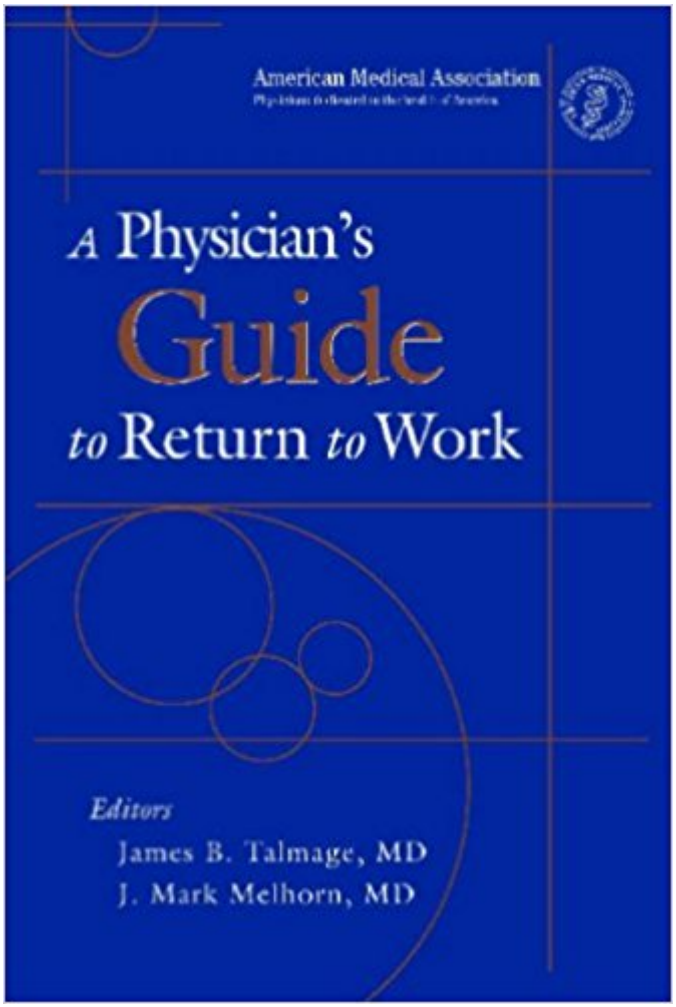
A Physician's Guide To Return To Work



Synopsis

Finally a guide book to help primary care physicians and care providers navigate return-to-work issues. This needed reference is written from the healthcare provider’s point of view combining the science with the art of medicine. "A Physician’s Guide to Return to Work" teaches physicians and health care providers how to think through the issues of "risk", "capacity" and "tolerance" when negotiating return-to-work and stay-at-work issues with patients.The most common questions faced by physicians, insurers, attorneys, employers and workers’ compensation managers are answered with the most current science available. It is written by practicing physicians and legal experts who regularly face return-to-work issues. It provides practical aspects of evidence-based medicine, causation analysis, functional capacity evaluations and the legal aspects of return-to-work decision making. It presents ways that primary care physicians can help patients negotiate return-to-work decisions. It discusses the implications of medication, work aspects, and driving. It describes the health consequences of unemployment. It provides specific examples and case studies help appropriate disability ranges to a specific diagnosis. It includes tables and charts from the most current edition of "The Medical Disability Advisor".

Book Information

Paperback: 356 pages
Publisher: American Medical Association Press; 1 edition (January 1, 2005)
Language: English
ISBN-10: 1579476287
ISBN-13: 978-1579476281
Product Dimensions: 8.9 x 6 x 0.8 inches
Shipping Weight: 1.1 pounds
Average Customer Review: 5.0 out of 5 stars 3 customer reviews
Best Sellers Rank: #316,806 in Books (See Top 100 in Books) #38 inÃ Â Books > Textbooks > Medicine & Health Sciences > Medicine > Clinical > Occupational & Industrial Medicine #46 inÃ Â Books > Medical Books > Medicine > Internal Medicine > Occupational #225 inÃ Â Books > Textbooks > Medicine & Health Sciences > Medicine > Clinical > Diagnosis

