Worker Disability System Criticized as Destructive

BY BRUCE K. DIXON
Chicago Bureau

CHICAGO — The fundamental cause of most lost workdays and lost jobs attributed to medical conditions is not really medical necessity. Instead, it's uncoordinated, nonmedical decision making that distorts the stay-at-work/return-to-work process employed by the disability benefits system, Dr. Jennifer Christian said at the annual conference of the Academy of Organizational and Occupational Psychiatry.

In addition to being disruptive to employers and wasteful for the economy, needless work disability is destructive to the employee, in that it threatens his or her career and self-esteem and leads to iatrogenic invalidism, Dr. Christian said.

By needless work disability, she meant run-of-the-mill medical conditions that should not prevent a return to work, as opposed to severely disabling injuries.

"We as a society should adopt a work disability prevention model that addresses those behavioral and circumstantial realities that prolong work disability," said Dr. Christian, president and chief medical officer of Webility.md, which describes itself as preventing medically unnecessary disability through Internet-based training and collaboration.

The stay-at-work/return-to-work (SAW/RTW) process determines whether a worker stays at work despite a medical condition or whether, when, and how a worker returns to work during or after recovery, according to the American College of Occupational and Environmental Medicine (ACOEM), which cosponsored the conference.

A work disability prevention model developed late last year by the ACOEM's Stay-at-Work and Return-to-Work Process Improvement Committee points out that a large minority of workers on disability "fail to recover successfully, adopt a disabled self-concept, and experience either a needlessly prolonged absence or a permanent withdrawal from work."

Dr. Christian, who chaired the ACOEM committee, said the SAW/RTW process is ill-suited to detect and effectively address the most important issues related to disability outcomes.

By "medicalizing" the SAW/RTW process and allowing it to function as a series of separate decisions made by several parties, and by failing to acknowledge the powerful contribution that motivation makes to outcomes, a class of invalids is being created, she said.

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DR. CHRISTIAN

"The process often stalls and gets sidetracked by the tendency to focus on corroborating, justifying, or evaluating the disability rather than preventing it. The SAW/RTW process is a team sport and we haven't been playing it like one," said Dr. Christian, who is an occupational medicine specialist in Wayland, Mass.

"If we're going to adopt a work disability prevention model, we first of all have to increase awareness among all stakeholders, including psychiatrists, of how rarely work disability is medically required and how often those days away from work are due to nonmedical things," she said.

In addition, physicians should be paid for disability prevention work to increase their commitment to it, she added.

It is important to support appropriate patient advocacy by getting treating doctors out of their "loyalties binds," Dr. Christian said. "We should be working with employers to accomplish a common goal."

Psychiatrists, drawn into disability issues because of the increasing use of anxiety and depression as reasons not to go to work, often are not trained or prepared to deal with SAW/RTW issues the way they are able to deal with such issues as marriage and other relationships, she said.

Each year, 100 million to 200 million return-to-work information or benefits documents, telephone calls, and e-mails move back and forth between doctors offices, employers, and insurers, Dr. Christian said.

Because there is no standardization of content or format, she said, physicians often resort to improvisation. ■

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