described in Part 1 & 2. A standardised approach from appropriately trained clinicians will improve consistency to medical reporting. However, care must be taken to ensure an overly rigid approach does not impede the expert opinion being given.

Royal College of Surgeons in Ireland (Orthopaedics) – Moderately Agree. Best to use broad categories for classifying injuries. Less likely to be variable and more likely consistent.

Royal College of Surgeons in Ireland (Physiotherapists) – Strongly Agree. A standardised approach to examination of whiplash associated disorder (WAD) is international best practice. Classifying the WAD grade, in alignment with QTF recommendations, provides an indication of the severity of the injury, which is particularly important for such a heterogeneous cohort.

Department of Health – Agree. Yes, I think this is an important first step. However, if the objective is to provide greater consistency, then this needs to be evaluated. This evaluation process must be thought out and appropriate performance indicators agreed at the beginning. The approach needs to be kept under constant review and updated as new evidence becomes available.

Health Service Executive – Strongly Agree. The current advice for the diagnosis and management of whiplash associated disorder (WAD) would recommend a standardised approach to reduce variation in the diagnosis and management of WAD.

Department of Social Protection – Agree. Will bring uniformity, focused approach and more importantly for the awarding Body a streamlined application process, improving efficiency in dealing with volume of claims.

2. To what extent do you agree or disagree with the proposed standardised approach outlined (parts 1 – 5 of this consultation refer)?

Irish College of General Practitioners – Moderately Disagree. It is probably more important to bring the level of awards for a questionable diagnosis such as whiplash into line with other EU states than to focus on the approach of Clinicians in diagnosing it. Recent evidence suggests that the presence of a compensable injuries system is more important than any actual demonstrable pathology in determining key outcome variables (Disability Insurance Benefits and Labor Supply Decisions: Evidence from a Discontinuity in Benefit Awards Müller, Tobias and Boes, Stefan (2016): Disability Insurance Benefits and Labor Supply Decisions: Evidence from a Discontinuity in Benefit Awards.

Irish Association of Emergency Medicine – Agree. The approach to diagnosis outlined in Part 1 is sensible and this is the approach used by Consultants in Emergency Medicine in daily practice. The Grades and Scoring outlined in Part 2 (QTF/VAS) are evidence based and widely used by Emergency Medicine in daily clinical practice and medical reporting. Part 3 is a useful guide, but can be overly rigid. Each patient's presentation, assessment and treatment follow its own particular clinical course and do not always follow the rigid structure outlined. Inclusion of the NDI form template would be useful for patients. Repeated NDI can assist in tracking recovery.

Royal College of Surgeons in Ireland (Orthopaedics) – Mildly Agree. Agree with overall concept but would suggest keeping things as simple as possible to ensure more streamlining.

Royal College of Surgeons in Ireland (Physiotherapists) – Agree. The standardised approach outlined could be further strengthened by reference to even more recent clinical guidelines in this area i.e. Motor Accident Authority Guidelines for the management of Acute WAD for Health Professionals - Sydney Australia , third edition , 2014.

Department of Health – Strongly Agree. This is a definite first step but as stated above, should be monitored and reviewed. I would like to see all elements of the approach as part of a computer assisted programme which would consolidate the responses from 1-5 and deliver a Disability Rating. The quantum of compensation can be then be more accurately assessed.

Health Service Executive – Strongly Agree. The proposed standardisation approach is in the keeping with the current evidence base.

Department of Social Protection – Agree. By using a uniform application process, incorporating evidence based international assessment tools i.e. Quebec task force grading system and a detailed medical report form with Neck disability index, I feel it will capture subjective and objective information to all applications promoting greater consistency. However bearing in mind, clinical examinations are user dependent, furthermore in a significant number of cases litigation claims may affect clinical manifestations, literature reports on several clinical tests that may suggest exaggerated response in these situations, tests such as Axial Compression may be used in appropriate settings. Reliability of Spinal Palpation for Diagnosis of Back and Neck Pain: A Systematic Review of the Literature. Seffinger, Michael A. DO*; Najm, Wadie I. MD, Mishra, Shiraz I. MD, PhD ; Adams, Alan DC, MS; Dickerson, Vivian M. MD; Murphy, Linda S. MLIS; Reinsch, Sibylle PhD** Spine: 1 October 2004 – Volume 29 – Issue 19 – pp E413-E425.

3. Are there any additional frequently used tests that should be considered by the PIC? Yes / No

Irish College of General Practitioners – No. There are many tests (Radiological and / or objective tests of functional capacity), but given the frankly spurious nature of most compensated whiplash, unless there are clear objective examination findings of consequences, these should not be embarked upon for reasons of cost, and for avoiding unnecessary complexity.

Irish Association of Emergency Medicine – No.

Royal College of Surgeons in Ireland (Orthopaedics) – Yes. MRI. Early imaging such as MRI is now often inexpensive and can provide early reassurance and allow speedier access to rehab and resolution of claims.

Royal College of Surgeons in Ireland (Physiotherapists) – Yes. Inclusion of the Impact of Event Scale provides a measure of psychological assessment and is now recommended by the more recent Australian clinical guidelines (MAA 2014). Assessments of all prognostic indicators, such as psychological distress, will improve the capacity of any clinical assessment in informing a more accurate prognosis. In addition, a simple question asking the claimant about their expectation of recovery is now also recommended within the same clinical guidelines, as expectation also holds prognostic value.