Customer Reviews

This book is better than "Occupational Medicine Practice Guidelines, Evaluation and Managemtn of Common Health Problems and Funcitonal Recovery of Workers" published by the American College of Occupational and Environmental Medicine. They cover simelar topics. The AMA book is shorter,

more specific and has sharpter definitions. The ACOEM book frequently is more a commentary than a summary of the material they reviewed.Here is a summary, from a mental health perspective.Talmage, J.B. and Melhorn, J.M. (2005). A Physician's Guide to Return to Work. AMA Press.----------1. Why Staying at Work or Returning to Work Is in the Patient's Best InterestThis book focuses on the less obvious and less severe illness and injury situations in which many patient with similar problems work, and yet some patients consult with physicians, seeking disability certification.Rest should have a black box warning. Warning: This drug is detrimental to your patient's mental, physical and social well-being! Therefore, you will harm the patient by giving them excess time off.----------2. How to Think About Work Ability and Work Restrictions: Risk, Capacity and ToleranceRisk = Chance of harm to the patient or the general public. In response to risk are work restrictions. A work restriction stops a patient doing something even if they can do it and want to do it. There is little objective evidence for this stuff but there are consensus documents.If there is not objective evidence of substantial risk or significant harm, the patient may choose whether or not to work despite symptoms. This means that, logically, it is still the patient's decision when they request disability certification.Capacity = an individuals theoretical maximum ability. It includes things such as strength, flexibility and endurance. Current ability = an individual's current ability and is equal to or less than their capacity. Current ability and capacity can be higher, equal to or lower than the demands of a job. Work and other treatment improve current ability. Fitness can be measured in terms of metabolic equivalents. Functional capacity evaluation (FCE) does not measure capacity unless the person is already at maximum fitness. In the only published test of FCE for back pain, things were best when the results were ignored and the patient returned to work.Tolerance = ability to tolerate sustained work or activity at a given level. It is a psychophysiological concept. It is dependent on rewards. It is not scientifically measurable. Tolerance will always be less than ability. When doctors hold differing opinions on this, they look stupid/dishonest and are trying to answer an unscientific question.When objective pathology is dramatic, poor tolerance is more believable.Where there is no objective pathology and symptoms are disproportional to pathology, most physicians agree working poses no major risk and can work if they wish. "... alleges intolerable pain when attempting to lift a postage stamp has an issue of tolerance rather than risk or ability."Physicians can play secretary, try to assess tolerance, abstain and leave the decision to the patient. Should say "... there is no problem with risk or ability, just with pain. Only you can determine if working with the pain is worthwhile."Evaluating Work Ability1. Find about what the job requires.2. Find out about the medical problema. Objective featuresb. Subjective

featuresc. Relationship between objective and subjective featuresd. Permanent/temporarye. Helped with work/treatment/time or stable and stationary3. Risk and restrictions4. Current ability and limitations5. Tolerance6. Decisiona. If risk/restrictions acceptable and wants to return to work, they canb. If risk ok, does not want to work and objective pathology is present: Specify that the patient is disabled but can work if they wish.c. If risk ok, does not want to work and objective pathology is absent: medically unanswerable question.Criticism of the chapter1. The difference between a scientific question and a value judgment is not as clear as made out here. For example, acceptable risk is not a scientific question, just what the risk is.2. The cascade they have is: risk, pathology, tolerance (where different decisions are made according to pathology). The cascade they should have is: risk, pathology, somatiform disorder, tolerance. In other words, the authors discount the existence of psychogenic pain treat the same pain differently depending on if it is due to a physical disorder or to hysteria. I suppose you could argue that tolerance, by their definition, depends on rewards, so it makes no difference if the decision is made consciously or unconsciously (!) but that is a bit of a stretch. It is not clear if the authors ignore hysteria for convenience, because they do not believe it exists as a disorder (beyond tolerance) (it is in DSM IV) or because they are following a societal convention in ignoring it.In Australia, hysterical disorders are regarded as real. If a doctor has to make a value judgment about what it is reasonable to ask one to tolerate, giving more credence to someone with greater objective pathology has some intuitive appeal. On the other hand, this intuitive appeal might be because the presence of objective pathology is short hand for risk of exacerbation of the injury with work and it is intuitive forget that it is not ethical to worsen a patient’s condition by allowing them to not return to work when they could (issues of autonomy aside).3. With psychological injuries, insufficient tolerance is excessive risk, because distress is what is driving the condition. In other words, in psychological injury, capacity and tolerance blur into one another. Notwithstanding the central role of exposure to all psychological treatments.----------3. How to Negotiate Return to WorkFundamentals: risk, capacity, tolerance. Focus on retained capacity rather than deficits. Accommodate while you remediate. Some bosses do not want the worker back until the worker is "100%," and some workers do not want to go back until they are "100%." First element of motivational interviewing is education. Negotiation and agreement.Occupational injuries/occupational illnesses. Probability has a legal, rather than medical, definition. Impairment = loss of use or derangement of any body part, system or function. Disability = loss of capacity to meet personal, social or occupational demands (or statutory stuff). (Alternative: disability function and handicap role.) Might need to do an impairment rating.Return to work can be delayed by

