Disability Prevention Principles in the Primary Care Office

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The simple request for a sick note can disguise important medical, psychologic or social issues. Disability may be influenced by social and cultural factors as well as by patient expectations. Assessment of impairment and subsequent disability is best made on the basis of objective data by use of a biopsychosocial model to ensure that the expression of disability does not mask other unaddressed psychologic or social issues. Enabling prolonged disability in such a situation can be a dysfunctional physician response to a maladaptive process. The physician's role is to treat the condition, to fulfill the appropriate role of patient advocate, to facilitate health (including resumption of activity), to offer proactive advice on the basis of prognosis, to be familiar with the patient's social obligations and resources and to provide education about the therapeutic benefits of returning to optimal function. This factual, medical-based approach offers an effective preventive strategy that will save many patients from unnecessary disability and morbidity. (Am Fam Physician 2001;63:679-84.)

Although busy family physicians may be frustrated when the sole purpose of a patient's visit is to obtain a sick note for the workplace, this simple but sometimes annoying request can disguise more complicated issues. For example, the patient may more urgently need treatment for community-acquired pneumonia than an excuse to give to his or her employer; however, regardless of whether medical attention or only a sick note is required, important disability issues can be identified and favorably dealt with by the astute physician.

Prolonged absence from usual roles, including work, is detrimental to physical, mental and social well-being.[1] It is important for family physicians to recognize the financial impact of disability on our patients. The total lost income for the U.S. work force in 1994 during the first six months of disability was $81.1 billion. A disproportionate $55.2 billion was lost from nonoccupational conditions, $36.2 billion of which was unrecoverable from wage protection programs.[2]

Under current economic conditions, including a shrinking labor force and the passage of the Americans with Disabilities Act, employers have been required to make worksite accommodations and are seeking to extend these for general medical as well as work-related conditions. These trends require physicians to recognize the impact of a health condition on functional and social status. We are challenged to address the interaction between the disabled individual, the workplace and society, and to link medical interventions with strategies to reduce vocational and avocational disability.[3]

Unfortunately, most physicians have not received sufficient training regarding disability prevention practices as a method of secondary prevention—that is, the reduction of disease-associated disability[4] or the therapeutic benefit of optimal activity, including early return to work when appropriate.[5] Although unnecessary disability can be generated by inappropriate prescriptions for bed rest and inactivity,[6] current reimbursement does not recognize the importance of, or adequately compensate, disability prevention practices.

Impairment vs. Disability

To carry out disability prevention principles, a physician must be able to discriminate between impairment and disability. Physical examination and ancillary testing establish impairment, an objective anatomic or physio-

Disability is an impairment-associated curtailment of activities, but impairment does not always lead to disability.

logic deficit. Disability, on the other hand, is an impairment-associated curtailment of activities. Impairment alone does not determine the disability. Other factors—age, general health, education, motivation, satisfaction with job or supervisor[7] and social support—are important effect modifiers.[8] Individuals with the same objective degree of impairment can have different disability outcomes. Disability has a subjective component, determined by the patient's testimony and demonstration as well as by the observations of family, friends, co-workers and employers.

Sick Leave

In turn, sick leave (temporary disability) is not limited to impairment but may also relate to factors such as job stress and burnout or the care of a sick child.[9,10] Sick leave is frequently generated by the patient, with the individual seeking documentation for his or her perceived disability from the physician.[11] Rates of sick leave vary widely between societies. In Poland, the 1994 rate of sickness-related absences averaged 25.1 days for female employees,[12] compared with 7.9 days for employees of the state of Minnesota in the United States (unpublished data from the State of Minnesota Department of Employee Relations). A small segment of the population accounts for a disproportionate amount of disability. Ten percent of one working population in an Israeli study[13] was found to be on nonaccident sick leave for more than 20 days. This group averaged 11 episodes of sick leave per employee, 4.9 days per episode, and 54 days per individual per year. Such marked variations suggest that disability has important social determinants.[5]