Department of Health – Yes. The Functional Rating System (FRI) and the Self Efficacy Scale can also be used. However, it is probably prudent to commence with the NDI and VAS and consider changing following evaluation if objectives are not being met.

Health Service Executive – Yes. Hospital anxiety and depression scale or the Beck Depression Inventory as a screen for depression. Depression is associated with poor outcome in WAD.

Department of Social Protection – No. Again using the minimum tests, which are widely accepted and evidence based will promote consistency.

4. To what extent do you agree or disagree with the inclusion of self-testing measures to reflect a claimant's own perception of their pain levels and to benchmark same in the context of any improvements ascertainable in later examinations?

Irish College of General Practitioners - Strongly Disagree. Where it is a compensable allegation of injury, self-testing measures are particularly unreliable.

Irish Association of Emergency Medicine – Mildly Agree. Self-scoring gives a patient the opportunity to express how their symptoms affect them. The NDI only reflects that the patient understands of the level of disability at a moment in time. Recovery is usually a fluctuating course and a self-assessment is not always a predictor of future pain. Repeated self-scoring may demonstrate symptom abatement.

Royal College of Surgeons in Ireland (Orthopaedics) – Disagree. Systems of self-determination will encourage catastrophizing as there may be drivers to encourage poor response.

Royal College of Surgeons in Ireland (Physiotherapists) – Agree. This remains international best practice but should be considered in the context of the modern clinical assessment which allows for value judgements to be reached regarding consistency between patient report outcome measures and specialised physical testing e.g. Neurological exam, Joint Position Error and somatosensory hypersensitivity using Quantitative Sensory Testing.

Department of Health – Agree. Pain is subjective – seeing an improvement is an important clinical outcome. In addition assessment of client's pain is an important prognostic indicator of recovery.

Health Service Executive – Strongly Agree. The issue of malingering has long since been proven to be overstated in discussions about WAD. Self-testing is commonly used in the assessment and management of many pain disorders.

Department of Social Protection – Mildly Disagree. In compensation claims there may be an element of subjective / functional overlay. Is a lifetime history of neck injury in a traffic collision associated with prevalent neck pain, headache and depressive symptomology? P Cote JD Cassidy L Carroll - Accident Analysis & Prevention 2000 – Elsevier. The self-measuring tools are not exactly quantifiable (objective) and lead to interpretation difficulties however their use 1) affords claimants opportunity to express level of symptoms 2)interval changes may help assessment of improvement or deterioration 3) should be used in conjunction with other information and clinical examination.

(Part 2 – Grading & Scales)

5. To what extent do you agree or disagree with the use of the QTF classification as the preferred model for the grading of WAD injuries?

Irish College of General Practitioners – Moderately Agree. The categorisations are clear, easy to follow and make good clinical sense, particularly so given that they are based on examiner perception / examination as opposed to subjective criteria applied by the claimant.

Irish Association of Emergency Medicine – Strongly Agree. Quebec Taskforce scoring for Whiplash Associated Disorder is internationally validated and used by Consultants in Emergency Medicine is both daily clinical practice and medical reporting.

Royal College of Surgeons in Ireland (Orthopaedics) – Moderately Agree. Agree with the use of system with relatively small and distinct categories.

Royal College of Surgeons in Ireland (Physiotherapists) – Strongly Agree. QTF classification provides a good indication of injury severity. Grade II describes the largest cohort of WAD patients, who have variable prognostic profiles, which requires that other tools are needed to provide prognosis, as has been outlined in this document e.g. VAS, NDI and IES.

Department of Health – Agree. It appears that most assessment models are based around this type of classification. It is based on the WHO International Classification of Functioning, Disability and Health (ICF). In that classification, five impairment classes permit the rating of the patients from no impairment to most severe.

Health Service Executive – Strongly Agree. It is the most commonly used tool internationally although it has limitations given the heterogeneity of WAD.

Department of Social Protection – **Agree.** It is an internationally accepted evidence based tool. It's clear, concise and practical.

6. Are there any alternative grading models that you would consider appropriate for the grading of WAD injuries? Yes/ No.

Irish College of General Practitioners – No. As previously indicated, a better approach to this entire issue would be to formally reconsider the approach in Ireland where Whiplash has been monetised to the extent that it has been, resulting in a legally generated level of claims driven inappropriate sick role behaviour. The issue is not to improve Clinician Grading of Whiplash so much as to bring the level of awards down to levels seen in comparable jurisdictions in similar societies such as our own.

Irish Association of Emergency Medicine – No.

Royal College of Surgeons in Ireland (Orthopaedics) – Yes. May develop a modification using an MRI as adjunct (better than clinical exam and ROM). See original developed when MRI was less available.

Royal College of Surgeons in Ireland (Physiotherapists) – No.

Department of Health – Yes. American Medical Association Guide to the Evaluation of Permanent Impairment, 6th Ed (may be more complex however).

Health Service Executive – No. There is no other tool with a strong evidence base currently.

Department of Social Protection – Yes.

