

ANATOMY OF RECOVERY CARE

A standard for the recovery that begins when the hospital door closes

Assembled from what the world's best-resourced care systems already specify — for the people those systems never reach. What they specify, who never receives it, and a standard stated for adoption.

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Abstract

Structured, protocol-driven recovery care after injury is not aspirational; it is documented, current practice in the world's best-resourced care systems. A military medical system, an international sports-medicine consensus, and statutory motor-accident and workers'-compensation schemes on three continents — with no shared governing body among them — have converged on a common anatomy of care: structured assessment at first contact, validated instruments in place of impression, a pre-specified follow-up calendar, gated return, and psychological screening embedded within the physical-injury pathway. This paper documents that convergence from primary sources; documents the population it does not reach — most acutely, the ordinary United States adult treated and released after a motor-vehicle collision, for whom no United States body specifies any systematic assessment or follow-up; and documents that even where such protocols exist, audits show they are frequently not delivered. It then gives the converged anatomy a name — **the Anatomy of Recovery Care**, a standard for recovery care after injury — and states it for adoption by any program that cares for injured people. The standard claims no outcome evidence beyond what its components carry. Those components are individually evidence-based: validated instruments, effective treatment for those identified, and safety rules built for the rare catastrophic case. Trials of fully assembled programs remain few — a bar that almost no deployed standard of care, in any specialty, has been asked to meet, including usual care itself. The standard is stated on the same basis on which its source systems were built: component evidence, safety logic, and the convergent judgment of accountable institutions. The authors' interest is declared plainly at the close: we are building a program to this standard, and we commit to being audited against it.

Summary points

- The world's best-resourced care systems, without coordination, specify the same eleven-component anatomy of structured recovery care after injury.
 - No United States body specifies systematic assessment or follow-up for the non-hospitalized adult injured in a motor-vehicle collision; the mandatory trauma standards exclude this population by their own scope.
 - Where protocols exist, audited delivery is poor; execution, not knowledge, is the binding constraint.
 - The Anatomy of Recovery Care states the converged anatomy as an adoptable, auditable standard for the post-acute, outpatient phase of recovery — the phase that begins when the hospital door closes.
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1. The question, and the purpose of this paper

Whether an injured person receives structured recovery care today is determined less by the injury than by the category: soldier, athlete, admitted trauma patient, injured worker — or none of the above. This paper asks three factual questions, each answerable from primary documents:

1. What does state-of-the-art recovery care after injury consist of, where it is fully resourced and institutionally mandated?
2. Who receives it — and who does not?
3. Where the protocols exist, are they delivered?

It then does something deliberate with the answers: it assembles what these systems already specify into a single, named, adoptable standard — the Anatomy of Recovery Care — stated so that any program caring for injured people can implement it and be measured against it. Most of what the standard requires is deliverable with tools that exist today: the instruments are published, the protocols are written, and the follow-up architecture is proven in other systems. Nothing in it awaits an invention. What it awaits is delivery.

2. Methods

The findings below derive from a structured review, conducted in July 2026, of primary standards documents, clinical practice guidelines, statutory scheme rules, and the peer-reviewed literature. Research-literature claims were subjected to adversarial verification — three independent verification passes per claim — and claims that failed verification were discarded and are not cited here, including several that would have supported the authors' own thesis. Population figures are stated as ranges where the underlying literature is heterogeneous. Findings that cut against the standard's rationale are reported alongside those that support it, beginning in the Abstract.

Two scope notes. First, the systems surveyed span four countries on three continents (United States, United Kingdom, Australia, Canada) — all common-law, English-speaking jurisdictions whose guideline communities cross-cite; we claim alignment among independently regulated systems, not statistical independence of their expert panels, which we did not audit. Second, source documents initially characterized from secondary sources were subsequently verified against their primary texts (July 2026); retrieval records are archived, and attribution notes appear in the Limitations (§10.4).

3. The hidden burden: injury's consequences are systematically under-recognized

Three independent measurements, in three populations, point in one direction.