communication, litigation, disputes, administration, lack of desire. Most common reason by Drs: not want to force back, employer has a policy against light duty work, caught between versions of events, conflict between two physicians, emotionally uncomfortable, differing opinions between stake-holders.ENGAGE THE WORK PLACE CASE MANAGER. Modified work is the cornerstone or rehabilitation.Job satisfaction, demands/autonomy, single supportive telephone call, happy to be rid of them, demarcation dispute. Look for the 5Ds: dramatisation, dysfunction, dependency, disability and drugs. Most people do not need any time off work at all.Essential functions are those bits of jobs that can not be easily modified.Motivational interviewing: in order to get the patient back at work fast, you must 1) educate them that you are on their side and 2) educate them that rapid return to work is in their best interest. Be firm on the science and soft on the patient.Note: nociception, suffering, pain behaviour, and disability.----------4. Return to Work: Forms, Records and DisclaimersWork guides allow a doctor to make recommendations that are not initially specified as limitations, restrictions or reasonable tolerance. Contents of files will end up with lawyers.Initial report: in addition to usual stuff: onset of symptoms, relationship to the workplace, causation/aggravation/exacerbation, job in detail, current ability, accommodations, prognosis.Interval reports: response to treatment, admin and relationship stuff that is impacting, treatment options, work guides.Final report: if stable and stationary, if need vocational rehabilitation, work guides, determination of permanent impairment.In records:1. Return to work i. Is the injury going to make it hard to go back ii. Is the boss/workers going to make it hard iii. Figured out a way to return despite the injury2. The grocery store3. The molehill sign4. The obstacleTerminology* limited 0 to 12% of the day* occasional 0 to 33% of the day* frequent 34 to 66% of day* constant 67% to 100% of the dayEach physician should develop their own standard return-to-work form.Disclaimer. The above statements have been made within a reasonable degree of medical probability. The opinions rendered in this case are mine alone. Recommendations regarding treatment, work and impairment ratings are given totally independently from the requesting agents. These opinions do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.This evaluation is based upon the history given by the patient, the objective medical findings noted during the examination and information obtained from the review of the prior medical records available to me, with the assumption that this material is true and correct. If additional information is provided to me in the future, a reconsideration and an additional report may be requested. Such information may or may not change the opinions in this report.Medicine is both an art and a science, and although the patient may appear to be fit to work with the abilities and restrictions described above, there is no guarantee that they will not be injured

or sustain a new injury if they chose to return to work.----------5. Evidence-based Medicine----------6. Causation AnalysisBy Genovese, E.Hill Criteria of Causation Analysis* Temporality* Biological plausibility* Predictive performance* Gradient* Reversibility* Strength of association (not frequency)* Consistency of association (coherence)* Experimental evidence / Analogy (from animal studies)* SpecificityPresumption = disease process is legislatively determined to result from an exposure or in association with a particular occupation.Precipitation = injury or exposure causes a "latent" or potential disease process to become manifest. For example, having a MI at work that would have occurred anyway.Aggravation = a particular event or exposure permanently worsens a condition.Exacerbation = an exposure or event temporarily worsens a condition.Recurrence = signs or symptoms attributable to a prior illness or injury occur in the absence of a new provocative agent. For example a return of radicular symptoms in a situation that would not be expected to cause such symptoms.Probable = 51% chance or greater.Possible = Between 0 and 50% chance.Causality determination* What happened* What happened since* Other workers?* Happened before?* Medical problems?* Hobbies and stuff?* Like job, supervisor, coworkers?* Doing now?* Past problems with depression or drug use?And* Get collateral records* Get history from employer* Hill criteria consider and/or researchLater* Progressing as expected?* If Sx resolved, will they return if they return to work?* If Sx not resolved, is there a physiological explanation?* If there is a physiological explanation for symptoms, will return to work exacerbate them? If not, are there objective reasons why the patient is not back at work?* If there are no physiological explanation for symptoms, is there a medical reason the person is not back at work?----------7. The Functional Capacity Evaluation: Is it Helpful?20 separate functions can be measured, including walking, sitting, lifting, seeing, hearing, tasting and fingering. FCEs test tolerance, occasionally capacity and not risk. FCE can help measure progress, set goals and measure disability. FCE can measure current ability and match them to a job.If someone reports pain during the test, vital signs at the time should be recorded to see if there is physiologic correspondence to pain levels. Vitals should confirm the stated ability to, for example, lift. Should have data, conclusions and reccomendations that are related to each other.Validity = measures what it is supposed to measure. Reliability = reproducibility of test. Most FCE systems do not have these. Not good at detecting submaximal effort. On was sensitivity of 67% and specificity of 84%.Avoid confrontation by always having the patient do useful stuff from the start, and have RTW on the agenda right from the start. This will mean that work-centered stuff will