7. Are there any alternative or additional scales that you would consider appropriate for the evaluation of soft-tissue ('whiplash') and / or non-soft-tissue ('whiplash') injury? Yes/ No

Irish College of General Practitioners – No. There are several research studies which examine long term outcomes in Whiplash. The Nord-Trøndelag Health Study: HUNT2 and HUNT3 is of particular interest, given that it originates from population based study in a society with relevant similarities to our own in Ireland. At 11 years, a sample of over 600 cases of whiplash was reported on, where it was noted that only less than one third (31.6%) continued to report symptoms. Persistent long term symptoms were had string associations with pre accident characteristics of the individual, and with high levels of usage of medicalisation around the time of the accident. The latter may well relate to severity of injury, but the latter relates to a complex and questionably related range of personal predisposing factors independent of physical injury arising from the incident. Additional rating scales, focused on either self-reported symptom scores or rating clinician examination findings are unlikely to be helpful in this context. Factors Related to Non-recovery from Whiplash. The Nord-Trøndelag Health Study (HUNT) Intl Journal of Behavioural Medicine June 2013.

Irish Association of Emergency Medicine – No.

Royal College of Surgeons in Ireland (Orthopaedics) – Yes. Symptoms with / without underlying degenerative disease. Symptoms with / without radiographic evidence of acute injury.

Royal College of Surgeons in Ireland (Physiotherapists) – Yes. As outlined in the MAA (2014) clinical guidelines, use of the Impact of Event Scale and expectation of recovery (i.e. Do you think you will get better soon?) are also recommended to strengthen clinical assessment within the first 12 weeks.

Department of Health – No. I think what is proposed is evidence based and should be piloted. If, following monitoring and evaluation, it requires to be changed, then consideration needs to be given to this.

Health Service Executive – No. The literature does not support the use of an additional scale. However, it must be taken into consideration that WAD is not often simply soft tissue injury.

Department of Social Protection – Yes. The degree of a patient's neck pain or dysfunction can be evaluated using standardised scales at the time of a clinical encounter or during the performance of clinical research protocols. The choice of a scale with the most appropriate characteristics, however, is always a challenge to clinicians and researchers. Articles concerning scales for functional evaluation of neck pain or dysfunction were identified by computer searching of MEDLINE (January 1966 to June 1999) and CINAHL (1985 to 2000), citation tracking using the Citation Index, hand searching of relevant journals, and correspondence with experts. Results. Five standard scales were found. These scales were remarkably similar in terms of structure and psychometric properties: the Neck Disability Index, the Copenhagen Neck Functional Disability Scale, and the Northwick Park Scale. However, only the first instrument has been revalidated in different study populations. The Neck Pain and Disability Scale provides a visual template for collection of information, but its usefulness is limited if the questionnaire must be read to the patient. The Patient – Specific Functional Scale is very sensitive to functional changes in individual patients, but comparisons between patients are virtually impossible. Conclusions. The five scales identified in this study have similar characteristics. The Neck Disability Index, however, has been revalidated more times for evaluation of patient groups. For individual patient follow-up evaluation, the Patient –Specific Functional Scale has high sensitivity to change and thus represents a good choice for clinical use. The final choice should be tailored according to the target population and the purpose of the evaluation.

(Part 3 – Forms)

8. Who do you suggest should complete self-testing measure records? Claimants / Medical Experts.

Irish College of General Practitioners – Medical Experts. Expecting Claimants to reliably complete self-testing measure records in a monetised process such as compensation is naive, and impractical.

Irish Association of Emergency Medicine – Claimants. See above: The NDI gives insight into a patient's experience of their symptoms.

Royal College of Surgeons in Ireland (Orthopaedics) – Medical Experts. Trained experts using as objective criteria as possible.

Royal College of Surgeons in Ireland (Physiotherapists) – Claimants. Validity testing of many of these patient report outcome measures rely on claimants completing the tool rather than verbal completion e.g. NDI. The potential impact on validity of responses of medical expert completing the tool requires consideration.

Department of Health – Claimants. This can be verified by the examiner by observation of the patient performing certain tasks, e.g. untying shoe laces, transferring to the couch etc. I think it is also important that these self –testing measure records are compared across a time frame from initial injury. People with poor prognosis are associated with high pain VAS scores and high NDI scores.

Health Service Executive – Claimants. The self-testing should be supported by objective assessment of the claimant.

Department of Social Protection – Claimants. Mainly Claimants. I think both should complete self-testing measure records: for reasons mentioned in 4. above.

(Part 4 – Training & Accreditation)

9. To what extent do you agree or disagree that compulsory formal training, accreditation and qualification for those medical professionals reporting on soft-tissue ('whiplash') injury will improve the consistency and quality of reports?

Irish College of General Practitioners – Moderately Agree. A more formal approach to formal training, accreditation and qualification for medical professionals reporting on soft tissue injury is likely to improve both consistency and accuracy of reporting. Further, the reporting system should evolve, and periodic updated training modules will enable ongoing refinement of the reporting pro formas.

Irish Association of Emergency Medicine – Strongly Disagree. IAEM is of the opinion that Consultants in Emergency Medicine are appropriately trained to provide expert opinion in WAD. Consultants in Emergency Medicine are experts in assessment of 'Whiplash Associated Disorder' (WAD), through Specialist Training and daily clinical practice. Consultants in Emergency Medicine are on the Specialist Register of the Medical Council, having achieved Fellowship of the Royal College of Emergency Medicine (FRECM or equivalent). Ireland has a structured training programme and FRCEM is internationally recognised. A training course in legal aspects of report writing may assist in standardising report format, but will not assist with clinical expertise.

Royal College of Surgeons in Ireland (Orthopaedics) – Agree. Formal training for people to provide reports in cases with less severe injuries – less expensive and often more difficult.