Strategies to Assist in Returning to Work

Although prolonged absence may create a "point of no return," with less than one half the disabled workers in one study[14] returning to work after an absence of eight weeks, early efforts to help the patient regain function appear to be effective. For example, the risk of developing chronic pain in patients with an initial acute musculoskeletal condition was eight times lower for an "early activation" group compared with usual care.[15] Early return to activity helps patients avoid illness reinforcers, such as disability income, family and community sympathy, reduced responsibility and assumption of disability, as a method to resolve conflicts.[16-18]

Another important component of disability prevention relates to the biopsychosocial paradigm.[19] Biologic health has long been a recognized physician domain, with increased attention focused on mental health issues in the past 30 years. Similarly, we are now increasingly aware of the impact of lifestyle

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and social factors, such as employment, on health status.[20] We now appreciate the potential for unfavorable interaction between biologic deconditioning, psychologic depression and the social isolation and lost opportunities that result from prolonged separation from usual activities.[18]

The risk of developing chronic pain in first-time sufferers with acute musculoskeletal problems was eight times lower in an "early activation" group compared with usual care.

Importance of the Physician-Patient Relationship

The effective implementation of disability prevention practices relies on a successful physician-patient relationship. It is essential to make a positive connection and demonstrate a sincere interest by listening closely to patients' concerns, including their perspectives on how the condition may influence their activities and lifestyles. Discussing the illness or injury in light of its natural history and prognosis can alleviate anxiety and further facilitates discussion regarding lifestyle and activity. An activity prescription or plan can help patients remember the details and anticipate changes in activity level.

It is also important to recognize that patients may be physically, psychologically or socially unable to return to work. Most patients with febrile pneumonia or who have lost a family member, for example, will do better if they are away from vocational activities for a short while. Prescriptions for bed rest should only be used with recognition of the risks, including muscle atrophy, cardiopulmonary deconditioning, bone mineral loss, risk of thromboembolism and perception of severe illness, as well as the economic consequences of time away from work.[21] In these situations, it is advisable to schedule a return visit in the near future to follow up on the patient's condition and to continue the discussion of appropriate activity after the period of incapacitation.

Assessing the Patient's Capacity for Activity

In the absence of complete disability, the next consideration is the capacity of the patient for activity. While firefighting with a healing fracture of the radius would be inadvisable, desk work may be appropriate. Reduced endurance and effort arising from a medical condition can also be accommodated, if necessary. Occasionally, the employer will not have accommodations available, preventing the patient from returning to work until completely able to perform his or her usual tasks. The return-to-work process ideally relies on patient and employer negotiation. If accommodations are required, the physician can provide appropriate activity recommendations once patient permission has been obtained.

The discussion of appropriate activity relies heavily on the physician's understanding of the pathophysiology and natural history of the impairment, as well as on the level of disability that may be reasonably expected. For example, most patients with the impairment of a mild to moderate ankle sprain can expect some difficulty with bearing weight for seven to 10 days but can expect significant improvement thereafter. Avoiding excessive weight bearing for the first week, followed by gradual resumption of activity with follow-up if the anticipated course of recovery is not realized, would therefore be reasonable advice on the basis of what we know about this condition.

Factors That May Delay Recovery

Factors that may delay recovery should also be considered. For example, an obese patient with type 1 diabetes (formerly known as insulin-dependent diabetes) may benefit from an early referral to physical therapy to help with early mobilization and to avoid other complications, such as thrombophlebitis.

The most effective tools in facilitating return-to-work strategies are compassion and understanding combined with firm therapeutic goals.

Similarly, a patient with a history of significant disability in the past can be evaluated early for economic, legal, psychologic or other factors that may need to be addressed to avoid a repeat episode of delayed recovery.

