OCCUPATIONAL MEDICINE

A BASIC GUIDE

07: Psychological Factors and Workforce Health

Delayed Recovery from Injury or Illness

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Human beings have an intuitive desire for human-to-human relationships; hence the formation of societies. Societies are built on the idea that individuals contribute to the betterment of the group and the social benefits the individual. In general, working—whether it produces income or not (such as family child rearing or elder care)—is the way individuals contribute to society. Working is good for health and well-being and has an overall positive effect on mood, self-esteem, and identity. It builds confidence and provides financial stability. Unemployment has been associated with increased psychiatric hospitalizations and suicide rates. Sustaining the worker's functional health encourages continuing contributions to society, which in turn decreases the costs of disability programs and promotes a more prosperous society.

People identify themselves to a great extent by their occupations. Excelling in one's occupation provides significant meaning to life. Similarly, our personal intimate relationships also form an important part of self-identity and give our lives meaning. That is why when a therapist counsels a patient who is undergoing marital stress, divorce is not usually discussed as the first step. However, when a patient describes work stress, leaving work is often seen as the solution instead of attempting conflict resolution and preservation of relationships. Although providers understand the need to protect and foster role-functioning in personal relationships, the similar importance of role-functioning at work is often overlooked.[i]

Movement: The Best Prescription for Recovery

Over the past few decades, scientific studies have continued to demonstrate that the historical model of "rest" as a treatment for injury, is frequently not the right answer and in fact, can worsen the injury and/or delay recovery. This is reflected in the recent conversion of the traditional treatment advice from "RICE" (rest, ice, compression, and elevation) to "MICE," where the "R" for "rest" was replaced with "M" for "mobilization" or "motion." This advice applies to both injury and surgical recovery.

Many chronic medical conditions are effectively treated with physical activity. Examples include chronic pain, fatigue, and fibromyalgia. Remaining at work or returning early to some form of productive labor improves clinical outcomes compared to passive medical rehabilitation. Therefore, activity prescriptions such as exercise, active self-care, and the earliest possible safe return to work should be included in all treatment plans.

Discouragingly, some providers continue to prescribe rest, inactivity, being off work, and passive rehabilitation treatment plans that promote continued negative outcomes. These inappropriate prescription practices commonly occur when providers succumb to patients' demands as opposed to rendering care consistent with evidence-based guidelines.

Unnecessarily prolonged absence from work can cause needless and significant harm to workers' well-being. A prolonged absence from work is likely to cause their self-identity to shift from that of a functioning worker to that of a sick, injured, or even disabled person. The worker disconnects from social relationships with coworkers, which jeopardizes his or her self-esteem and unnecessarily reduces quality of life. The "injured worker" label excuses his or her absence from normal responsibilities and too often inspires a victim mentality. This role enables people to receive help from others instead of helping others. Functional recovery and return to work are needlessly delayed, sometimes resulting in preventable permanent total disability. To recover, the worker needs to redefine him or herself as a productive worker.

Avoiding Delayed Recovery

Every day, workers decide whether to stay at home or go to work. When a worker has a cough, backache or headache, he or she has to decide whether to call in sick, request modified work or hours, or "tough it out." In making this decision, the worker considers his or her functional impairments and limitations, as well as the psychosocial and economic effects of working while injured versus missing work. The first encounter with a provider can be the difference between the worker's rapid recovery and permanent disability.

The U.S. military long ago discovered that when service members with relatively simple physical injuries were left to recover without medical supervision or received inappropriate treatment for low-grade deployment-related stress, some would become permanently and totally disabled. Under the circumstances of combat stress, the innate human protective psyche is often depleted and what were initially simple, repairable injuries were transformed into socially acceptable and serious disabilities. Once the military labeled a service member disabled, he or she was released from duty. In response to these circumstances, the U.S. military evolved a treatment model, referred to as the S.P.I.C.E. model to promote their members' full physical and emotional recovery (see Chapter 2, Musculoskeletal Injuries). The model emphasizes making timely and simple diagnoses and treatment plans that fuel patients' healthy identities and expectations of a speedy and full return to work.

Multiple key decision makers are involved in the process of keeping an injured worker at work or helping him or her return from an injury related absence. The employer decides whether modified work duties or hours are available; the physician determines the treatment plan and when to prescribe activities; the claim administrator decides on compensation benefits; and the worker ultimately has the final say. Often, these decision makers are not aware of the harmful effects of prolonged work absence and unknowingly contribute to a downward spiral of system-induced loss of function and disability. Several studies have confirmed that the likelihood of returning to work decreases with each day off work. Prevention is key, and all decision-makers' efforts should apply the BPSE model and be focused on early, thorough, and timely response to occupational injuries to achieve the earliest return to function as possible.

The Role of Workers' Compensation in Recovery and Return to Work

Delays in recovery can be due not only to the complex interactions described by the BPSE model but to administrative issues as well. Examples include delays in specialty referral and care, lack of available modified work, inefficient communication, and ineffectual leadership. The worker's recovery is heavily influenced by his or her interactions with the work environment, medical provider, and the workers' compensation system, as well as the interactions among these components. Workers' compensation plays a large role, because it is responsible for authorizations and payments for injury claims, medical treatment, and rehabilitation. Multiple parties may be involved in a worker's claims: case managers, benefits administrators, insurance carriers, supervisors, human resources staff, medical providers, lawyers, union representatives, and often the employee's families.

