‘I’ve broken my neck or something!’ The general practice experience of whiplash

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Russell G and Nicol P. ‘I’ve broken my neck or something!’ The general practice experience of whiplash. \textit{Family Practice} 2009; 26: 115–120.

Objective. To explore the experiences of patients and GPs concerning the management of mild to moderate whiplash.

Methods. Qualitative study using phenomenology. In-depth interviews with patients and their treating GPs. General practices in the northern suburbs of Perth, Western Australia. Participants. Maximum variation sample of nine patients suffering from mild to moderate whiplash and their treating GPs. GPs identified patients with recent whiplash. In-depth interviews were conducted with both groups. Patients were telephoned 3 months later to evaluate progress. Analysis used a constant comparative process and independent transcript review assisted by N-Vivo software.

Results. Patients articulated a need to be understood by a physician whom they knew and trusted. For all, the principal underlying concerns were about pain and the financial and physical impact of the injury, particularly in view of its perceived potential to harm the spine. While most patients expected medical interventions to help facilitate speedy recovery, physicians were far more pessimistic. Despite acknowledging the importance of addressing psychological needs, most GPs underestimated the degree of patient distress in the post-injury period. Although guardedly supportive of the local insurance system, GPs were scornful of patients seeking inappropriate compensation.

Conclusions. Findings highlight the influence of the patient–doctor relationship on clinical care in patients with whiplash, suggesting that the path to patient recovery and physician satisfaction may benefit if clinicians better understand patient experiences. The disconnect between patient and practitioner conceptualization of the problem challenges quality patient-centred care.

Keywords. Family medicine, occupational health, pain, patient-centred care, qualitative research.

Introduction

Whiplash is a common result of motor vehicle accidents (MVAs). Since its initial description in 1928,\textsuperscript{1} the clinical manifestations of whiplash [whiplash-associated disorders (WAD)] have challenged insurers, clinicians and medical educators. Recent studies and systematic reviews have begun to illuminate the clinical picture of whiplash; however, it continues to account for one-quarter of the costs borne by the insurance organizations compensating victims of MVAs.\textsuperscript{2}

With an annual incidence in North America and Western Europe of 1 per 3000 inhabitants,\textsuperscript{3} presentations of WAD range from minor stiffness of the neck to fracture dislocations.\textsuperscript{4} Up to one half of patients with mild to moderate whiplash still report pain at 12 months,\textsuperscript{5} while up to a third suffer from some psychological morbidity.\textsuperscript{5,7} Poor outcome seems related to the degree of early post-injury neck pain and headache and, possibly, to the presence of significant radicular symptoms. Other determinants of outcome are unclear.\textsuperscript{8} Observations of significant variations in the proportions of patients reporting persisting symptoms at 12 months\textsuperscript{9} have contributed to suggestions that psychosocial factors, and, in particular, the culture in which the injury occurs, may significantly modify the clinical course of the condition.\textsuperscript{10}
Most patients with whiplash injuries are cared for by GPs—a regular target for guidelines and educational interventions designed to reduce costs and improve clinical outcomes for WAD.\textsuperscript{11,12} Although considerable uncertainty surrounds much of the clinical care of whiplash, recent research suggests that less severe WAD is best managed by early mobilization, simple analgesia, neck-specific exercises and discretionary manual therapy.\textsuperscript{11–13} Recent observational studies have also found better outcomes to be associated with less active medical intervention.\textsuperscript{14}

Some have suggested that some of the uncertainties surrounding WAD could be resolved if the condition is seen from a biopsychosocial perspective.\textsuperscript{15,16} Such an approach would require an appreciation of context, patient experience and of the agendas brought by both patient and clinician to the clinical situation. This study used a phenomenological approach to data collection and analysis\textsuperscript{17} in an effort to understand the lived experience of patient and physicians with respect to the primary care management of whiplash.

**Methods**

This qualitative study was set in the northern suburbs of Perth, Western Australia. It used in-depth interviews to explore the experiences of patients suffering from mild to moderate whiplash and their treating GPs.

