"Ask Dr. J"

The "Ask Dr. J" columns are authored monthly by Jennifer Christian, MD, MPH, President of Webility Corporation. See previous columns at www.webility.md.

Dr. J's columns also appear in the monthly Bulletin of the Disability Management Employer Coalition (DMEC). To purchase a book of Dr. J's collected columns, go to www.dmec.org.

The columns often summarize issues discussed by the Work Fitness and Disability Roundtable, a free, multi-disciplinary e-mail discussion group moderated by Dr. Christian. Apply to join the Roundtable at www.webility.md.

March 2008 – Designated Guessers

Dear Dr. J:

It is so frustrating when the doctors in our community delay filling out disability and workers' comp benefit forms -- and then write stuff that seems totally inappropriate about their patients' ability to stay at or return to work! We have a lot of people out of work because we keep getting these forms back from doctors with "none" written in all the boxes for the physical capacity estimates, and just a scribbled comment saying the person can't work at all.

Florence in Fresno

Dear Florence:

Here's my advice, but be prepared: it may sound weird at first. Begin by having compassion for the doctors, and interpreting their delay and reluctance as a sign of their ignorance and discomfort with what you are asking them to do. If you start from that position, and get to work making them feel more comfortable, you will start producing better results.

Doctors should really be called the "designated guessers" in disability benefits and workers' compensation systems. Long ago, somebody decided that treating doctors are the best place to turn for advice . . . advice for workers, their employers, for benefits claims adjudicators and sometimes for the courts about what an injured or ill person should avoid and what they can do safely -- in advance of the worker actually doing it.

Doctors are actually being asked to predict the future, and to forecast people's performance at work based on the physician's fragmentary knowledge of medical /physical factors only. However, they are making forecasts in an area where other non-medical factors also influence what actually happens.

In addition, no doctor CAN know how to do this accurately. There is little or no evidence-based science that supports using medical information to base predictions about who will actually be able to work safely and at what, nor are there any studies supporting any of the specific

estimates that the doctors are expected to make about work capacity. Only a few studies have been done, and they either ignore entirely or refute the ability of the methods doctors commonly use to predict “real world” outcomes.

“Objective measurements” are not necessarily the answer, either. Again, only a few methods of assessing capability have been tested and analyzed using high quality research designs and published in peer reviewed journals. Although some have proven to be reproducible and valid with regard to gauging performance of some highly standardized maneuvers, that does not mean they accurately predict ability to succeed in a real job environment. There’s only one study of which I am aware that has tested whether adding data from a functional capacity evaluation (FCE) helps doctors more accurately predict people's ability to perform successfully. In fact, the people who went back to work based only on the doctor’s best guess did better than the ones where the doctor relied on the FCE data!

Moreover, research in other disciplines clearly shows that non-medical factors predict functional /disability status much more powerfully than medical ones do. These factors include external factors such as the nature and extent of job demands, the availability and features of wage replacement benefits, the nature of the tangible and non-tangible (interpersonal) work environment, the willingness of the employer to make adjustments to the work environment or the job demands. Additional factors that are often even more important include the worker’s own skill /training /expertise, natural talent and vitality, extent of physical conditioning, temperament, motivation, cultural and personal beliefs, individual tolerance for discomfort and fatigue, social and emotional support in the workplace and at home, etc.

So, let’s go back and re-examine why doctors are involved in this process at all. People who want advice about what someone can do safely have four logical options:

1. One possible way to tell if people can do a job safely and comfortably would be to let them try doing it. Unfortunately, retrospective advice is not what is usually required, and not every worker wants to succeed at the tasks. It’s also true that just because someone has been safe /comfortable /capable "so far" is not a guarantee that they will continue to be so.

2. Another way to figure out in advance what people can do would be to simply ask them. There are two problems with that approach:

    a. There may be medical risks in the situation that the workers can't anticipate. They may not understand the process of wound healing or the side effects of their medications or overestimate their stamina or be unaware of the typical length of recuperation, or be so desperate to work that they will put themselves or others at unacceptable risk. This is where we really do need medical expertise, but the problem is that almost all doctors have never been taught either a logical or a standard method for figuring these issues out (and there IS no widely-accepted method yet).

    Unfortunately, there is NO authoritative and comprehensive resource available that lists the medical risks for workers with particular diseases or in particular work environments or trades. This reality is pointed out on page 11 of the new ACOEM Guideline on *“Preventing Needless Work Disability by Helping People Stay Employed”*. The new book *A Physicians Guide to Return to Work* by Talmage and Melhorn from the AMA Press is the closest approximation available.)

b. Another reason why employers/payers don't simply ask workers what they can do is that they don't trust the workers to be truthful -- their answer may be influenced by whether they want to work or they don't. This is where things REALLY get complicated. Predictably, most doctors' usual reaction to being put on the spot is .. . . . to ask the workers what they can do! Doctors are looking for the quickest and most efficient way to answer the questions, have at hand little or no basis for any other answer -- and have no dog in the fight. So what good did it do for the employer /payer to put the doctor in the middle?

3. Another possible way to tell what someone can do safely at work is to send them to an expert and have them do an assessment. This kind of expert evaluation can be very useful (especially in technically complex situations) because it can insert useful factual input into a conversation which heretofore consisted of "he says, she says." A physical or occupational therapist can figure out the demands of particular tasks and then ask a worker to do maneuvers that provide great insight into whether that person can actually drive a car safely, can see well enough to operate complicated machinery, ambulate safely over rough terrain, get up into the cab of the truck or throw the cable over the load and climb up to tie it down, etc. However, besides the problem I already mentioned about the unproven predictive accuracy of even the best assessments, this method is less helpful when in situations where the worker might have reduced motivation to perform, and is usually too time-consuming, expensive and logistically cumbersome method to use on a routine basis.