Royal College of Surgeons in Ireland (Physiotherapists) – Moderately Agree. Without knowing the level of consistency in reports currently provided, it is difficult to provide an opinion. Familiarity with all of the proposed outcome measures and the QTF classification scheme are currently being taught to our undergraduate students within the BSc Physiotherapy programme. A definition of medical professionals reporting on WAD has not been provided but the specialised physical assessment outlined includes measures that are administered exclusively by physiotherapists and so their inclusion as potential report writers would be appropriate.

Department of Health – Undecided. In my opinion a training course can provide two important elements; Education on best practice management of acute and chronic whiplash disorders which will lead to better outcomes for patients and more accurate and standardised assessments of patients for compensation purposes.

Health Service Executive – Strongly Agree. Whilst most WAD is mostly a self-limited condition, those with persisting problems can have complex biopsychosocial implications that need an experienced assessor.

Department of Social Protection – Strongly Agree. Clinicians with "Specific" specialist qualification such as Orthopaedics, Neurosurgery, and A&E would be highly desirable for a thorough assessment, but these specialities may not be readily available. Other specialists such as Neurology, Sports medicine, Rheumatology, and General Surgery may be reasonably qualified for this role. Compulsory training I feel should be required for clinicians outside the above fields, such as Occupational physicians, other specialists, General Practitioners.

10. To what extent do you agree or disagree that a continuous professional development based accreditation / qualification is the appropriate level of expertise required for medical experts completing medical reports on soft-tissue ('whiplash') injuries?

Irish College of General Practitioners – Moderately Agree. Most clinical process benefits from periodic educational review. This can be undertaken on the basis of an initial process of a foundation module, followed by ongoing completion of an updater module at 2-3 year intervals. The initial module should include completion of an online e learning module (best suited for imparting relevant factual data), followed by attendance at a taught course (best suited for demonstration of relevant clinical skills, and validation of practice of skills e.g. through an Objective Structured Clinical Examination or OSCE). Updating modules could reasonably be restricted to re fresher e learning modules. Examiners who were felt to be reporting inconsistently could be referred for a repeat of the foundation module. The process could be communicated as a Certificate in Advanced Practice in Disability Evaluation. The ICGP is well placed to develop such modules.

Irish Association of Emergency Medicine – Disagree. Consultants in Emergency Medicine, through Higher Specialty Training and daily practice, are experts in assessment and reporting of WAD. If opinions are being sought from doctors that require further training in this assessment, then these opinions may not be expert. CPD does not infer expertise. A CPD course in legal (rather than clinical) aspects of reporting may assist is standardising the format of reports.

Royal College of Surgeons in Ireland (Orthopaedics) – Agree. Remove financial incentive for providing / getting reports.

Royal College of Surgeons in Ireland (Physiotherapists) – Undecided. Skills and knowledge required to follow this standardised approach forms part of routine clinical practice and is found on the BSc Physiotherapy curriculum.

Department of Health – Moderately agree. As stated in the answer to Question 10, education and training in the management of acute/chronic whiplash injury will lead to a more standardised assessment. There should also be a medico-legal module included. I would agree that this should be a CPD based accreditation.

Health Service Executive – Agree. For simple WAD, no additional training would be required. For WAD ≥ III additional training would allow the assessor to accurately reflect the complex issues where guidelines exist. However such guidelines may eliminate the requirement for such expertise.

Department of Social Protection – Agree. I would agree a continuous professional development based accreditation/qualification is appropriate for Non Specialists.

11. To what extent do you agree or disagree that a training course for medical experts on soft-tissue injury medical reporting should be delivered?

Irish College of General Practitioners – Moderately Agree.

Irish Association of Emergency Medicine – Disagree. Clinical expertise in soft tissue injury is based on eligibility for the Specialist Register in Emergency Medicine and daily clinical practise. A training course in legal aspects of report writing may assist in standardising report format, but will not assist with clinical expertise.

Royal College of Surgeons in Ireland (Orthopaedics) – Agree.

Royal College of Surgeons in Ireland (Physiotherapists) – Undecided.

Department of Health – Moderately Agree. As stated above as part of a comprehensive training programme for best practice management of acute and chronic whiplash associated injuries.

Health Service Executive – Agree. Training would facilitate reduced variation in the assessment of WAD.

Department of Social Protection – Agree. Given the very specific area a focussed training course would be helpful for all clinicians involved in this process. It affords them opportunity to develop their knowledge and skills. Promotes consistency and quality.

12. Who should deliver a training course for medical experts on soft-tissue injury medical? Individual medical bodies to their own respective members / Independent Training Provider / s.

Irish College of General Practitioners – The educational process above would best be undertaken by relevant Postgraduate Training Bodies, with one leading the development, and drawing expertise from the others where appropriate. The ICGP is well positioned to lead this, and in a position to utilise links with postgraduate education in the RCPI, the RCSI, together with relevant inputs from Radiology, Physiotherapy and Psychology as appropriate.

Irish Association of Emergency Medicine – Consultants in Emergency Medicine possess expertise in assessing and treating WAD through Higher Specialty Training and daily clinical practice. No 'course' will deliver the same level of expertise.

Royal College of Surgeons in Ireland (Orthopaedics) – Independent Training Providers. More vocational and psychological than medical.

Royal College of Surgeons in Ireland (Physiotherapists) – Individual medical bodies to their own members. The expertise currently exists within the Irish Society of Chartered Physiotherapists to currently provide such training to their own members, as well as those of other professional bodies, should that be needed.