Mild traumatic brain injury, unselected emergency-department population. In a nine-month surveillance study at a major Sydney trauma hospital, 30,479 adults aged 18–65 were screened, of whom 351 met World Health Organization criteria for confirmed mild traumatic brain injury (mTBI). Only 81 (23.1%) had the diagnosis clearly recorded in the medical notes: 270 of 351 confirmed cases (76.9%) left the department without the diagnosis documented [1].

Mild TBI, United States trauma centers. Among 1,641 adults receiving head computed tomography at two US trauma centers, 53% (412/775) of patients whose own charts documented American Congress of Rehabilitation Medicine criteria for TBI received no documented emergency-department diagnosis of TBI [2]. Three scope limits attach: the study measures under-documentation rather than proven under-recognition; its records (2009–2013) predate current diagnostic criteria; and its population is CT-selected trauma-center patients, not

specific to motor-vehicle collisions. The same study found the converse error — 21% (182/866) of criteria-negative patients nonetheless received a TBI diagnosis (sensitivity 47%, specificity 79% against documented criteria). Unstructured clinical judgment both misses and over-calls.

Post-traumatic stress after major trauma. Among major-trauma survivors screening positive on a validated post-traumatic stress disorder (PTSD) instrument, 62–89% (95% confidence interval) reported never having received a formal diagnosis (n=37 of 203 respondents; 24% response rate; diagnosis status self-reported) [3]. Meta-analytically, PTSD prevalence after road-traffic collisions spans approximately 18–26% across three systematic reviews — a range rather than a point estimate: heterogeneity is high ($I^2 \sim 94\text{--}96\%$), significant publication bias has been reported, and self-report screens run higher than clinician interview [4–6].

The mechanism is not clinician failure. It is structural: thoroughness does not survive a ten-minute encounter, and a single encounter — at any time point — cannot detect a condition that has not yet declared. Injury's consequences do not arrive at once. Post-injury psychological sequelae, persistent post-concussive symptoms, and the transition to chronic pain each tend to emerge over weeks to months, on their own clocks, not at the first visit. Only a schedule can see a trajectory.

4. The convergence: what the best-resourced systems specify

4.1 The soldier (US Department of Defense and Veterans Affairs)

Department of Defense Instruction 6490.11 mandates concussion evaluation for every service member exposed to a potentially concussive event — not merely the symptomatic — using a mandatory screening checklist, with quantified return-to-duty gating: a 24-hour minimum rest after any qualifying event; a second concussion within twelve months adds seven days beyond symptom resolution; a third triggers a mandatory recurrent-concussion evaluation before return [7]. Every post-9/11 separating service member is screened for TBI; a positive screen triggers the Comprehensive TBI Evaluation — specialist-administered, multi-domain, built around the 22-item Neurobehavioral Symptom Inventory — against a 30-day completion target tracked as a Veterans Affairs performance measure [8, 9]. The VA/DoD Clinical Practice Guideline for mTBI (v3.0, 2021) specifies a two-module algorithm with GRADE-rated recommendations and per-domain protocols (headache, vestibular, visual, sleep, cognitive, behavioral), embeds mental-health screening (PHQ-2/9, GAD-2/7, PCL-5, AUDIT-C, C-SSRS) within the physical-injury pathway, and designates a case-management function [10]. The companion PTSD guideline (2023) specifies a screen–confirm–monitor sequence — PC-PTSD-5, then a validated clinician-administered interview, then a validated instrument such as the PCL-5 to detect symptom change over time — with initial treatment effects expected after four to eight sessions, typically delivered over eight to twelve weeks [11].

4.2 The athlete (Concussion in Sport Group, Amsterdam 2023)

The international consensus specifies mandatory removal from play on defined signs and a multimodal structured acute assessment (SCAT6), followed in the subacute phase by the SCOAT6 — an office tool designed explicitly for serial multi-domain re-evaluation, including orthostatic vital signs, cervical examination, timed dual-task gait, modified vestibular-ocular motor screening, and embedded mental-health screening [12]. Return is graduated and gated: a six-step return-to-sport ladder with a minimum of 24 hours per step and full symptom resolution required before contact stages, a four-step return-to-learn ladder, and written clearance by a health-care professional before unrestricted return [12]. Where resourcing permits, the standard adds individual baselines; the National Hockey League protocol mandates annual baseline testing for all players on a club's reserve list [13]. Outside the professional tier, adherence collapses — a point taken up in §7 [14].