Although workers' compensation programs vary from state to state, all provide basic benefits to the employee who is out of work because of a work-related injury. Temporary disability benefits cover lost wages during recovery; permanent disability covers a lasting disability, resulting in a reduced earning capacity after maximum medical improvement is reached. However, most worker's compensation systems treat mental and behavioral conditions different from medical conditions with less coverage or other limitations.

Logistical hurdles, such as a delay in authorization of surgical repair, are common in the workers' compensation system and can directly and indirectly impact workers' recovery and return to work. Studies confirm that the workers' compensation system is confusing and administratively taxing to both providers and injured workers. Delays in the submission of records to workers' compensation officials can be viewed as "non-cooperation" by the patient, which in turn can result in decreased or even terminated reimbursements. Additionally, though workers' compensation adjusters prefer black and white opinions from providers regarding causation, it is often difficult to make a clear determination. These factors can result in incomplete and/or incorrect communications among parties and lead to more complications for workers' recovery.

A systematic literature review found that the vast majority of the interactions workers have with workers' compensation insurers are negative at every stage of the claims process, from delays that occurred in the initial claim to prolonged disputes over the claim settlement. It also found that the injured workers' interaction with insurers caused significant psychosocial consequences, and some of these effects remained long after claims were settled.[ij]

Although many employers, employees, and intermediaries work out disability claims in a mutually acceptable manner, opposing interests are what lead to legal involvement. Employees can be dishonest—creating fictitious injury claims or exaggerating the symptoms of a legitimate injury. Supervisors and management may unjustly influence workers not to report injuries—or may have failed to correct the dangerous working environment that caused the problem. Workers' compensation insurance administrators may be subjected to pressure from management to deny claims, and benefit administrators may request that medical providers elicit language from patients that can be used to their advantage. Moreover, providers may be incentivized to inappropriately medically manage the patient to support the position of the organization, insurance company, or patient. Although these parties may have different incentives, ultimately they are all influenced by financial gain.

Many injured workers hire legal counsel out of frustration with the claim process. There are benefits and disadvantages to legal assistance. Often it prolongs the resolution of contested decisions, and in circumstances where medical care is pending payment authorization, the delays can increase the suffering of the injured worker. The legal system tends to draw out the recovery process because the worker is forced to rehearse and relive the injury events and the symptoms of the injury. The longer the worker remains out of work, the greater the likelihood of poor functional outcomes. This process can result in the artificial and unnecessary creation of a worker's newfound identity as a disabled person. Still, there are circumstances in which injured workers have no other recourse than to turn to legal counsel to be granted the benefits to which they are entitled.

Managing Difficult Cases

Injured workers may present themselves to the provider for reasons that are difficult to determine and that sometimes may not even be entirely understood by the patient—especially in the event of "system-induced disability,"—that is, disability that could be avoided with appropriate and timely treatment. There may be both a conscious and/or unconscious awareness of their intentions for secondary gain. Providers inevitably have to confront workers who try to game the system. Hidden agendas can lead to incorrect diagnoses, workups, treatments, and otherwise avoidable poor outcomes. They may be seeking a particular diagnosis or treatment pathway to obtain or maximize disability benefits.

Several factors can complicate the provider's approach to a potentially unscrupulous patient. First, it can be time-consuming to untangle a patient's history, and a provider may want to avoid offending the patient. Moreover, it takes time to understand the many complicated disability benefit plans, and how providers' actions can affect the worker's future.

But providers should be careful when making medical decisions if the data reported by the injured worker significantly deviate from the objective findings or if symptoms are vague or over-dramatized. Ideally, providers can attempt to unsheathe ulterior motives and address them with the patient. For example, the worker's ongoing harassment by his or her supervisor could be the cause of chronic back pain. Alternatively, this same person could have sustained a back

injury in a car accident, resulting in severely herniated discs, but is alleging an occupational injury to obtain disability benefits. The provider-patient relationship is built on trust, and a provider's initial tendency to believe the patient.

The provider's approach to the injured worker whose recovery is delayed beyond reasonable expectations should be hands-on, with frequent follow-up, clear communication, and well-defined expectations. The provider should frequently and openly communicate with the involved parties, including the employers' human resources staff and insurers. The provider should frequently and appropriately prescribe advancing activities. Applying the BPSE model to these cases will alleviate frustrations and end in more successful and timely functional restoration.

Diagnostics and treatment plans should follow objective evidence-based medicine. ACOEM Practice Guidelines are the gold standard in effective treatment of occupational injuries and illnesses and are available at MDGuidelines.com ®, These guidelines can help the provider determine whether to order a specific diagnostic test, which therapy and treatments to use, or when an injured worker may be able to return to full duty.

Return to work should always be part of the treatment plan, whether it is modified or full duty. At every visit this aim should be discussed and planned with the injured worker. The provider's mindset should not be "functional recovery to be able to return to work," but "return to work to achieve functional recovery." When employers do not have any modified work available, providers should take even greater steps to ensure that the worker's time spent away from work is mentally and physically productive. Consider prescribing more physical therapy, yoga, tai chi, meditation, walking, swimming, and any other forms of physical activity.
Remember that movement is improvement and keep in mind that the purpose of treatment is to improve function; if there is no improvement in function, consider alternative evidence-based treatments. Providers who apply the BPSE model will have greater success in restoring function.

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