MEDICO-LEGAL ASPECTS OF PAIN:
TOWARDS A BIOPSYPHCHOSOCIAL APPROACH TO CLAIM MANAGEMENT

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Financial Disclaimer

No relevant personal financial relationship
Subjectivity - Objectivity debate

Pain is subjective yet law & policy require objective evidence.

- IASP definition of pain (1994): “An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.”

- Pain without explainable medical pathology commonplace: e.g., Kroenke and Mangelsdorff (1980):
  - survey of over 1,000 patient records in an internal medicine clinic
  - examined somatic complaints (e.g., chest pain, back pain, headache, fatigue, dizziness, numbness, cough, constipation)
  - less than 16% of pain could be attributable to a medical cause
Is Cartesian Model still alive?

- Pain defies biomedical model prevalent in law and disability compensation.
- Pain is not a diagnosis and not an injury.
- Is pain a mental disorder?
- Pain Disorder diagnosis in Diagnostic and Statistical Manual of Mental Disorders (DSM-IV):
  - mind-body dichotomy: either “medical” or “psychological”
  - the word “may” or “appear” occurs 9 times in 10 sentences under “Associated descriptive features and mental disorders” and 3 times in 3 sentences under “Associated laboratory findings” and 3 times in 3 sentences under “Associated physical examination findings and general medical conditions.”
Pain in DSM V

Pain Disorder from DSM-IV has been re-conceptualized in DSM-V as:

• biopsychosocial
• medically unexplained but authentic
• relegated to being a specifier of a new diagnosis
• combined with “old” somatization disorders and hypochondriasis into a new classification of Complex Somatic Symptom Disorder
• somatic symptoms involving signs of distress and dysfunction
• Cluster B: “overwhelming concerns or preoccupation with symptoms and illness”

Concerns

• unclear validity and reliability of diagnosis
• problematic measures
• although recognized as biopsychosocial, still treated as mental disorder
• disconnect between DSM-V and pain & pain disability research; does not stimulate future research and practice advances (Young, 2009)
Causation Problems

Causality determination problems:

• multifactorial causality and/or
• exacerbation of “underlying condition”: “an environmental exposure or behaviour that is associated with an increased likelihood of symptoms does not necessarily cause the underlying condition” (Crites Battié, 2003)
• the “causal” role of occupational factors often modestly or poorly understood; work relatedness difficult to establish
• it is not clear how to establish “causative significance”; “but for” principle is largely discarded in law
Impairment & Disability

1. Definitions of impairment and disability poorly articulated and often confused. Poor correlation between impairment and disability.

2. Impact on work capacity not clearly understood.

3. Motivational and coping factors mediate between impairment and disability yet are difficult to account for in determination of impact on function and work.

4. Ongoing dispute over pain magnification, exaggeration, secondary gain and malingering factors.
Secondary gain and malingering in pain

Myriad of ill-defined “code words”:
- malingering
- faking
- secondary gain
- subjective complaints
- psychological overlay
- illness behaviour
- exaggeration
- symptom magnification
- deception
- lying
Secondary gain and malingering in pain

Anachronistic dichotomous and moralistic thinking:
• malingerer versus “honest”

Simplification of complex motivational processes:
• Most patients have secondary gains
• Secondary gain in isolation from secondary losses
• How to prove intentionality of behaviour?
• “Partial” malingering, gradation of malingering, and exaggeration
• Malingering as self-deception
Issues in assessing secondary gain and malingering in pain

Fragmented evidentiary basis:

- Highly variable and often exaggerated base rates of malingering:
  Realistically: 1.25 to 10.4% of chronic pain patients are probable malingerers (Fishbain et al., 1999)

- Research design problems:
  - paid simulator design: no real malingerers
  - claim status used as proxy for malingering
  - malingered efforts are unreliable
  - studies do not control for factors affecting effort: e.g. pain, fatigue, dissociation, seizures, ADHD, dislike of the assessor or interfering medical symptoms
Issues in assessing secondary gain and malingering in pain

Lack of empirical support for almost all methods of malingering detection, with the possible exception of isokinetic testing (Fishbain et al., 2003) including:

- facial expressions
- forced choice methods
- clinical examination
- grip strength
- isometric techniques

Also, no evidence for association between Waddell signs and secondary gain and malingering (Fishbain et al., 2003, 2004)
New Advances