4.3 The injured motorist — where a scheme funds one

In New South Wales, the State Insurance Regulatory Authority's whiplash guideline specifies Quebec Task Force grading at the initial visit, application of the Canadian C-Spine imaging rule, baseline pain (visual analogue scale) and disability (Neck Disability Index) measurement, and a mandated review calendar — 7 days, 3 weeks, 6 weeks, 12 weeks — with numeric escalation triggers (pain score >5/10; Neck Disability Index >15/50) and a post-traumatic stress screen at three to six weeks, with scores above threshold referred to psychology [15]. The same guideline bars routine computed tomography and magnetic resonance imaging in whiplash-associated disorder grades I–II [15]. Victoria's Transport Accident Commission and WorkSafe agencies jointly promulgate a clinical framework built on outcome measurement, a biopsychosocial approach, and function-focused goals; practitioners enrolling in WorkSafe's service frameworks sign a declaration committing to deliver care in line with it [17]. Ontario operates a statutory Minor Injury Guideline pathway [18]; Alberta's Diagnostic and Treatment Protocols Regulation pre-authorizes graded care by injury severity without insurer pre-approval [19]; and the United Kingdom's Rehabilitation Code provides an early Immediate Needs Assessment by a named case manager in serious injury claims [20].

4.4 The injured worker, the child, and the UK patient

In United States workers' compensation, occupational-medicine practice guidelines are incorporated by statute into state systems — most prominently California's Medical Treatment Utilization Schedule — and govern which care is authorized; in a large claims analysis, workers whose care followed those guidelines lost 11.5 fewer workdays, a 29.3% reduction [21]. Ontario's Workplace Safety and Insurance Board operates mandatory eight-week Programs of Care for musculoskeletal injury and mTBI, the latter built on the Ontario Neurotrauma Foundation guideline — 96 recommendations, mechanism-agnostic, and explicitly inclusive of motor-vehicle collisions [22, 23]. For children, the Centers for Disease Control and Prevention's pediatric mTBI guideline provides nineteen graded recommendation sets, validated symptom scales, and a six-step return-to-play progression with provider clearance [24, 25]. In the United Kingdom, NICE guideline NG232 mandates structured discharge-advice content and written general-practitioner notification within 48 hours of any head-injury discharge, with a defined referral pathway for persistent symptoms [26].

4.5 The hospitalized trauma patient (United States)

The American College of Surgeons' *Resources for Optimal Care of the Injured Patient* (2022; reaffirmed July 2025) makes screening a condition of trauma-center verification. Standard 5.29 (Mental Health Screening, Type II — mandatory) requires a protocol to screen patients at high risk for psychological sequelae, with referral to a mental-health provider. Standard 5.30 (Alcohol Misuse Screening, Type II) mandates screening of "all admitted trauma patients greater than 12 years old," regardless of activation status [27] — a scope that, by its terms, does not reach patients treated and released. The registry that anchors these standards, the National Trauma Data Standard, captures only patients who are admitted, transferred, or deceased [27]. The mandatory standard's own scope draws the line: admitted, protocol; treated and released, nothing.

4.6 The newest extension proves the direction — and the boundary

In 2025, the ERAS Society — authors of Enhanced Recovery After Surgery, the most successful named recovery standard in modern medicine — jointly published with the International Association for Trauma Surgery and Intensive Care a three-part guideline extending enhanced-recovery principles into trauma: ERATIC, Enhanced Recovery After Trauma and Intensive Care [28]. Its stated scope runs from pre-hospital care through the operative, intensive-care, and post-resuscitation phases, with no provision addressing post-discharge outpatient recovery. The extension is doubly instructive: it confirms that the field's most authoritative recovery-standard body regards trauma as the next frontier for structured recovery care — and its scope ends, once again, at the hospital door. The post-acute, outpatient arc of recovery, the weeks and months in which the conditions of §3 declare, remains without a standard. The Anatomy of Recovery Care is stated for that space as a complement to ERATIC and its family, not a rival: where enhanced-recovery pathways carry the patient through the acute episode, the Anatomy specifies what carries them from discharge to recovery.

