# REHABILITATION of the INJURED WORKER

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Workers' compensation injuries are challenging to both health care professionals and lawyers. Besides the threshold questions of causation and whether the injury arose out of and in the course of employment, the ultimate goal for everyone is to return the injured worker to the job. Although often the lawyer is on the sidelines in the rehabilitation process, an understanding of rehabilitation philosophy and the obstacles to be faced allows the lawyer to participate more in unison with common objectives, as opposed to just defending the workers' rights.

The vast majority of work injuries are musculoskeletal, with back injury and repetitive motion injury being the most common. At least three-fourths of these have a good prognosis and need no special effort beyond good, acute, medical or surgical management and an appropriate period of recovery. But, the other fourth accounts for the bulk of medical and economic costs. Often, prolonged disabilities cannot be explained by objective medical pathology alone. This may be because of limitations in diagnostic methodology or because of controversy in scientific formulations. Almost invariably, pain, specifically chronic pain, is a presenting feature. Modern rehabilitation approaches rely on psychological input to understand the experience of pain, to deal with accompanying emotional symptoms, and to assist in recovery.

Since chronic pain is so common in our society, it is important to distinguish between pain, impairment, and disability. These terms are often used interchangeably, but are quite different for compensation purposes. Pails is the perception of an unpleasant situation that is -2 associated, at least in the mind of the individual, with tissue damage. Impairment is the loss of the use of any body part or function. Disability is the loss of the capacity to meet personal, social, and occupational demands. Usually, physicians do not rate disability; they rate impairment. But, they do give opinions about disability in workers compensation determinations. Most workers' compensation systems require only that the employee be unable to perform his or her former employment, or unable to obtain other employment suitable to his or her qualifications and training. The ability to perform work at a lower activity level has less consideration in the award of workers' compensation benefits.

A relevant issue in the rehabilitation of the injured worker is compensation-driven disability. Over the last century, it has been acknowledged that patients who seek compensation for their injuries have a prolonged recovery period and a less satisfactory response to treatment. A number of observations support this. One is that there has been an exponential growth of musculoskeletal disabilities which can not be explained on changing work place conditions. For example, military medical records of British forces in the first and second world wars, show a five-fold increase of low back pain complaints and a four-fold increase in the duration of disability for World War II versus World War I soldiers. Another observation is that in third world countries where presumably there should be similar percentages of back pain, there is relatively little disability. Even in western countries which have limited or no workers' compensation benefits, relatively low numbers of workers are disabled. Financial gain, therefore, appears to be a powerful reinforcer of disability and common sense suggests that someone who is embroiled in litigation to prove damages or to seek disability payments may

need to have symptoms continue to make the point. One author described this situation as: a state of mind, born out of fear, kept alive by avarice, stimulated by lawyers, and cured by a verdict.

However, this connection is not universally accepted and, in some studies, patients receiving workers' compensation do just as well as those who do not. More importantly, it might be assumed that once compensation issues have ceased to exist or a financial settlement is reached that symptoms of disability also improve. Interestingly, this is not the case. Studies have shown that even up to five years after a settlement of a claim, there is often no significant reduction in morbidity, and disability continues. It may be also inferred that some of these injured workers are malingering. No doubt this does occur, but that diagnosis is very difficult to make and often used by physicians who are frustrated with a difficult to treat patient. At times the label is given after a limited period of observation or examination. Not uncommonly physicians say that a patient hobbled into the office, but then was seen in the parking lot walking without any difficulty at all. While that could be some evidence of malingering, it falls short of being sufficient for the diagnosis since patients can have variable symptoms, and some pain behaviors can easily present with inconsistencies but may not indicate intentional falsification.

The rehabilitation of injured workers can create significant conflicts in management, based on different perspectives of the involved parties. Patients who receive workers' compensation benefits are often in conflict with the insurance company that pays the bills. They may see the insurance company as being only concerned with money and quotas, rather than the injury which they feel was caused by the employment. They feel pain and frustration with their limitations and face adjusters who appear to doubt the sincerity of their suffering. Often, the workers' compensation payments are the only source of income for the patient and the patient's family, so -4when an adjuster stops payment, the personal consequences are devastating. Not infrequently, animosity between the patient and the insurance company or employer grows and becomes an additional source of stress that complicates recovery. The patient may feel unrealistic pressure to return to work in a capacity that even the physician may not yet allow. If an adjuster is incredulous of the patient's claim, even medical care may not be reimbursed without a legal battle.

From an insurance company's standpoint, pain that does not show clear medical pathology is often regarded as bogus. Adjusters do become incredulous of a patient's complaints and the lack of progress in treatment, and may fight the claim through hearings. They see redundant treatment by various practitioners leading to no greater results. When the tremendous cost of chronic pain is taken into account with such poor results, it is not surprising that this type of reaction would occur on the part of the insurance company. Too many clinicians offer me too solutions that use endless resources with little gain. Sometimes, expensive treatments such as surgical procedures even complicate the course of recovery, with untoward effects that lead to longer and more expensive treatment. Insurance companies hire investigators who can document greater functional ability than the patients claim, and adjusters lose faith in clinicians who blindly support such patients and, knowingly or unknowingly, foster continued disability.

