Disability

This document is the first of several that are being provided for the 2013 meeting of the American Osteopathic College of Occupational and Preventive Medicine

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The AMA Guides to the
Evaluation of Work Ability and Return to Work

Reference:

A. Vocational work is good for health, and should be a central part of the treatment plan:

- Scientific findings have strongly supported the principle that vocational work is good for health. (Page xv)
  - “Simply stated: it is usually in the patient’s best interest to remain in the workforce”. (page 2)
  - “…remaining at work has clear health benefit for the individual and thus is in his or her long-term best interest.” (Page 17)
• Therefore, the physician’s role is to encourage participation in vocational work (staying at work in spite of health problems, returning to work quickly if one has withdrawn from work, etc.). (Page xv)
  o Clinicians “should encourage early and ultimate return to work whenever possible”. (page 2)
  o Vocational work should be a considered a core part of a treatment plan. (Page xv)

• “Consensus statements”... “strongly recommend that physicians return patients to their usual work roles as soon as possible”: (pages 2-3)
  o American Medical Association
  o Canadian Medical Association
  o American College of Occupational and Environmental Medicine
  o American Academy of Orthopaedic Surgeons

• Scientific findings – being away from work is associated with: (pages 4-5)
  o “many adverse health outcomes”
  o “increase overall mortality” (“even when controlled for potential social, behavioral, work, and health-related confounders”; “despite a reduction in mortality from motor vehicle accidents”; being away from work “increased the risk of death by nearly 50%”)
  o “mortality from cardiovascular disease”
  o Suicide
  o “more symptoms”
  o “more...objectively validated illnesses”
  o More medication consumption
  o Higher rate of hospitalization
  o “decreased physical and mental health”
  o “greater use of health services”

NOTE: People who were well, but who chose an early retirement because they could financially afford to do so, had a higher mortality rate than those who continued working (“consistent with an adverse effect on health of retirement itself”). “A five year delay in retirement was associated with a 10% reduction in mortality”. (page 5)

NOTE: “There is also strong evidence that re-employment leads to improved self-esteem, physical health, and mental health.” (page 5)

NOTE: References from the Guides discussion of this issue include…
• My review of the scientific literature which indicated that work increases the probability of a good outcome for:
  o Pain
  o Mental illness
  o Brain injury

• Waddell and Burton’s encyclopedic review of scientific findings which indicate that vocational work leads to better health, and that withdrawing from work leads to worse health outcomes. Reference: Waddell G & Burton AK. Is Work Good for Your Health and Well-Being? The (UK) Stationary Office, London, 2006.

• Summary statement: “Thus, there is sound science indicating that unemployment is hazardous to a patient’s physical, mental, and social well-being. As patient advocates, physicians therefore should strongly urge patients to return to work or to stay at work and should decline to certify disability unless it is obvious.” (page 5)

B. The USA is experiencing a disability epidemic that does not make sense from the occupational or health science perspectives.

• Vocational work in developed nations has progressively become, and is still progressively becoming, less physically demanding, less dangerous, etc. (Page xvi)

• Health care has progressively improved, and is still progressively improving (e.g. some diseases have actually been eradicated). (Page xvi)

• In contrast to the above points, the rate of claimed disability has increased dramatically, and is continuing to increase at a rate that is faster than the rate at which the population is increasing. (Page xvi)
  o “…from 1978 to 2006 the US population increased by 35%, yet the number of Americans on government funded disability increased by 236%” (page 2)
C. It is largely inappropriate for clinicians (especially treating clinicians) to offer judgments regarding vocational disability.

- To a very large extent, this is not an area in which clinicians have relevant expertise. Clinicians do not typically receive significant training, during their full-time education, focused on facilitating their patients staying at work / returning to work (Page xvi)
  - “most have received little or no training in how to evaluate their patient’s work ability” (page 9).
- “In the final analysis, return-to-work decisions are always those of the patient and his or her employer.” (Page xvii)
- Clinical presentations “that clearly leave patients unable to engage in any meaningful work activity” are “objectively obvious” (and, consequently, do not require judgments regarding vocational disability from a clinician). (page 2)
- “In cases in which there is neither obvious severe disability nor obvious major pathology…returning to work is clearly indicated”. (page 2)

NOTE: Treating clinicians have extreme conflicts of interest (both financial and social) when they become involved in issues of vocational disability (or any other forensic issues). Additionally, when treating clinicians become involved in such issues, such involvement creates a substantial risk of compromising the quality of the health care. Consequently, it is usually not in the best interest of the patient/claimant (or in the best interest of the clinician) for a treating clinician to become involved in such issues. The treating clinician will be making a wise and justified decision when he/she refuses to become involved in such issues. This issue is addressed to a very limited extent in the work ability Guides (for example, page 128), and has been discussed for more extensively in another AMA publication, reference: Barth, RJ, and Brigham, CR. Who is in the better position to evaluate, the treating physician or an independent evaluator. *The Guides Newsletter*. September/October 2005: 8-11. American Medical Association.