The pattern generalizes, and it explains the boundary. Process engineering in medicine flourishes where resources and accountability concentrate — the trauma bay, the operating theatre, the intensive-care unit, the professional sideline: dense institutional environments that can afford checklists, teams, verification reviews, and the iteration that produces engineered process. The systems of this section are what medicine builds when it can afford to engineer. The outpatient environment, where recovery is actually lived, has never had that density: care there is delivered in brief visits by unconnected practices, with no verification body and no protocol infrastructure. The hospital door is therefore not a clinical boundary; it is a resource boundary. The injury crosses it. The engineering, historically, has not. The premise of the standard stated below is that this constraint is no longer fixed: the engineered process — the calendar, the instruments, the gates, the escalation logic — was never made of institutional density, and technology now makes process engineering portable into the settings where recovery happens.

5. The Anatomy of Recovery Care: eleven components, four countries, no shared governing body

Across a military medical system, a sports-medicine consensus, and statutory injury schemes with no shared governing body, the same skeleton recurs. Stated as a standard, it is as follows (Table 1).

Table 1. The Anatomy of Recovery Care: components and exemplar specifications.

#	Component	Exemplar specification (source)
1	Structured multi-domain assessment at first contact	VA/DoD guideline domain protocols [10]; SCAT6 modules [12]; SIRA initial-visit bundle [15]
2	Named validated instruments, not clinical impression	Neurobehavioral Symptom Inventory [8]; PCL-5 / CAPS-5 / PC-PTSD-5 [11]; SCAT6 / SCOAT6 [12]; VAS / NDI / IES [15]
3	A pre-specified follow-up calendar	SIRA: reviews mandated at 7 days, 3 and 6 weeks, 12 weeks [15]; VA: 30-day evaluation target [9]; PTSD guideline: 8–12-week response-assessment window [11]
4	Graduated, gated return with objective advance criteria	Six-step return-to-sport, ≥ 24 h per step [12]; DoD 24-hour / 7-day / recurrent-evaluation ladder [7]
5	Numeric escalation and referral triggers	SIRA: VAS >5 , NDI >15 , stress screen above threshold [15]; VA: symptoms persisting >30 days [10]; SCOAT6: >4 weeks $\rightarrow$ multidisciplinary referral [12]
6	A named care-coordination role	VA case management and the Polytrauma System of Care [8, 10]; UK Rehabilitation Code case manager and Immediate Needs Assessment [20]
7	Red-flag safety-netting before the benign pathway	DoD immediate-referral indicators [7]; Canadian C-Spine Rule [15]; WAD grade IV carved out to emergency care [15]
8	Baseline data enabling individualized comparison	NHL mandatory annual baselines (all reserve-list players) [13]; SCOAT6 comparison to pre-injury scores where available [12]
9	Psychological screening inside the physical-injury pathway	Stress screening embedded in a whiplash guideline [15]; PHQ-9 / GAD-7 / PCL-5 embedded in a brain-injury guideline [10]
10	Explicit avoidance of low-value testing — disciplined, not maximal	VA/DoD recommendations against routine imaging, EEG, and computerized batteries [10]; SIRA bar on routine CT/MRI in WAD I–II [15]
11	Written, accountable clearance before final return	Written health-professional determination before return to sport [12]; independent-practitioner clearance after recurrent concussion [7]

The deepest commonality is dynamic, not static: these systems monitor on a schedule and adjust through pre-specified gates. Serial measurement with pre-committed response — monitor and adjust — is the state of the art. No system in Table 1 treats assessment as a single event.

6. The distribution: who receives this, and who does not

Table 2. Populations with and without a structured recovery-care protocol.