Department of Health - Independent Training Providers. I think it might be useful to obtain this expertise from jurisdictions and providers that are experienced in this type of assessment. This will include medical competency based training but also specific disability assessment and legal issues.

Health Service Executive – Individual medical bodies to their own respective members and Independent Training Providers. Either could deliver a training course that delivered an agreed curriculum with knowledge and skills required explicitly stated.

Department of Social Protection – Individual medical bodies to their own respective members. The involvement of the Royal College of Surgeons (from Specialists in the disciplines of Orthopaedics and Trauma, Neurosurgery & Accident and Emergency Medicine should be encouraged.

13. Please provide comments on the content for inclusion and delivery of proposed training for medical experts as regards soft-tissue ('whiplash') injury medical reporting.

Irish College of General Practitioners - Content should include relevant elements from Anatomy, Psychology, Sociology, Therapeutics, Examination Skills, Radiology, Evaluation of Sick Role Behaviour, Underwriting, and Reporting Skills. Preferred delivery for content would include an online distance learning (e learning) module for imparting factual knowledge, on completion of which candidates would be required to attend a taught / evaluation module (e.g. 1 day workshop) where standardised examination technique is demonstrated and taught, and they are subsequently required to demonstrate elements of this in a formal process of objective evaluation. On satisfactory completion of both of these elements, a Certificate in Advanced Practice in Disability Evaluation can be awarded, and subjected to 2-3 yearly re validation, the latter achievable on completion of an updated e learning module. Maintaining the candidates on the examining panel would be subject to this process, together with an evaluation of a sample of their reports at interval by the Injuries Board.

Royal College of Surgeons in Ireland (Physiotherapists) - Content of any training should include familiarity with the proposed outcome measures, as well as specialised physical exam. In addition, inclusion of the current literature on prognostic indicators would be of significant importance, given the requirement to make a prediction of prognosis.

Department of Health – This should be a face-to-face training course. The content of the course as well as providing the technical expertise, needs to educate practitioners of the context of their assessment, i.e. costs to the State of claims (tax payer), and the importance of encouraging claimants to get back to work (psychological issues).

Health Service Executive – Definition, Pathophysiology, Grades & Classification, Evidence, Guidelines, Assessment, Management – Acute / Chronic, Biopsychosocial model and pain, how to complete a report.

Department of Social Protection – Detailed history to include mechanism of injury/onset of pain. Immediate clinical course subsequent to onset of pain. History to include description of activities of daily living or its limitations. Focused clinical examination to include direct observation and indirect observations. Careful documentations of same. Training to read and interpret investigation reports for cervical spine i.e. Plain radiographs CT and MRI scans. Clear description of injury, description of Pain, resulting limitations of ADL, disability or limitation of function of Neck/upper limb. Preferably on a standardised examination proforma facilitating assessment at review. Outline treatment course. Expected duration of disability and outcome. Anticipated extent of recovery with reference to return to level of Work capacity. Suggested further review report if indicated.

(Part 5 – Expert Evidence)

14. Please provide comments on the level of expertise that should be required of medical experts in general?

Irish College of General Practitioners – The level of expertise should include a demonstrated ability to evaluate cases consistently and objectively, and with reference to a common reporting template.

Irish Association of Emergency Medicine - The essential criteria for inclusion in the panel of experts assessing injured patients in general, should be inclusion in the IMC's register of Medical Specialists for a specialty where the training programme encompasses formal training in the assessment and management of patients with traumatic injuries. In relation to spinal injuries, Consultants in Emergency Medicine, Orthopaedics and Neurosurgery are trained in the management of spinal injuries. Consultants in Emergency Medicine are also trained in both early and ongoing care of soft tissue spinal injuries. Emergency Medicine also has a good understanding of the importance of 'mechanism of injury' in the causation of injury. This is particularly useful in cases where there is a concern that the symptoms complained of are not in keeping with or are out of proportion to the mechanism of injury. We believe the 'expert' in WAD should have completed Higher Specialty Training in Emergency Medicine via FRCEM (or equivalent).

Royal College of Surgeons in Ireland (Orthopaedics) - Experts should be those who deal with non-specific injuries. Should aim for situation where medical experts are only required for cases with objective severe injuries.

Royal College of Surgeons in Ireland (Physiotherapists) - In relation to physiotherapists, clinical specialisation within the area of musculoskeletal physiotherapy should be evident. There are several mechanisms for demonstrating this, such as a relevant masters degree, level 2 membership of the relevant clinical interest group (Chartered Physiotherapists in Musculoskeletal Therapy) and or specialist membership (musculoskeletal) of the ISCP.

Department of Health – Registered medical practitioner. Should have competency in assessment of x-rays, MRI scans etc. Should have expertise in psychological evaluation.

Health Service Executive – There should be two levels of medical expertise; (a) Acute: experience in the management of WAD, (b) Chronic: extensive experience in the assessment and management of WAD and the biopsychosocial consequences of WAD.

Department of Social Protection – Clinicians with "Specific" specialist qualification such as Orthopaedics, Neurosurgery, and A&E would be highly desirable for a thorough assessment, but these specialities may not be readily available. Other specialists such as Neurology, Sports medicine, Rheumatology and General Surgery may be reasonably qualified for this role, a focussed course delivered would be minimum requirement. Compulsory training I feel should be required for clinicians outside the above fields, such as Occupational physicians, other specialists, General Practitioners.

15. To what extent do you agree or disagree that a medical expert with an on-going relationship with a claimant is independent and free from conflict when providing an expert opinion?