be on the agenda from the start. Better outcome if ignore the FCE of back pain and go back to work anyway.----------8. The Medical and Legal Aspects of Return-to-Work Decision MakingWaldner, P.F et al.It is rumored that a lawyer might tell a patient not to go back to work. Can end up as a scam.Questions* Agree best to return to old function* Agree job more important than claim* Do you want me to be truthfulFind out the physical requirements of the job from the patient and the employer. If want to know when they can return to work, ask the insurer or employer.In the USA, the doctor does not have a duty to third parties; if the worker's knee collapses and they drop a girder on someone's head, no problem. Form a friendly relationship with a trial lawyer.The patient's confidentiality always belongs to the patient. On the other hand, if the court insists on records, make sure they are subpoenaed.The disclaimer if you see the file and not the patient is: The opinions in this case are the opinions of the reviewer. The review has been conducted without a medical examination of the individual reviewed. The review is based on documents provided with the assumption that the material is true and correct. If more information becomes available at a later date, an additional service/report/consideration may be requested. Such information may or may not change the opinions rendered i this report. This report is a clinical assessment of documentation and the opinions are based on the information available. This opinion does not constitute per se a recommendation for specific claims for administrative functions to be made or enforced.----------9. Can This Patient Work? A Disability PerspectiveLoCascio, J.WHO disability definition: "... any restriction or lack... of ability to perform an activity in the manner within the range considered normal for a human being."The patient is disabled if their current ability does not meet the needs of the job. Not the doctor's job to determine if stuff can be "reasonably accommodated." The physician does not determine if a patient is disabled, just what they can do.Diagnosis does not equal disability. Diagnoses with pathology or less capacity for hysteria are better but not needed.Impairment does not equal disability. By the above definition of impairment, an elite athlete who gets asthma and can only run an eight minute mile has impairment. They are not disabled, but, yet.Functional capacity = current ability. Patient must be capable of something before they can be restricted. Symptoms in excess of findings are the hallmark of subjective R/Ls. Doctors usually assume that the patient is telling the truth and consciously and unconsciously wants to get better.The test of symptoms in excess of findings in consistency. Dimensions to be consistent in include: time, observers, known syndromes, situations.Psychiatric diagnoses are syndromic in character. On the other hand, can have neuropsychiatric tests and tests with faking scales built in done. Axis V becomes important (!)----------10. Medications, Driving and WorkAronoff,