4. Which brings us to the treating physician solution. They are presumed to "know their patient" because they are already involved in the medical condition which has caused the issue of ability to work to arise. By tradition, physicians have become the generally free source of this information. If they don't answer the questions, their patient won't get the job or won't be paid, which obliges the doctors to cooperate, if only slowly and half-heartedly.

I suppose it's actually better to have doctors doing the guessing than carpentry supervisors or benefits clerks. At least the doctors have been trained in anatomy, physiology, and they have watched lots of people get sick and then heal and get better. And a few doctors -- especially those in occupational medicine -- have had a bit of training in how to think these things through logically. A doctor's opinion could certainly be presumed to be more "informed" than the carpenter's or the clerk's. But it's still a guess.

Studies have also shown that most doctors' advice tracks more closely with their own beliefs about the value of work, how to behave when ill, and the hazards of activity in general than with any factual information. Orthopedists and occupational physicians (those who treat lots of work-related injuries) get more practice and thus are more comfortable with making these SWAGs (scientific wild-**sed guesses) than most other doctors are. But they are still making guesses.

What's really weird (and sad) is how these guesses are transformed into expert opinions which then become the "revealed truth" written in stone. Why can't we continue to talk after that first guess has been made?

Things won't get better until we all acknowledge the reality that the doctor is guessing. Not just one doctor, actually, but ill-prepared doctors around the country (and world, for that matter) are being pressed into service as the "designated guessers." Doesn't it seem like we should train as many of them as possible on a consistent method of thinking logically through these situations? More than two-thirds of the occupational medicine doctors I have surveyed report that they simply made up the methods they are using now by themselves.

I've been giving introductory lectures on evidence-based decision-making in return to work for clinician audiences, mostly physicians and chiropractors. They look stunned at first and then laugh with relief when I acknowledge that we're all simply making guesses and winging it. Then they pay rapt attention and are grateful for the material. They have been feeling awful about having to make these decisions day in and day out without any conceptual or clinical model to rely on. Not many of them are willing to admit it because it's hard to acknowledge that "the emperor has no clothes." Remember, these are people who went into their chosen profession because they like feeling expert and masterful.

In the interim, until most treating clinicians are more ready to give sound advice in these matters, here are my suggestions for how YOU can help doctors make better quality guesses.

1. Let's start thinking of the stay-at-work and return-to-work process as a team sport with members in different sectors of society. Let's communicate with each other as though we share the same goals:

    - preventing harm to people by avoiding needless work disability and job loss
    - protecting and supporting them so they can stay productive during recovery
    - reducing overhead costs for businesses
    - recapturing the economic productivity lost to society when people sit home who could have been making a contribution.

2. You and the other parties who have personal knowledge about the situation should try to help the doctors as much as possible in order to make it easier for them to make a better decision. Among the easiest ways to do this are to:

    - Express your concern for the worker along with your intention to actively manage this situation. Communicate your caring and your philosophy that returning people to work benefits both the worker and the company.
    - Contribute the data and background information you have, pointing out the issue which is of paramount concern, describing other aspects that have a bearing on the situation, etc. For example, send a job description that describes functional job demands, but instead of just sending off the whole thing, spend a minute highlighting those aspects that are of concern in this particular case at this point in time.
    - Make it look simple, easy to read, and like there is no need to "take sides". Ideally, present the doctor with a solution that has already been agreed by the worker and supervisor, and simply ask if the doctor is OK with it. Provide a couple of alternative solutions with checkboxes for the doctor to approve. This means NOT making the doctor waste time pawing through detailed data. Boil it down, digest it, highlight the key issue, get it all on a single sheet with a few check-boxes.
    - Make it clear that you intend to protect the worker, will honor the doctor's medical restrictions, and that you want to be notified if there are any problems so you can take corrective action. It will really look like you mean it if you provide a name and phone number for the doctor to call.

3. Think of return to work communications as a conversation or a problem-solving dialogue, not one time shot.

- Treat the doctor's initial advice as a tentative “first cut”, instead of the truth written in stone.
- Assume that an “off base” report from the doctor reflects the doctor’s ignorance -- or yours -- of the real situation or some kind of discomfort that requires reassurance. Is there something you don’t know that you should, such as that this patient has other medical problems of which you are unaware, or that this doctor had a previous experience with a patient who was promised “light duty” and then harassed or mistreated by this employer or insurance company? Start and keep exchanging information with each other so you enrich each other’s view of the situation. Very likely, a decision that seems reasonable to both parties will result.
- If the doctor's opinion seems off base, then provide additional data in a helpful and face-saving manner to the doctor. (“Doctor, I understand now that you had to make that decision without some key information. I see how you got that impression, and apologize that you weren’t aware of this or didn’t have access to this information when you filled out the form.") Then ask for a re-thinking in light of the additional information. Or ask: “Doctor, is there any additional information that you would need in order to feel comfortable lifting that restriction? Or, even better, ask to talk with the doctor in a problem-solving session where the topic is “how can we make this work?” or “what needs to happen for you to feel comfortable?” instead of sending formal missives back and forth to resolve the issue.

So, the bottom line is that you will be less frustrated and hit fewer dead-ends if you start viewing the forms coming to you from physicians as conversation starters rather than fiats. Have compassion for the treating doctors who are doing their best with an impossible task, and start collaborating with them. Keep exchanging information until the doctor has a complete enough picture of the situation to feel comfortable making a decision with a solid basis -- and you have a complete enough picture of the situation to manage it.

Thanks for asking. Physician communications is a very common source of frustration for thousands of people in companies like yours. It’s more fun for me to give advice when I hear back whether my input was helpful. Let me know, OK?

Smiling,

Dr. J