**Participants**

A purposive, maximum variation sample of GPs and their patients who had attended for care of a recent whiplash-associated injury.

**Recruitment**

First, a maximum variation sample of urban-based GPs working in the northern suburbs of Perth, Western Australia (showing variation in years in practice, gender and expressed interest in occupational and/or musculoskeletal medicine) was generated following discussions with members of the Discipline of General Practice at the University of Western Australia. Physician participants (initially contacted by letter) were asked to identify and contact patients who had, in the last 3 months, consulted them following a whiplash injury (Quebec Task Force; QTF grades 1–2). Following verbal consent (given to a practice representative), patients were contacted by telephone by a research assistant and invited to participate in a face-to-face interview.

Eleven GPs (seven males, four females) participated (from 16 approached). They had between 5 and 30 years of clinical experience—two had postgraduate experience in musculoskeletal and/or occupational medicine.

Nine of the GPs were able to identify a suitable patient for interview. The nine invited patients (all of whom participated) were aged between 22 and 60 and were interviewed between 3 weeks and 8 months following their accident. All patients were driving a car or light van at the time of the accident—only one was at fault for the accident.

**Data collection**

In-depth interviews were conducted to ascertain physicians’ experience with the clinical care of WAD and patients’ experience of the injury and its care. Interviews (lasting between 20 and 60 minutes) followed an interview guide which was designed following a literature review. The guide was progressively modified as data collection and analysis progressed. Question sequencing was flexible, allowing participant responses to guide ongoing exploration of their experiences. GP participants were interviewed in their offices and patients in their homes. Seven patients were recontacted for a telephone interview 3–4 months after the initial interviews. Interviews were conducted by a graduate student experienced in qualitative research and by a GP studying sociology at an undergraduate level. They were performed between September 2004 and March 2005.

**Data organization and analysis**

Interviews were audio-recorded, transcribed verbatim and analysed using the iterative technique of immersion–crystallization.\textsuperscript{18} Transcripts were read independently by researchers and meetings were held at which emergent themes, patterns and connections were reviewed. Theme saturation was reached after the eighth GP and sixth patient interview. The remaining interviews allowed for elaboration of the themes. Data organization was aided by the use of N-Vivo software.\textsuperscript{19}

Ethics approval was given by the University of Western Australia Review Board for Research on Human Subjects.

**Results**

**Early experiences**

Patients’ narratives were characteristic of mild to moderate whiplash: pain evolved over 48 hours, headaches, arm and back pain were frequent and most reported sleep disturbance. Nearly, all visited their GP within 3 days of the accident. The GPs were remarkably consistent in describing their model of care of whiplash. All said they initially attempted to discount serious injury through history and limited examination. They believed that the condition was, for the most part, self-resolving:

I tell them that depending on the severity of the strain they’ve had, that they will get better; it’s just a matter of time, regardless of what treatment they have . . . [GP #1]

Early patient experiences followed two related themes: a search for reassurance and a desire for...
patients’ distress was not always recognized by the physicians. One patient [Patient #27] said she was so shocked she could not even remember how she got home from visiting the GP. The GP recalled that, at presentation, ‘there was not much wrong with her’. [GP #7]

Patients’ fears of significant injury were evident in an expressed need for some action to be taken towards recovery. This was revealed in consistently positive patient attitudes to early physiotherapy or imaging referral. Some were frustrated in their desire to be referred for additional investigation or therapy:

I’d like to think that a doctor would make a fair assessment of how much damage has taken place, and obviously refer you to, um, physio or a chiropractor, um, I would have liked him to give me scans ... But he wasn’t interested. [Patient #4]

However, although most participating GPs saw some value in referral for short-term physiotherapy, most doubted whether any intervention would hasten recovery. Rather, referrals were viewed as helping with pain management and patient reassurance. Some GP participants, especially those with experience or training in musculoskeletal medicine, rejected the idea of referring for reassurance—one deeming it as ‘intellectual dishonesty’. However, most were less convinced, feeling that referrals for imaging or therapy could help keep patients ‘on side’ and positive during what may be a prolonged road to normal function.