Physical limitations out of proportion to the diagnosis could signal misdiagnosis or complicating psychosocial factors. A related consideration is the determination of appropriate recovery periods. Even allowing for individual variability, physicians have a wealth of information about the usual natural history of most conditions. Just as unexpected types of limitations should be measured against pathophysiology, so should prolonged recovery periods be compared with the typical prognosis.

Prolonged disability should prompt diagnostic review and a search for unrecognized psychologic or social factors. Attention to the course of activity recovery has the advantage of being a patient-centered approach based on the patient's best interests. If risk factors for delayed recovery *(Table 1)* are recognized early, intervention strategies, including appropriate referrals, can be formulated. Discussing these concerns with the patient may also lead to insight regarding specific issues, which may diffuse potential problems. This approach enables physicians to determine appropriate activity and to assess patient reports with respect to their biologic, psychologic and social significance.

If the diagnosis is correct, perpetuation of physical limitations past the time of biologic necessity produces iatrogenic harm through deconditioning while not providing treatment to psychologic or social factors, which may contribute to undesirable outcomes. Enabling prolonged disability is a dysfunctional physician response that risks iatrogenic injury within an already maladaptive process.

TABLE 1
Risk Factors for Delayed Recovery

Personal or family history of prolonged disability
Symptoms or disability out of proportion to diagnosis
Perceived exaggerated pain behavior
Dysfunctional family dynamics
History of physical or other abuse
Chemical dependency
Depression
Job dissatisfaction
Workplace friction
Economic or legal factors
Underlying medical conditions

Principles of Good Physician Interaction

Useful principles outlining an optimal physician interaction with the patient and employer when dealing with return-to-work issues have been articulated by the Canadian Medical Association; these are summarized in *Table 2*.[1]

Application of these principals can assist the family physician with effective disability prevention practices to help their patients achieve optimal physical and vocational recovery and avoid unwarranted disability and resulting morbidity.

Ultimately, the physician's role is to treat the condition, to fulfill the appropriate role of patient advocate, to facilitate health (including resumption of activity), to offer proactive advice on the basis of prognosis, to be familiar with the patient's social obligations and resources, and to provide education on the therapeutic benefit of returning to optimal function with the knowledge that such factual, medical-based opinions present an effective preventive strategy. Referral to other health care professionals, such as physical

TABLE 2
The Physician's Role in Helping Patients Return to the Workplace After an Illness or Injury

Encourage early communication between the patient and employer.
Be familiar with the patient's family and community support systems.
Engage in early patient discussion of expected healing and recovery times and the role of early, graduated activity increase on physical and psychologic healing.
Be knowledgeable about, and use appropriately, the services of a multidisciplinary team of health care professionals.
Recognize that ultimately the employer determines the type of work that is available and the feasibility of accommodating the physician's recommendations.
Obtain, when appropriate, information regarding workplace policies, in-house resources, essential job demands and possible workplace health and safety hazards.
Be as specific as possible when describing the patient's capabilities to work.
Consider task limitations in light of the job demands, schedule modification, environmental restrictions, medical aids or personal protective equipment.
Be aware of the risks to the patient, co-workers or the public that could arise from the patient condition or drug therapy and put public interest before that of the patient.
Respect the patient's right to confidentiality.
Consider referral to an occupational medicine physician if conflict between employer and employee or other complication arises.
Obtain all relevant medical records when seeing a patient with a longstanding condition for the first time before offering advice regarding safe, timely return to work.
Clearly inform the patient when the physician believes that the patient has recovered sufficiently to return to work safely.
Provide a copy of the return-to-work documentation prepared by the attending physician to the patient.
Counsel the patient on preventive strategies whenever possible.

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therapists, mental health professionals and social workers, can also provide invaluable help in specific situations.

It is essential, however, that in order to implement these strategies effectively, the family physician should recognize that the most effective tools, as outlined by Welter,[22] must be compassion and understanding combined with firm therapeutic goals.

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