D. How to make sense of claims of vocational disability: risk, capacity, and tolerance

Issues of work ability should be considered in terms of three potential obstacles to work: risk, capacity, and tolerance. (page 9)
D. 1. Most disability claims are focused on tolerance (rather than risk or capacity)

Page 18
“…tolerance for symptoms is the usual problem in contested disability cases, and tolerance is not scientifically measurable.”

Page 13
“…the term work restrictions means what the patient should not do on the basis of risk of harm to self or others. Symptoms do not harm, so “work restrictions” are not appropriate if based only on symptoms.”

Page 14
It is “inappropriate” for “work restrictions” to be based on “the patient’s symptom tolerance”.

Page 17
“…it is best that physicians not pretend that there is a medical answer to this question.”

Page 17
“…remaining at work has clear health benefit for the individual and thus is in his or her long-term best interest.”

Page 17
In cases for which “there is no medical evidence (translation: health science which indicates) that (the patient/claimant) is at high risk of significant harm (from) working, (the clinician) cannot certify that (the patient/claimant is) disabled for this job.”

Page 17
“Whether the rewards of working are sufficient for (the patient/claimant) to choose to remain at work, or whether the pain (the patient/claimant) feel(s) is sufficient for (the patient/claimant) to choose a different type of work, or not to work at all, is a question only (the patient/claimant) can answer.”

Page 19
“If there is no medical answer to when (translation: no relevant credible health science to address when) a condition with mild or moderate pathology is significant enough that the individual should choose to pursue a different career or to stop work entirely, physicians should not pretend there is a medial answer, and thus physicians should decline to certify such individuals as disabled or unable to work. This is ultimately the patient’s decision.”
D. 2. Risk:

- “Risk refers to the chance of harm to the patient, co-workers, or to the general public, if the patient engages in specific work activities.” (page 10)
  - Example: uncontrolled seizures create a chance of harm for commercial driving

- Such risk is a reason for restrictions: “something a patient can do, but should not do” (page 10)

- “Unfortunately, there is little scientific literature on the real-world observed risks of working despite known medical conditions.” (page 10)
  - “Most often there is no scientific study that can clearly be generalized to the specific patient’s work risk questions.” (page 13)

  NOTE: If the scientific knowledge base is inadequate on this issue, why are doctors, who are supposed to be men and women of science, drifting into this issue?

- “…the Americans with Disabilities Act of 1990 permits the employer to deny the tentatively offered employment only if, on the basis of objective information, the work activities of the essential job functions pose a substantial risk of significant harm to self or others that is imminent…these criteria would be the basis for physician-imposed work restrictions that would disqualify an applicant from working.” (page 10)
  - “A substantial risk of significant harm” … “means an objectively verifiable worsening in the patient’s condition, and not merely an increase in previously present symptoms, like pain or fatigue.” (page 10)

  NOTE: Warning in regard to restrictions that are based on nothing other than tradition: “…For decades, spine surgeons placed permanent lifting and other activity restrictions on patients who had good results after a first-operation lumbar discectomy. Recently, studies have shown that those with good results can return quickly to full work with no increase in the incidence of disk re-rupture.” (page 11)

D. 3. Capacity:

- “Capacity refers to concepts such as strength, flexibility, and endurance.” (page 11)
“The individual with a rotator cuff tear in the shoulder who cannot raise his arm high enough to reach the overhead controls of a factory press is an example of lack of capacity.” (page 12)

“While physicians impose work restrictions (proscribe certain activities), physicians describe work limitations (what the patient is not physically able to do). (page 12)

Doctors are often asked to address “current ability”, even though “Current ability can increase with exercise and activity (“including progressively more difficult work activity”), or it can decrease with inactivity.” (page 11)

“There are situations in which a patient lacks the “current ability” for specific work activities…However, many, but not all, can acquire this ability with an exercise training program.” (page 12)

“Many times the physician has no objective way to decide whether the patient does or does not have the current ability to do a task.” (page 12)

“Functional capacity evaluation…lacks proven validity and reliability.” (page 16)

“...ignoring FCE findings improved the treatment results” (page 16)

“The term functional capacity evaluation is a misnomer in that it tells the physician whether or not, on the day of testing, the patient was or was not willing to demonstrate the “current ability” to do a job or job tasks…it does not measure capacity. It usually reflects tolerance for symptoms, and not necessarily current ability.”