Physicians are also caught in the conflict because of more than one role that they are asked to play. The first, of course, is that of a caring clinician to the injured patient who comes to them in distress. When physicians, because of cynicism or frustration, lose that perspective, they are rarely effective and perpetuate the frustration of their patient. Yet, paradoxically, in chronic pain the healer is really the patient himself or herself who must take ownership of the problem and actively participate in the rehabilitation. A personal stance by the physician that allows patients to maintain invalidism, inadvertently reinforces disability. It is a fine line that physicians must walk between empathic caring and mobilizing the patient to greater functional activity. The other role of the physician is that of an expert who determines impairment and gives opinions about disability. For treating physicians this is particularly conflictual, since they must decide whose agent they actually are, i.e. the patient's or the insurance company's. In either case, objectivity can easily be lost. The ideal position is for the physician to remain a facilitator who sees the patient's and society's interests as similar, and who tries to promote those interests through comprehensive understanding of the patient and the patient's milieu.

No matter which side is correct, the hostility that develops between all of these conflictual interests has a negative effect on the recovery and rehabilitation of the patient. Unknowingly, the various parties can reinforce the conflict that already exists. As a consequence, there is a significant waste of resources within the workers compensation system. Unnecessary treatment may be repeated or necessary care may be withheld for the sake of cost containment. In the long run, both can be costly. Knowledge of the nature of potential conflicts can help decrease artificial polarization and destructive fragmentation in therapeutic rehabilitation.

Many therapeutic methods that are used unsuccessfully in the rehabilitation of injured workers have individual merit and potential. However, they are doomed to failure when applied independently. The two fundamental elements for successful rehabilitation are the patient's ownership of the problem and coordinated care. As simple as it may sound, these are the missing pieces in one way or another in most failures of treatment. Ownership means that the patient -6must assume an active and optimistic role in the rehabilitation, even if cure is not possible. No restorative work will succeed without this. The traditional medical model of diagnosing disease and supplying necessary treatment does not work well here. Patients, physicians, therapists, insurance adjusters and lawyers must understand this. Obviously, this involves a change in mental attitude, since the patient must stop looking for external solutions and realize their own necessary contribution that, with therapeutic guidance, can bring them to a state of well-being and greater functional ability. The second principle of effective rehabilitation is coordinated care so that the treatment plan and various disciplines that participate are unified in their approach. Even with good communication between multidisciplinary specialties, fragmentation can easily occur. When there is poor communication, fragmentation is inevitable. The medical records of most injured workers with chronic disability show a potpourri of well-meaning treatment attempts, often redundant and uncoordinated, and mostly unsuccessful.

Along with various core and ancillary disciplines that provide clinical treatment to an injured worker, case management, coordinated vocational rehabilitation, and psychological care are necessary. Most psychological approaches utilize a behavioral model which applies not only to the psychological treatment itself but should pervade the entire rehabilitation process. The

foundations of this behavioral approach are education, motivation, motion, and reverse conditioning. Education is necessary, because no patient will accept treatment and take ownership unless he or she is given a clear and believable understanding of the problem. The most essential point that must be taught is the need for the patient's ownership of the pain, since it usually determines whether rehabilitation will be genuinely and effectively pursued. Education is complicated by the fact that the patient may have already been to other clinicians who have given a variety of contradictory opinions. Motivation of the patient to participate in recovery flows naturally from proper education. If the patient believes that this team really understands what is going on, then full participation is more likely. Creating motivation also means removing factors that are disincentives to progress which include the various conflictual issues that were described above. Unfortunately, these factors often linger throughout the course of treatment and present an insurmountable obstacle. An adversarial relationship, which can be inadvertently fostered by lawyers, must also be minimized or it distracts from the difficult journey to functional improvement. In addition, there is no way that patients can recover without increasing motion Obviously, this is limited by pain and structural defects. But without motion, there is no increase in functioning. With proper guidance and pacing, most patients can improve functioning substantially and even if they hit a stone wall with regard to their primary defects, they can look towards alternative functional growth. All of this is designed to help them find meaning in an active life in spite of pain and limitations. Finally, reverse conditioning is an important goal since deconditioning is the most malignant perpetuating factor of disability. Patients must learn to reduce conditioned fear and avoidance, eliminate reinforcers of disability, and focus away from pain and toward improved functioning. A good dictum is, even if you must live with pain, at least make your life meaningful. In the course of doing so, functional improvement and reentering the work force is often possible. (see Drukteinis, A.M.: The Psychology of Back Pain A Clinical and Legal Handbook. Springfield, IL, Charles C. Thomas, 1996.)