Population	Structured protocol	Force of mandate
Soldier	Full: screen-all-exposed -> comprehensive evaluation -> guideline [7–10]	Mandatory (DoD instruction; VA performance measure)
Elite athlete	Full: baseline -> SCAT6 -> SCOAT6 -> gated return [12, 13]	Contractually mandatory in professional leagues
Hospitalized trauma patient (US)	Screening standards 5.29/5.30 [27]; ERATIC for the acute episode [28]	Mandatory for trauma-center verification — admitted patients only
Injured worker (US and Ontario)	Occupational guidelines / Programs of Care [21, 22]	Mandatory: governs authorization; "first line of care"
Injured motorist (Australia)	SIRA guideline with review calendar [15]; TAC framework [17]	Mandatory — condition of the insurer's licence [41]
Child with concussion (US)	CDC guideline and graded return [24, 25]	Graded recommendations; state return-to-play laws
UK patient (head injury)	NG232 discharge structure and 48-hour GP notification [26]	National Health Service standard
Ordinary US adult, treated and released after a motor-vehicle collision	None found (see text)	—

The absence in the final row is a sourced, positive finding, not an incomplete search. We searched the American College of Emergency Physicians, the American Academy of Family Physicians, the American Academy of Neurology, the American Academy of Physical Medicine and Rehabilitation, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, and the American College of Surgeons. What exists for this population is limited to single-visit imaging decision rules — NEXUS and the Canadian C-Spine Rule — and generic discharge advice [39, 40]. No United States body specifies a reassessment timepoint, a standardized instrument, or a referral schedule for the non-hospitalized adult injured in a motor-vehicle collision. The nearest candidate, the American College of Emergency Physicians' 2023 clinical policy on mild TBI, is confined to head injury, excludes most collision injury by scope, and specifies no follow-up schedule [29]. The trauma system's own registry design excludes the treated-and-released patient from every downstream requirement built upon it [27]. Whether an injured person receives the standard is decided by the system they happened to fall under — the same neck, the same brain, a different net. One of the widest holes in that net sits under the everyday crash: the injury that can happen to anyone, on any commute. The documented negative is specific to the collision-injured adult — the population we searched — but nothing in the registry design or the guideline landscape suggests other treated-and-released injuries fare better; the standard, accordingly, is stated for injured people generally, not for one mechanism of injury.

7. The execution gap: a protocol on paper is not a protocol delivered

Where the protocols exist, delivery has been measured, and it is poor. In New South Wales, an audit of 288 randomly selected claimant files found the regulator-mandated whiplash guideline largely unexecuted: Quebec Task Force classification was applied in 19.9% of cases and prognostic instruments in 12.8%, while guideline-discordant imaging appeared in 45.8% of mild-grade cases and non-recommended passive therapies in 94.0% [16]. In community and school sport, medical clearance before return was obtained in 53.7% of concussions and a graded return protocol followed in 30.4% [14]. Among veterans, 24–34% of positive TBI screens never proceed to the Comprehensive TBI Evaluation despite the 30-day target [9]. (The unselected emergency-department under-documentation figure of §3 reflects a different mechanism — care delivered with no governing protocol at all — and is deliberately not listed here.)

The pattern is uniform. The constraint is not knowledge; the standard is written. The constraint is execution. Guideline publication does not deliver care — that is the audit authors' own conclusion, not ours [16]. What separates the populations that receive the standard from those that do not is the convergence of resourcing, institutional mandate, and accountability — never the existence of the document. Execution is a systems problem, and systems problems have engineering solutions.

8. The standard, stated for adoption

The Anatomy of Recovery Care is stated so that any program caring for injured people — a clinic, a health system, a scheme, a payer — can implement it and be audited against it. Table 3 states, for each component, what implementation requires.

Table 3. Implementation requirements of the Anatomy of Recovery Care.