‘It should be fixed’
All but two of the patients reported continuing pain and disability beyond the first few days following the accident. Most were bewildered at their slow recovery.

I was finding it very frustrating, because nobody had fixed me, and all I had was a car-accident, and I should be okay by now, and I did not believe that I would have an injury that would last any length of time. I figured a couple of weeks I should be back to normal, back at work full time, no side-effects, nothing [Patient #7]

As time went by, most with persisting symptoms came to view their GP as a coordinator and a motivator rather than a provider of treatment. Several suggested that their GP’s ongoing support and guarded optimism was fundamental to their eventual recovery.

In one of the closest patient–doctor relationships, the patient spoke consistently of how ‘we’ (the patient and GP) were dealing with the problem.

She’s my family GP, she will listen and I think that you need that in circumstances like this, where you are suffering with pain ... (she was very good with) what I went through, sort of, mentally, and emotionally too. [Patient #6]

‘I’m not sure that I can make a difference’
The GP participants spoke at length about patients who were slow to recover. For these, the GPs saw their role as helping the patient come to terms with an inevitably slowly resolving condition. They viewed themselves as motivators, saw reassurance as valuable and acknowledged the importance of managing the emotional experience of the injury, one suggesting that ‘the battle to help them get better is not just trying to achieve symptomatic improvement, it is also trying to, perhaps, sort out the unpleasantness of it all’. [GP #2]

Most participating GPs believed that non-injury factors had much to do with eventual recovery.

And you are at the same time, ascertaining the physiological make up of this patient and their personality characteristics, because, overwhelmingly those are the things that are ultimately going to determine the success of whether they improve or not ... [GP #5]

While the GPs accepted their role in care of patients with persisting disability, few welcomed it. They were reluctant to become involved with compensation issues, and most spoke of discouraging patients from seeking legal compensation for minor injury and loss. This contrasted with many patients’ sense that they should not have to suffer financially for the effects of their injury. It was clear that many GPs felt a conflict between what they saw as their role as advocate for the patient and the demands of the compensation environment. Many were frustrated by the contradiction between their attempts to guide the patient to recovery and the relationship between injury symptoms and financial compensation. Although few could recall patients who had actively exaggerated their symptoms, many found it hard to strike a balance between ‘keeping the patient on side’ and encouraging them to take responsibility for their own recovery.

Sometimes you get a bit too soft, when you should be a bit tough. There’s times when you should.
really confront them about something, and you tend to let it slide . . . [GP #5]

Discussion

There has been little published on primary care experience of early whiplash. Our methods allowed a comparison between patient and provider concepts and experiences relating to the condition, its course and treatment. Our findings revealed several important themes, each having implications in the clinical care of patients with whiplash resulting from MVAs.

The gap between patient and provider

First, there was a substantial gap between patients and physicians in terms of perceptions concerning implications of whiplash and of expectations concerning its clinical course. Notwithstanding the difficulties that patients have in expressing their concerns in general clinical course. Notwithstanding the difficulties that patients have in expressing their concerns in general practice settings, our interviews of patient and provider pairs revealed the inaccessibility of the patients' early illness experience for a number of GP participants. Patients spoke of their fears concerning the implications of the injury and, ironically, of their expectations of early recovery and effective treatment. By contrast, GPs viewed whiplash in terms of its benign physical nature, but predisposition to chronicity and lack of response to interventions.

A number of our participating physicians seemed unaware of their patients' ideas, feelings and fears about their condition. While this gap between patient and provider conceptualization of health conditions is not unique to whiplash, it suggests a potential barrier to effective patient-centred care.