Irish College of General Practitioners – Moderately disagree. This is a value judgement based on clinical experience. The current process used in the Injuries process works well where it is fully and appropriately utilised by the third party medical examiner. The current process, whereby a report is sought from the plaintiff's own GP, which in turn is available to the third party examiner, works well, so long as the third party examiner remembers to refer to it, and in an appropriate manner. Due to the dynamics of the doctor patient relationship, the treating physician is hopelessly compromised in this context in terms of objective reporting, especially where there is a history of complex illness behaviour, which in itself is especially likely to be the case in that minority of cases with high levels of reported symptoms, and a pre-existing history of high levels of health service usage on the part of the plaintiff.

Irish Association of Emergency Medicine – Strongly Disagree. The doctor/ patient relationship needs to be protected, especially if that relationship is ongoing e.g. 'Cradle to grave'. When the patient is a claimant, an unsupportive medical report may damage an ongoing patient/doctor relationship. IAEM recommends, therefore, that General Practitioners should provide factual reports only in such instances, outlining number of attendances, investigations performed and their results, as well as treatment given. The more contentious issues of the validity of patient complaints, their relationship to the index accident and the prognosis can then be dealt with, on a no-conflict basis, by the panel expert report.

Royal College of Surgeons in Ireland (Orthopaedics) – Disagree. It is very hard to provide a report for a patient that is likely to be poorly received by them so it is hard to be truly independent.

Royal College of Surgeons in Ireland (Physiotherapists) – Agree. A clinician who has an ongoing relationship with the claimant has been in a position to undertake both assessment and re-assessments of the claimant allowing for a stronger ability to determine consistency of subjective and physical findings, as well as prognosis.

Department of Health – Disagree. The doctor/patient relationship and the public/private mix of healthcare in this country make it difficult for the medical expert to be independent. However I think a comprehensive training course on management of acute and chronic whiplash associated disorder, together with disability assessment module and medico- legal component will help reduce this source of error.

Health Service Executive – Undecided. A medical expert with an on-going relationship cannot be considered independent. However often this expert is the GP who has a long term relationship with claimants and can often accurately reflect impact. A standardised assessment performance could reduce conflict of interest.

Department of Social Protection – Disagree. Conflict of Interest and more so if in private practice relationship.

Additional General Comments

The Dept. of Health, RCSI (Orthopaedics) and the DSP provided additional general comments over and above responses to the consultation paper questionnaire. IHCA provided a letter included in this section and a partial response was also received directly from one individual member;

Department of Health - A consistent well designed methodology to evaluate whiplash injuries enhances the relevancy of impairment ratings, improves internal consistency, promotes greater precision and standardises the rating process. However this can only be achieved if the assessing practitioner is trained and up to date in the best practice management of acute and chronic whiplash-associated disorders. The overall goal should be to provide a rating guide that is authoritative, fair and equitable to all parties. However, the process of defining impairment of the complexities of human function are not perfect. I feel that this work being carried out by the Personal Injuries Commission is a first step towards standardisation process. However, it will be important to audit this process and continue to assess the latest scientific research and evolving medical opinions provided by nationally and internationally recognised experts in this area and, as a result, update this tool as necessary. If separate clinical guidance is being developed in Ireland, this should follow the National Clinical Effectiveness Committee (NCEC) standards for clinical practice guidance. One has to consider the costs of training and who will pay. Is the training information based or skill –based? How are skills assessed? Re-training at what interval? In addition I came across this report which makes other useful recommendations in relation to reducing costs of claims. www.frontier-economics.com/documents/2015/.../frontier-report_aviva-09-03-15.pdf Building on findings from across the jurisdictions, the report makes 5 recommendations for reform: shorten the period allowed for submitting a claim after a road traffic accident from 3 years, and place a greater weight on timely evidence of the injury; introduce objective diagnosis with clear and workable severity scales; introduce a transparent table of the levels of compensation that will be paid for particular injuries; ensure formal accreditation of medical practitioners who diagnose whiplash and soft tissue injuries; lower costs to claimants of involving intermediaries where appropriate, such as lowering the proportion of the value of successful claims that lawyers are allowed to retain.

Personal Injuries Commission *"Whiplash"* Consultation

Response from RCSI Orthopaedics.

General Comments

The proposed QTF classification is useful mainly because it divides patient into a small number of finite and easily distinguishable groups.
The NDI produces a less useful broad spectrum of levels of disability. It is also very subjective and experience with such things is that patients "learn" responses. There is a very good example of this in orthopaedics where a questionnaire was used to determine the level of disability associated with hip arthritis so that the patient in most need would be treated first. Patients then learned which answers would advance them up the list and it became unreliable.

Both of these assessments are mainly based on clinical symptoms and signs. The QTS system dates from a time where advanced imaging like MRI was expensive and not widely available. This is not now the case. Plain x-ray is seldom indicated even in cases with fracture and early MRI is a useful assessment and screening tool for pre-existing disease and the presence of an acute injury. For each of these it is best performed as soon as possible after the injury. Experience shows that a patient having had an MRI currently is seen as a surrogate marker for a more severe injury i.e. *"the injury was so bad I had to have an MRI"*. It may be possible to adapt the QTF system to include early MRI and make it more objective and more useful for assessment and treatment. Specifically early MRI can reassure with regard to early rehabilitation which will have beneficial effects on long term outcome and may also allow for early resolution of compensation claims which will have a similar effect.