#	Component	What implementation requires
1	Multi-domain first-contact assessment	A structured intake evaluation capturing baseline instruments (pain, function, region-specific, psychological screen), a coded diagnosis, and a clinician's evaluation, within one encounter
2	Named validated instruments	Instruments with published validation and independently derived change thresholds. Free, unencumbered instruments exist for every required domain (e.g., the Neurobehavioral Symptom Inventory; PCL-5; PHQ-9/GAD-7; PEG-3; the Patient-Specific Functional Scale; the Roland–Morris questionnaire); cost is not a barrier to adoption
3	Pre-specified follow-up calendar	A standing schedule of brief structured check-ins from day one; instrument re-administration at pre-set intervals; a pre-specified re-evaluation window in the sub-acute weeks
4	Graduated, gated progression	Recovery tracked against the patient's own baseline; care stepped up, stepped down, or closed on measured change, never on a single reading
5	Numeric escalation triggers	Pre-committed flags: absence of improvement by the instrument's published minimal clinically important difference by the re-evaluation window triggers clinician review; red-flag answers escalate immediately
6	Named care coordination	A named coordinator — typically a nurse — across the whole recovery: monitoring review, coordination, navigation, behavioral-health coordination
7	Red-flag safety-netting	An always-on red-flag and crisis layer in every contact, routing to human escalation, with explicit disclosure that the program is not an emergency service
8	Baseline for individualized comparison	A day-one baseline on every instrument; every subsequent score read against the patient's own baseline rather than a population norm
9	Psychological screening inside the injury pathway	Mood, anxiety, and post-traumatic-stress screening embedded in the standard recovery check-ins for every patient in the program, surfaced to a clinician and never diagnosed by software
10	Disciplined, not maximal	No routine imaging of mild injury; screening bounded to what changes management; a deliberate patient-burden ceiling; no yield targets of any kind anywhere in the program
11	Written accountable clearance	A physician or equivalent accountable clinician makes every diagnostic and treatment decision; the program surfaces candidates and organizes evidence; a clinician adjudicates every flag, every positive screen, and every discharge

Three properties of the standard warrant statement beyond the table.

Monitor and adjust is the standard's spine. Serial measurement with pre-specified response is the deepest commonality of the source systems. An implementation that assesses once and files the result has not implemented the Anatomy.

The honest negative is a required output. An implementation records what it finds and what it does not, and communicates a documented "assessed, within normal range" to the patient as the answer it is. A program that can say no is the only kind whose yes means anything.

Execution must be measured, not presumed. The audit literature (§7) shows that mandates do not deliver protocols. An implementation of the Anatomy therefore includes its own audit — completion, adherence, and calibration rates, including screen-positive rates monitored against the published epidemiology — measured and reviewed as a condition of claiming the standard is met. A program that does not measure its own delivery has not implemented component 11 of anything.

9. What the standard deliberately excludes

The same evidence base that specifies the Anatomy also marks its boundaries. These exclusions are part of the standard, not qualifications of it.

9.1 No routine imaging or escalating investigation of mild injury. The source guidelines counsel restraint on harm grounds — incidental findings and labeling cascades [10, 15, 36, 37]. The Anatomy adopts that restraint.

9.2 No software diagnosis. Instruments screen; clinicians diagnose. Screening tools in these populations are engineered rule-out instruments — high sensitivity purchased with modest positive predictive value — and are valid only with a confirmatory clinical evaluation behind them.

9.3 No universal psychological intervention. The evidence against unselected delivery is accepted in full: single-session psychological debriefing shows no benefit and measured harm [34], and multi-session early intervention offered to everyone exposed to traumatic events cannot be recommended [35]. Notably, the debriefing review's own authors propose targeted screen-and-treat as the appropriate alternative [34]. Monitoring and screening are not intervention; treatment follows only diagnosis, by a clinician.

9.4 No yield objectives. No target, metric, or incentive anywhere in an implementation may count diagnoses. The objective is coverage — every indicated question asked, every answer recorded, positive or negative — with calibration monitored against published base rates (§8).

9.5 No catastrophizing. The "diagnosis threat" literature indicates that labeling itself can worsen symptom experience [38]. Assessment under the Anatomy is framed around function and recovery, reassurance is treated as a deliverable alongside concern, and language is chosen to support the expectation of recovery.