- Economy of primary, secondary and tertiary (caregiver) gains and losses
- Primary loss: immediate, initial and obvious loss associated with injury
- Primary gain: immediate gain associated with trauma of injury:
  - “one person’s primary loss is another person’s primary gain.”
Secondary losses versus secondary gains

In chronic pain, secondary losses often outweigh secondary gains:

• Losses infiltrate all aspects of life (Leeman, 2000):
  • Autonomy
  • Social relationships
  • Financial stability
  • Employment
  • Familial role
  • Self-esteem
  • General world view
Secondary losses versus secondary gains

- Losses trigger secondary emotional problems:
  - depression and anxiety

- Unclear evidence regarding secondary gains although new research on the concept of perceived fairness and justice may offer explanations (Sullivan et al., 2009; Franche et al., 2009)

- No evidence that secondary gains equate with malingering

- Resolution of compensation or litigation issues does not result in decreased disability
  (Bellamy, 1997; Fishbain et al., 1991; Guest & Drummond, 1992; Mendelson, 1982; Norris & Watt, 1983)
Secondary losses versus secondary gains

• Poor prognosis in disability claims does not equate with secondary gain:
  • reduced responsiveness to treatment (Hadjistavropoulos, 2003);
  • reinforcement of sick role (Turk, 1997);
  • guarding against getting well due to adversarial challenges and fear of denial of disability (Bellamy, 1997)
  • presence of psychiatric conditions
  • difficulty in patient-clinician relationship (Allaz et al., 1998)
Secondary losses versus secondary gains

- Contextual factors: compensation laws, workplace and socioeconomic factors, mixed messages from physicians, IMEs, case managers, claims adjustors, employers and attorneys (Robinson et al., 1992)

- “Social iatrogenesis”: disease production by well-intentioned social programs, issues in patient-physician relationship, somatization and rationalization of symptoms (Bellamy, 1997)
PAIN AND DEPRESSION?

- Depression and psychological distress in general difficult to diagnostically separate from pain
- Effects of pain and depression on function cumulative: this combination may be as work disabling as brain injury
Pain & Cognitive Difficulties


Measurement

• Major advances made:
  - towards biopsychosocial assessment and best practices
    but
  - no standardized, reliable, valid and fair assessment procedures exist.
• Example:
  American Medical Association Guides to the Evaluation of Permanent Impairment:
  ➢ from self-report to evaluation of emotional distress and exaggeration
  ➢ unknown or poor reliability of procedures
  ➢ in low back pain: unknown or problematic convergent and discriminant validity for lumbar flexion, extension and lateral flexion; overlap between normal and pain populations (Hunt et al., 2001; Zuberbier et al., 2001)
  ➢ Also:
    ➢ Assessment of pain behavior in medical examination: problematic reliability (Prkachin et al., 2002)
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<th>Traditional</th>
<th>Biopsychosocial</th>
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<td>1. Assumes either biomedical or mental cause of disability</td>
<td>1. Assumes interaction between mental and physical aspects of disability</td>
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<td>2. Assumes that more physical impairment causes more disability</td>
<td>2. Assumes that relationship between impairment and disability is mediated by psychosocial factors. Beliefs about illness/disability as important as illness.</td>
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<td>3. Assumes that secondary gain and malingering are important and must be detected</td>
<td>3. Assumes that person’s motivation to cope is a function of secondary gains and losses.</td>
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<td>4. Independent medical examinations focusing on diagnosis and credibility of the individual</td>
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<td>5. Assumes that pain and psychological disability are less “real” than medical disability</td>
<td>4. Physical and psychological assessments focus on function, coping, barriers to RTW, and rehabilitation</td>
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<td>6. One-discipline, linear approach</td>
<td>5. Pain and psychological disability are as “real” as medical disability</td>
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<td>7. Case manager focused on entitlement and compensation issues and cost control; relies on health professionals knowing what to do.</td>
<td>6. Multidisciplinary approach</td>
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<td>7. Case manager or designate (e.g., Voc Rehab) an integral part of the rehabilitation/RTW team</td>
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<td>8. Early risk identification and intervention difficult and limited</td>
<td>8. Early risk identification and intervention prevents RTW failure, high costs and duration of disability</td>
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<td>9. Working with the employer: last resort</td>
<td>9. Employer: part of RTW strategy as soon as possible</td>
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<td>10. Contacting family members: rare</td>
<td>10. Family considered important in facilitating recovery</td>
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<td>11. Claimant: to comply with the treatment process set up for him/her</td>
<td>11. Claimant an active participant of the rehabilitation process; responsible for outcomes</td>
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### BIOPSYCHOSOCIAL VS. TRADITIONAL CLAIMS/DISABILITY MANAGEMENT APPROACH IN THE INSURANCE SYSTEM (cont’d.)