G. M. et al.Consider: medication, condition the medication is for, synergistic effects of medication, if ability is already reduced. Not able to drive does not mean not able to work unless driving is an essential part of the job. Benzos can increase risk by 50% and TCAs by 100%. Impairment in ability can also impair ability to judge ability. OTCs cam also be a big problem. You must warn the patient about the risk of driving, or you are liable.Effected by* Insight, judgment and poor insight into these* Alertness, reaction time* Vision, dizziness* BP, EPSESynergy with shift work and drowsiness.Ax: Sight, vision (acuity and fields), cognitive and motor. MMSE, using a calculator, trail making B, clock drawing. timed walking 10 feet and turning around, manual test of range of motion, motor strength. Guides are in HCP's Guide to Assessing and Counseling Older Drivers. Others: Aronoff test of reaction time, attn concentration, attention span, concentration, mood/affect.Same rules apply to other stuff where you need to be alert, too.Benzos: impair. Muscle relaxants such as cyclobenzaprine or carisoprodol impair. Opioids probably don't with long-term use.CNS stimulants: should not drive commercially if need these for adult ADHD. The decreased alertness that frequently occurs with dropping blood levels can lead to mistakes.Can enter in the chart "Based on today's evaluation, I find no basis to restrict this patient from driving or working, if he/she so chooses. They know that if at any time, they are not fully alert or if they experience any decrease in mental acuity, they are not to drive or engage in potentially hazardous activities."----------11. How the Primary Care Physician Can Help Patients Negotiate the Return-to-Work/Disability Dilemma.Know the secondary gain and the expectations of the extended family. Communicate expectation of recovery. "Early activation" helps. Health and wellbeing of entire family at stake.----------16. Working with Common Neurologic ProblemsKlimek, E.H.Need an enabling philosophy. All return to work will involve some risk. Gainful employment (here) means competitive employment with reasonable accommodations.Work autonomy means the ability of a worker to pace the work to suite the limitations and is related to the idea of workplace modifications. Without undue hardship to the employer.Can be static or slowly deteriorating. Determination, motivation and effort can overcome established neurological handicaps. Shift work will make worse. Fear avoidance accounts for 70% of back-pain non returns to work.HeadacheMigraine: headache, autonomic, stereotypic, +/- aura. Will be persistent and debilitating rare without: infection, increased ICP, temporal arteritis and head trauma.Acute PTH, up to 8 weeks, otherwise, chronic PTH.In primary headache, risk is not an issue. Capacity is not effected by pain, nausea, fatigue(!) Tolerance is the issue.With return to work, have a challenge of graded activity and exercise with a headache diary and headache scale. The failure to adhere to the

graded increase allows social and personal barriers to emerge and be addressed without being complicated by workplace stressors. So start exposure with work-like activities. Identify that work helps headaches.Debilitating chronic headache rarely occurs without amplification of other, normal body sensations. Patient who experience chronic headache also seem to confuse responsible therapeutic drug use with drug misuse for symptoms common to everyday life, which they understand as warning signs of serious disease. Some thereby express emotional distress constrained only by cultural and familial rules.EpilepsyIn the UK, 53% of employed people with epilepsy chose to conceal their illness. The reasonableness of accommodation is not a medical issue. Crux is prognostication for recurrence for work tasks to be addressed. Patients with first seizures are not a homogenous group. Recurrence within 2 years of first tonic/clonic seizure is as high as 40%.Ask about previous epilepsy-like Sx, EEG within 24hrs of seizure, sleep deprived EEG, MR. Most people have a standard letter about driving and other risks.Consider predictability and aura when considering return to work. The major risk factor might be poor attendance and productivity. Drug side effects can decrease productivity.Risks: driving, heights, machinery. Capacity is usually ISQ. Tolerance is an issue of patient choice.Brain InjuryMild traumatic brain injury (MTBI): headache, dizziness, lethargy, memory loss, irritability, personality changes, cognitive deficits, perceptual changes. If able to follow commands less than one hour after the injury, some studies say no long term problems, other says only 49% chance of "good recovery." MBTI paradox is that can have # and contusions and get back to work, or nothing much and not get back to work.MSKurtzke Extended Disability Status Scale. No risk to self. Tolerance: no mental fatigue in early stages. Fatigue/weakness that can not be objectively defined is a matter of tolerance. Personality changes can be a problem through motivation and effort. Without a limitation of walking (EDSS 4.0 or greater), this is rarely an obstacle to function.PolyneuropathyDriving skills will rarely be effected, but hypoglycaemia and retinal disease can be issues. Risk of falls and hazardous equipment and skin ulceration are risks that might need work restrictions. Capacity and work limitations. Usually no issues of tolerance.----------18. Working with Common Psychiatric ProblemsPro, J.D.See AMA guidelines for evaluation of permanent impairment.Presenteeism is a common problem. More than 80% of lost production occurs with patients who are at work. Understand how symptoms interfere with functioning.Find out about: ADLS, social fn, concentration, ability to tolerate stress, and ifFind out* ADLs +/- instrumentalo Self Careo Communicationo Physical activityo Sensory functiono Nonspecialised hand functionso Sexual functiono Sleepo Travelo Shopping, banking, cleaning* Role functiono Worko Socialo Familyo Spiritual* Ability to tolerate stress* Ability to tolerate work-like events (some