10. Evidence status and the limits of this paper

10.1 What the standard claims, and on what evidence. The Anatomy's components carry substantial evidence of their own. The instruments are validated against clinical criteria. Treatment is effective in those identified: trauma-focused cognitive-behavioral therapy in symptomatic patients yields a standardized mean difference of 0.64 (95% CI 1.06 to 0.23) against waiting-list control [33]. Red-flag rules exist to catch the rare catastrophic case — a rationale that can never be randomized. And guideline-concordant care has measured returns where studied: 11.5 fewer lost workdays, a 29.3% reduction, in a large workers'-compensation claims analysis [21]. What remains sparse is trial evidence for any fully assembled monitoring-and-management bundle. The closest such trial — stepped collaborative care for screen-positive PTSD at 25 US Level I trauma centers (N=635) — produced a small effect at six months (net 2.57 on the PCL-C; 95% CI 5.12 to 0.03; effect size 0.18) that was absent by twelve, with null results on depression, alcohol use, and physical function [30–32]. Read precisely, that trial tested one narrow overlay on one outcome family; it neither validates nor indicts the Anatomy. This is the ordinary epistemic condition of care standards: whole systems of care are rarely randomizable — usual care itself has never been trial-validated against anything — and the institutions of §4 adopted their protocols on component evidence, safety logic, and accountable professional consensus. When independently regulated institutions that answer for their outcomes converge, without a shared governing body, on the same specification, that convergence is itself a form of evidence — the kind on which most of medicine's standards rest. The Anatomy is stated on the same basis. What no implementer may claim on the strength of this paper is an outcome advantage of its own program; that claim requires the program's own audit data (§8). That audit extends to the program itself: whether structured, recurring assessment influences symptom reporting in its own right has not been tested for assembled programs, and it is among the questions an implementation's audit exists to answer.

10.2 Adoption figures are point-in-time. The execution-gap figures of §7 are single audits or cohorts in their respective systems and may have shifted; they are cited as evidence that execution is the binding constraint, not as current performance ratings of any named system.

10.3 Timing of symptom emergence. The week-level timing of post-injury symptom declaration varies by condition and study; this paper deliberately states it qualitatively ("weeks to months," §3) pending a dedicated natural-history citation set.

10.4 Source verification and attribution notes. All standards-document and protocol claims in this paper were verified against their primary texts in July 2026, with retrieval records archived. Three attribution notes from that verification: the insurer-licence condition and the three-business-day claimant risk screen belong to SIRA's Motor Accident Guidelines (s10.7; cl 4.78), a separate instrument from the whiplash clinical guideline [41]; the practitioner commitment declaration for Victoria's clinical framework is a WorkSafe service-framework registration requirement layered on the framework rather than a clause within it [17]; and ERATIC's outpatient exclusion is by omission of scope rather than an express carve-out [28].

11. Conclusion

The world's best-resourced care systems, having no common author, converged on the same protocol. It is structured, instrumented, calendared, gated, coordinated, psychologically integrated, disciplined about testing, and accountable — and it is delivered to the soldier, the athlete, the admitted trauma patient, the injured worker, and the motorist in the right country, while the ordinary injured person is handed a leaflet. Even the newest and most authoritative extension of recovery medicine — the enhanced-recovery family's 2025 reach into trauma — carries the patient only to the hospital door. And where the protocols exist, audit after audit shows them under-delivered, because execution was left to memory and mandate.

This paper gives the converged protocol a name — the Anatomy of Recovery Care — and states it for adoption. It belongs to no company. Its components are published, its instruments are free, and any program willing to be audited against it can implement it. The protocol should not stop at the hospital door — and now the standard for what lies beyond that door has a name.

Declaration of interest and commitment

This paper was prepared by InjuryDox, a healthcare technology and management company. We declare our interest plainly: we are building a recovery-care program designed toward the Anatomy of Recovery Care, and we commit to auditing that program against the standard — completion, adherence, and calibration measured and reviewed — and to being judged by the result. The standard itself requires no reliance on this declaration: every component cites public sources, and its adoption by others requires nothing from us. The protocol should not stop at the hospital door. Ours won't.

This paper states a standard and our program's design intent, not an inventory of current operations, and claims no outcomes beyond the cited evidence. Clinical care in our program is delivered by independent, physician-owned medical groups; InjuryDox builds and operates the systems that support them.

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