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<td>12. Claimants with non-specific pain conditions and those with labour-relations problems, or both, are suspect</td>
<td>12. Claimants who feel confronted or threatened by their insurance companies, tend to want to legitimize their claims; perception of injustice is one of the predictors of disability (Sullivan et al, 2009)</td>
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<td>13. Interventions delayed, sequential, unidisciplinary</td>
<td>13. Early risk identification followed by intervention targeting modifiable individual and workplace barriers; psychosocial factors recognized</td>
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Early Intervention (EI) in the medico-legal context:

1. Risk for disability identification:
   - multivariate predictive models advanced
     but
   - models valid for specific populations, contexts and outcomes
   - generalizability issues
   - issues with sensitivity and specificity

2. Compensation systems reluctant to measure psychosocial factors for risk determination; liability related to misclassification risks & adverse legal outcomes
Early Intervention (EI) in the medico-legal context:

3. Indiscriminate EI unlikely to be effective:

Evidence from recent study:

- Multifaceted EI developed for workers with subacute back pain at WorkSafeBC involving:
  - one-on-one motivational interviewing and reassurance by occupational health nurse from WorkSafeBC
  - occupational health nurse communicating with general practitioner
  - communicating with case manager and other WorkSafeBC staff
  - communicating with and visiting employer prior to RTW

was found to be effective for high risk for disability workers only (not moderate) and after 6 months rather than 3 months (Schultz et al., 2008)
Protocol-driven EI

- Recent randomized version of previous EI in the workers’ compensation setting used flexible versus fixed delivery of EI:
  - Fixed protocol driven EI produced twice as many interventions as flexible EI but the occupational outcomes were similar
  - For moderate risk workers: days paid, total costs and short-term disability costs within 6 months significantly lower for flexible EI compared to fixed EI
  - Positive association between job accommodation and RTW at 3 months for all groups
Conclusions from EI study

1. Workers with LBP at *high risk for occupational disability* constitute a special subset of injured workers with LBP. They likely require a goal-oriented, individualized and intensive interdisciplinary intervention involving the RTW stakeholders and ongoing monitoring intervention to sustain RTW.

2. Workers with LBP at *moderate risk for disability* do not benefit from intensive interventions designed for those at high risk. They likely benefit from flexible need-based, individual and low intensity interventions. For example, in hypertension, flexible interventions more effective than fixed (Linden & Moseley, 2006).

3. Fixed protocol-driven intensive early interventions applied indiscriminately to LBP claimants, and not specifically those at high risk for disability, consume more clinical resources and produce higher costs without evidence of improved outcomes.
Future EI studies in workers’ compensation

1. Control your control group within workers’ compensation
2. Larger N
3. Compare fixed and flexible EIs for different risk categories of LBP workers
4. Control job accommodations over time
5. Long term follow-up
6. Multiple and temporal outcome measurement
Pain in medico-legal context: Advancing research, policy and practice

1. New biopsychosocial definitions of pain, pain disorder, pain-related impairment, and pain-related disability to inform:
   - future research
   - clinical, occupational, disability management and legal/compensation practice
   - policy and legislation

2. Improved understanding of the role of motivational and coping factors, in research and practice, including balancing primary, secondary, tertiary gains and losses.
Pain in medico-legal context: Advancing research, policy and practice

3. Integrate ongoing contributions of neuroscience into understanding of pain, including relationship to distress, cognition and function.

4. Address psychometric issues in measurement and assessment of pain, pain disorders and pain-related impairment.

5. Disentangle multiple determinants and predictors of pain disability using biopsychosocial approach:
   - to implement risk identification:
     - Advance the right predictive model for “the right participants, in the right context and for the right outcome”
     - Balance sensitivity and specificity of the risk identification tool
   - Be aware of the model’s limitations:
     - Caution re: applications to comorbid, complex cases with unique, diverse sociodemographic characteristics, including culture
Pain in medico-legal context: Advancing research, policy and practice

6. In Early Intervention:
   • one size does not fit all
   • focus on workers at high risk for disability
   • address modifiable risk factors
   • integrate clinical, occupational and case management interventions
   • consider Readiness to RTW factors and psychosocial barriers and facilitators
   • significance of workplace factors and work accommodation as a social interaction process
   • flexible versus “fixed” delivery.
Thank you.

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