instrumental ADLs)o Personal affairso Meetings* MSEo General MSE, cognitive testing and psychiatric neurological examination and...o Concentration’ Attention’ Memoryo Persistenceo Paceo Pain behaviourso Beliefs about injuries and other’s responsibilityRisk: Occurs in safety-sensitive jobs. Note homicidal ideation to coworkers - not to return home. Paedophilia...Capacity assessment: decreased with psychotic disorders.Tolerance assessment: as discussed.Major DepressionCapacity: cognition, judgment, motor retardation, sleep deprivation. Those with mild depression can work - issue is tolerance.Pain DisorderDistorted beliefs about pain common. Can become suicidal with work. Capacity is not usually decreased but can become reconditioned. Tolerance: involve with setting goals.PTSDHalf resolves in three months. 80% comorbid with other mental disorders such as panic, agoraphobia, MDD and substance abuse. Capacity... modifications and accommodations. Tolerance: desensitization.Adjustment DisorderRisk: if the stressor is conflict with a person at work or a situation at work, the physician may be justified is restricting work. Analogy: occupational asthma. May chose to change employers or careers.Treatment PlanningModerate or marked impairment in work ability without concomitant at least moderate impairment in other areas of mental function does not occur. A few people, because of their job description, might need to be taken off work.Return to WorkDo this when most ADLs are ok and has adequate social stuff, concentration, persistence and pace. Demonstrate tolerance in a work-like setting. Be in control of anger. Side effects of medication should be ok. Stuff organised with the case manager and supervisor. Arrange discussions between the patient and his supervisor as this can dramatically improve work stress tolerance. Patients should agree that they are ready to return to work.----------19. Working with Common Functional Syndromes: Fibromyalgia and Chronic Fatigue SyndromeTalmage, J.B.Risk is not an issue. Capacity is generally not an issue in fibromyalgia. F and CF can have a decreased exercise capacity documented on treadmill testing. See if the test is stopped by fatigue/tolerance long before the predicted maximal heart rate is reached (exercise testing) or anaerobic threshold is crossed (cardiopulmonary exercise testing). If cognitive complaints effect the job, get formal neuropsychological testing. There is no logical reason for temporary work modification because the conditions are long-term.The patient’s plight is similar to that of patients with nonspecific regional arm pain or mechanical lower back pain. Tolerance is not an area of medical science, so reasonable doctors will disagree.

This book is written by physicians for physicians to give some guidance about work restrictions/limitations and uses common sense, art as well as the science in work-related injuires

and illnesses. At the same the authors helps to translate and make sense our of the legal definitions of the work comp world of lawyers, case managers, and employers. I wish I had read a book like this in medical school or residency. Easy to read and understand.

I recommend this book to anyone from physicians to workers' compensation adjusters. It is a great reference for anyone that deals with returning injured employees to work.

A Physician's Guide to Return to Work How To "Ace" The Physician Assistant School Interview: From the author of the best -selling book, The Ultimate Guide to Getting Into Physician Assistant School 2016 ICD-10-CM Physician Professional Edition, 1e (Ama Physician Icd-10-Cm (Spiral)) 2017 ICD-10-CM Physician Professional Edition, 1e (Ama Physician Icd-10-Cm (Spiral)) 2018 ICD-10-CM Physician Professional Edition, 1e (Ama Physician Icd-10-Cm (Spiral)) So, You Want to Be a Physician: Getting an Edge in the Pursuit of Becoming a Physician or Other Medical Professional AMA Guides to the Evaluation of Work Ability and Return to Work The Practicum Companion for Social Work: Integrating Class and Field Work (4th Edition) (Merrill Social Work and Human Services) Live & Work in Belgium, The Netherlands & Luxembourg, 3rd (Live & Work - Vacation Work Publications) Ethics and Professionalism: A Guide for the Physician Assistant Health Care Fraud and Abuse: A Physician's Guide to Compliance (Billing and Compliance) The Healthcare Executive's Guide to Physician-Hospital Alignment Colon Cancer Study Guide; Concise Information That Every Med Student, Physician, NP, and PA Should Know Physician Assistant: A Guide to Clinical Practice, 5e (In Focus) Physician Assistant: A Guide to Clinical Practice, 6e The Ultimate Guide to Getting Into Physician Assistant School, Fourth Edition (A & L Allied Health) My Physician Guide to Congestive Heart Failure: Heart Strong and Healthy Adverse Events, Stress, and Litigation: A Physician's Guide The Ultimate Guide to the Physician Assistant Profession Physician Assistant: A Guide to Clinical Practice E-Book