“FCEs are really a “tolerance test” and not a “capacity test.” (NOTE: tolerance is discussed in the next section of this article).

D. 4. Tolerance:

Definitional issues:

“The ability to tolerate sustained work or activity at a given level.” (page 12)

“Symptoms such as pain and/or fatigue are what limit the ability to do the tasks in question. The patient may have the ability to do a certain
task (no work limitation) but not the ability to do it comfortably.”  
(page 12)

NOTE: Chapter 22 similarly notes that psychological issues are almost always a matter of tolerance.

o “...dependent on the rewards available for doing the activity in question. Tolerance is exemplified when an individual chooses, because of pain, not to work for minimum wage at a job he dislikes, but, when offered a much more physically demanding job at three or four times minimum wage, he happily works and endures (tolerates) even greater pain.” (page 13)
  • “This patient clearly can perform the activity but chooses not to (tolerance) because he dislikes the symptoms associated with the activity.” (page 13)

• “…tolerance is not scientifically measurable or verifiable.” (pages 12-13)

• “If seeking work despite symptoms is the patient’s decision (and not the physician’s decision) when the patient is a willing job applicant (according to the Americans With Disabilities Act), logically the decision is still the patient’s when the patient is requesting disability certification.” (page 11)

• Review all of the notes in regard to tolerance from section A.4.a. above.

D. 5. A Seven-Step Process

1. What is the job in question? Do I have an adequate job description? Do I have information from both the individual and the employer as to what this patient is expected to do at work? If "no," request such information before answering.

2. What is this patient's medical problem? What are the objective signs of pathology? What are the symptoms? Is this permanent or temporary during recovery from injury/surgery? Is this problem improvable with time, or medical treatment, or exercise (which includes work)? If the condition is temporary or improvable, record this fact.

3. Does this patient have severe pathophysiology that appears to meet the Social Security Administration's criteria for total disability? If "yes," tell this fact to the patient and support his or her disability application if he or she chooses to apply for disability. If not, consider risk.

NOTE: The Guides provides this reference for “Social Security criteria”: Disability Evaluation Under Social Security. Baltimore,
4. Is there significant risk of substantial harm with work activity (not merely an increase in subjective symptoms)? If "yes" on the basis of sound science or a major consensus document, certify that work restrictions are appropriate on the basis of risk. If "no," consider current ability.

5. Is this patient actually able to physically do the task in question (not considering symptoms, but ability)? If "no," state the reason as a limitation ("lacks shoulder range of motion to reach overhead machine controls"). If "yes," consider tolerance.

6. If the patient has the ability to do the work task, at acceptable risk, and wants to do the job, certify that he or she is medically able.

7. If the patient has the ability to do the work task, at acceptable risk, and does not like doing the job based on tolerance for symptoms like pain and fatigue, is there severe objective pathology present that makes physician agreement on work problems based on tolerance likely? If "yes," certify that work "problems" are present "on the basis of believable symptoms and severe objective pathology," but certify that the patient may work despite the symptoms if he or she wishes. (Note that there will usually not be a line or box on the work ability form for "work problems" but there frequently is a line for "comments."). If "no," and the objective pathology is only mild or moderate, certify that the patient may work at the job in question, but that he or she describes symptoms at a certain level of work activity. This scenario represents a "medically unanswerable question" and should be labeled as such by physicians. The decision whether or not to work despite symptoms is ultimately the patient's, and not the physician's.

E. Complete list of chapters from the work ability Guides:

Chapter 1 Why Staying at Work or Returning to Work Is in the Patient’s Best Interest

Chapter 2 How to Think About Work Ability and Work Restrictions: Risk, Capacity, and Tolerance

Chapter 3 How to Negotiate Return to Work

Chapter 4 Return to Work: Forms, Records, and Disclaimers