There is accumulating evidence that, in a number of conditions, recovery is expedited by physician awareness of the patient's illness experience, an idea central to effective patient-centred care. The strong evidence for the benefits of patient-centred care in other conditions raises the possibility that effective patient-centred care may be an important factor in long-term resolution of whiplash. The stories of partnership in the strong patient–provider relationships and those of isolation in many of the others suggest that patient–provider relationships may have sufficient variability to influence overall outcome.

Clinical decision making

Participating GPs seemed mindful of the potential of the relationship between themselves and their patients. In particular, early clinical decisions seemed influenced by their perceptions of patient needs for reassurance combined with a determination to preserve the patient–provider relationship. The GPs appeared to balance the economic consequences of inappropriate referral with a perceived need to keep the patient as a partner in recovery, a balance made more difficult with the patient's expressed need for something to be done. Although physician attitudes to the effective care of WAD have been found to be generally in keeping with research evidence, others have found deviations from evidence-based care when primary care physicians make clinical decisions in order to maintain relationships with patients.

Something more to offer?

Outcome in whiplash is influenced by a set of sociodemographic, physical and psychological factors. Recent evidence from a large Canadian cohort study found intensive primary care for WAD to be associated with a delayed time to closure of their compensation claim. A natural corollary of this observation was the suggestion that appropriate primary care for mild to moderate WAD is represented by the 'avoidance' of clinical intervention.

While 'less is more' is a reasonable principle, it may be of little help to a clinician confronted by a distressed patient. Indeed, viewing whiplash care from a minimalist perspective disregards the potential that outcome may be influenced by the quality (as opposed to the number of episodes) of primary care. Our data suggest that, as with other conditions, a supportive relationship between patient and physician could help patients manage some of the negative consequences of whiplash, easing the path to patient recovery and improving physician satisfaction.

Patient-centred clinical care of WAD would involve a careful elicitation of patient agenda, fears and expectations following the injury, combined with clear provision of information concerning the likely clinical course. An acknowledgement of patient anxieties concerning the potential of spinal injury could be beneficial, particularly since patients are frequently unclear about the prognosis of WAD.

From the perspective of researchers, our study has tried to illuminate the 'black box' of the general practice consultation in the management of whiplash injuries. The influence of the patient–doctor relationship on whiplash outcome could be quantified by incorporating existing tools for the measurement of patient-centred care into studies incorporating baseline assessments of injured motorists.

Limitations

The transferability of the study findings is influenced by the fact that study participants lived and worked in an Australian urban environment. This is especially important in light of the observation that patient experiences in whiplash seem to vary in different cultural settings. Also, although the purposive sampling technique included an awareness of the need to search for alternative and disconfirming cases, we may have been unable to capture different attitudes shared by other
practitioners. Similarly, the reliance upon physicians to identify patient participants may have led to an overemphasis on those patients who valued a strong patient–provider relationship.

Conclusions

A greater understanding of the dynamic of the practitioner–patient interaction in the management of WAD gives an opportunity to identify important gaps in the clinical care of WAD and to begin to satisfy Ferrari’s request to conceptualize and manage WAD from a true biopsychosocial perspective. Our findings highlighted the influence of the patient–doctor relationship on the clinical care of patients with WAD. The disconnect between patient and practitioner conceptualization of the problem challenges quality patient-centred care.

Acknowledgements

The authors wish to acknowledge the contributions of Dr Lara Hopkins who assisted with recruitment and conducted several early interviews with providers and Dr Glenda Dare who assisted with the organization of the final manuscript. Author contributions: GR designed the study, obtained funding, supervised data collection, helped analyse the data and wrote the final version of the paper. PN performed most interviews, helped analyse the data and contributed to drafts of the manuscript. Both authors approved the final version of the manuscript.

Declaration

Funding: RACGP/CONROD Research Fellowship (established jointly by The Royal Australian College of General Practitioners (RACGP); Centre of National Research on Disability and Rehabilitation Medicine (CONROD)).

Ethical approval: University of Western Australia Review Board for Research on Human Subjects.

Conflicts of interest: None.

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