The comments regarding medical reporting and the use of experts are interesting. The most contentious of cases are often those without a significant injury. These would be best served with reports from specifically trained clinicians who are not necessarily *"experts"* e.g. spinal surgeons. This would make the reports less expensive, more expeditiously accessible, more consistent and of more use to the court.

The sample medical report template appears to be based largely on the PIAB report template. The section on examination findings includes things like cervical range of motion and neurological signs. The former is largely useless in determining the extent of an injury. It is not uncommon to see a patient with an *"abnormal"* range of motion that is inconsistent with his/her apparent injury. Similar comments can be made with regard to cervical tenderness. It is sometimes that case that markedly abnormal patterns of movement or tenderness more often represent fictitious rather than real injuries except in specific circumstances i.e. in the acute setting where there may be a fracture or dislocation which is not where medical reports are generated. Similarly *"hard"* neurological signs have vastly more import than soft or inconsistent signs such as non dermatomal sensory deficits or non myotomal weakness.

The best medical and medico-legal practice would be one of early reassurance together with advanced imaging. This would allow early categorisation and treatment. The former would allow prompt settlement of compensation claims which, combined with early rehabilitation, would accelerate patient recovery and improve the ultimate outcome.

Department of Social Protection (Interpreted) – A detailed history including account of Functional Activities of Daily Living is helpful to get prior to physical examination, in determining credibility. Clarity required in terms of which Visual Analogue Scales are being proposed. The proposed medical evaluation form template incorporates NDI which is referred to as a separate document in the consultation paper and the names should reflect this. WAD is a medical entity. To make legal qualification mandatory assumes otherwise. A careful thorough and objective medical assessment should be the sole aim of the medical process.

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29th August 2017

By email to secretarypic@djei.ie

Personal Injuries Commission
PIC Secretariat
Department of Jobs, Enterprise and Innovation
Earlsfort Centre
Lower Hatch Street
Dublin D2 D02 PW01

RE Consultation on standardising the approach to evaluation of soft tissue personal injury claims

Dear Mr

I am pleased to include below in summary format the following views received from IHCA members regarding the Commission's consultation on standardising the approach to evaluation of soft tissue personal injury claims. Due to the holiday period and the fact we do not hold an IHCA National Council meeting in August, the summary does not represent IHCA policy on the matter. Instead as you will note it contains different views on various elements of the draft document that you furnished. If you require an IHCA position on the draft, it will take more time as the matter will need to be considered at a future National Council meeting. The summary below is based on the views of individual consultants only.

In summary, some consultants have expressed approval in principle for a standardised approach if it has the effect of improving consistency and objectivity based on a scientific approach including grading and scales. In contrast, some consultants have expressed serious concerns that a standardised approach could fetter or interfere with clinical independence, autonomy and the doctor's duty to advocate on behalf of his or her patient. Other consultants have raised issues regarding the implementation of a standardised approach including training, qualifications, accreditation and other issues referenced in the consultant paper.

1. There is no mention in the draft of a standard format for imaging reporting or that this needs to be carried out by a person specialised in such imaging.

2. Concerns have been expressed regarding the establishment of training and accreditation and medical professional evidence. There is no rationale given as to why specialised training is needed other than it is done elsewhere. One school of thought is that there is no reason to limit consultants' current ability to provide such reports.

   For example a patient with a whiplash injury may also as a result suffer from balance issues. The most appropriate person to provide a report on this could be an ENT surgeon. If an individual consultant is not on the "list" it seems they may be prohibited from providing any such report. There is a concern this would limit plaintiffs' access to independent assessment and reports.

3. There is a balance to be achieved between "consistency in standard of reporting" and the fact that injuries can have very inconsistent effects. For example, taxi drivers with a whiplash injury may suffer far more from their injuries as they turn their neck a lot while driving as compared to an office worker.

4. Compulsory formal qualification is mentioned. This has implications in terms of time, expense, and the level of control or oversight that would be required to ensure that practitioners are "formally qualified". There is no mention of who will decide what this will entail. It could be half a day or much longer depending on the significance of the qualification.

5. In part 5 (Medical Professional Evidence) there is further reference to "specific qualifications" and a "national panel of trained and accredited Medical Advisors".

   Who decides this and how is independence maintained? How is it envisaged that doctors may continue to act as independent advocates for their clients?

6. Is there a solid rationale for changing the current system? There is a concern that in the attempt to resolve an insurance crisis (due to low interest rates and other factors), the need to ensure fair treatment may be neglected if there are restrictions or rules around the necessary reports.

7. Another view is that the medical profession's role and its ability to advocate independently for patients needs to be maintained. In this regard it is important that any standardised approach allows clinicians to maintain their clinical autonomy without censure to ensure patient issues are fully taken into account.

8. A medical report should give a balanced, fair and impartial assessment of the symptoms regardless of the views of the parties.

9. With regard to investigations, there is a question over the legality of requesting X rays and MRI scans for cases and this should be clarified. Is it limited to the plaintiff's solicitor and is it illegal for parties other than the plaintiff's solicitor to request X Rays or MRI scans in the context of legal proceedings?

10. An MRI scan may have a role to establish if degenerative disease is present and to rule out bony/disc/ligament injury.

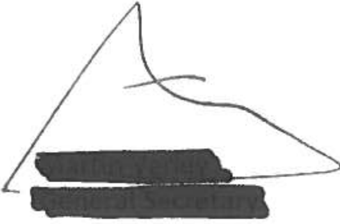
11. Some members expressed their agreement with compulsory formal training, accreditation and qualifications for those medical professionals reporting on soft-tissue ('whiplash') injury to improve the consistency and quality of reports because it increases objectivity and standardises reporting.

12. Other comments moderately agree with continuous professional development based accreditation/qualification to ensure that there are appropriate levels of expertise among medical experts completing medical reports on these injuries, i.e. a course should be sufficient together with a requirement for a minimum number of reports per year (20+). These training courses for medical experts on this type of injury should be delivered by Independent Training Provider/s which would facilitate/allow standardisation.

13. Another view is that the level of expertise required could be satisfied by demonstrating one's specialist training in the area and previous experience in medico-legal report writing. Conflict of interest in providing an expert opinion where there is an on-going relationship with a claimant is possible. One suggestion is that the treating physician would provide a report on factual events: injury and treatment to date, etc. Subsequently, an independent expert would provide a separate report in addition.

I trust the foregoing is of some assistance. If you require an IHCA position on the matter, please let me know and I will refer the matter for consideration by the IHCA National Council.

Yours sincerely,



cc IHCA National Council

IHCA individual member partial response received directly:

3. Are there any additional frequently used tests that should be considered by the PIC? Yes ☐ No ☐

Please explain your reasoning.

NO

Examination by a Neurosurgeon / or Neurologist / Neurologist in this Area GP qualified in this area should be standardised orthopaedic surgeon

4. To what extent do you agree or disagree with the inclusion of self-testing measures to reflect a claimant's own perception of their pain levels and to benchmark same in the context of any improvements ascertainable in later examinations?

Strongly Disagree	Disagree	Moderately Disagree	Mildly Disagree	Undecided	Mildly Agree	Moderately Agree	Agree	Strongly Agree

Please explain your reasoning.

100 open to Self-Assessment 9.89

(Part 3 – Forms)

8. Who do you suggest should complete self-testing measure records?

Claimants ☐ or **Medical experts** ☐

Please explain your reasoning.

(Part 4 – Training & Accreditation)

9. To what extent do you agree or disagree that compulsory formal training, accreditation and qualification for those medical professionals reporting on soft-tissue ('whiplash') injury will improve the consistency and quality of reports?

Strongly Disagree	Disagree	Moderately Disagree	Mildly Disagree	Undecided	Mildly Agree	Moderately Agree	Agree	Strongly Agree
						✓		

Please explain your reasoning.

Feedback on Medical Evaluation Template & Guidelines

ICGP and DSP provided additional comments specifically in relation to the proposed medical evaluation form template and sample guidelines;

1. Under date of accident – include box for indicating time elapsed since accident.

2. Under number of physiotherapy sessions – move this up on the proposed form to feature after number of GP visits

3. Amend palpation for tenderness to palpation for consistent tenderness; an important sign of inappropriate sick role behaviour is inconsistent tenderness.

4. Include in the WAD section; in your view are there pre-existing factors relevant to the client's symptoms / disability other than accident / event? No / Yes. If yes please indicate and elaborate in the space provided; previous psychological factors / previous medical factors / other.

5. Under Treatment / Investigations to date – include medications and dosage along with changes e.g. in last six months.

6. Under Relevant Medical History – include detailed history of condition immediately after accident injury and in subsequent few days.

7. Under are further investigations required section include – have all reasonable steps been taken by the Claimant and their own medical adviser / s to alleviate remaining symptoms / disability? If no, please elaborate.

8. Include in the sample guidelines; Past Medical History Please make reference to complexity of past medical history, noting significant previous illnesses and extent to which they were well managed by the Plaintiff as far as you ae able to do this.

Consultation Response Reference Material

- Disability Insurance Benefits and Labor Supply Decisions: Evidence from a Discontinuity in Benefit Awards Müller, Tobias and Boes
- Stefan (2016): Disability Insurance Benefits and Labor Supply Decisions: Evidence from a Discontinuity in Benefit Awards
- Reliability of Spinal Palpation for Diagnosis of Back and Neck Pain: A Systematic Review of the Literature. Seffinger, Michael A. DO*; Najm, Wadie I. MD, Mishra, Shiraz I. MD, PhD ; Adams, Alan DC, MS; Dickerson, Vivian M. MD; Murphy, Linda S. MLIS; Reinsch, Sibylle PhD** Spine: 1 October 2004 – Volume 29 – Issue 19 – pp E413-E425.
- P Cote JD Cassidy L Carroll - Accident Analysis & Prevention 2000 – Elsevier
- Nord-Trøndelag Health Study: HUNT2 and HUNT3 - The Nord-Trøndelag Health Study (HUNT) Intl Journal of Behavioural Medicine June 2013
- Axial Compression Test
- Joint Position Error
- Somatosensory Hypersensitivity using Quantitative Sensory Testing
- Impact of Event Scale
- Functional Rating Scale
- Self-Efficacy Scale
- Beck Depression Inventory
- Hospital Anxiety and Depression Scale
- Copenhagen Neck Functional Disability Scale
- Northwick Park Scale
- WHO International Classification of Functioning, Disability and Health (ICF)
- Australian Clinical Guidelines MAA 2014
- AMA Guide to evaluation of Permanent Impairment 6th edition.
- Fellowship of the Royal College of Emergency Medicine (FRECM)
- BSc Physiotherapy Programme
- Objective Structured Clinical Examination (OSCE)