Supporting Return to Work for People Living with Pain
Application of the principles of interdisciplinary treatment

Pain BC Conference, October 20, 2012

Case Study #1

Margaret Johnson was a 40 year old right handed Care Aid. She was injured in November 2009 while assisting with transferring a patient. She had immediate onset of pain in her right shoulder, but managed to finish her shift since the discomfort was not excessive at first. She was initially treated with anti-inflammatory medications by her Family Physician, followed by a cortisone injection, both of which were not helpful in alleviating her symptoms. Since the pain and stiffness in her shoulder were not getting better, she had to modify her work hours, but continued working.

In February 2010 Ms. Johnson was assessed by an Orthopedic Surgeon who felt that her pain was caused by soft tissue injury. He also queried a possibility of her developing Complex Regional Pain Syndrome (CRPS). A further diagnostic assessment concluded that she did not meet the criteria for CRPS. An MRI Arthrogram was performed in April 2010 which showed no obvious pathology around her right shoulder joint. A CT scan of her cervical spine showed no evidence of disc disease and no indication of degenerative facet joint disease. She was treated with physiotherapy which she found ineffective. She had tried a Graduated Return to Work (GRTW) two times, but was unsuccessful each time.

In June 2010 the Orthopaedic Surgeon performed an arthroscopic subacromial decompression consisting of acromioplasty and synovectomy. His post operative diagnosis was chronic impingement syndrome of the right shoulder. Ms. Johnson then attended an Occupational Rehabilitation 1 Program, followed by 10 weeks Occupational Rehabilitation 2 Program. During the OR2 Program she had a “severe relapse”, which took her 6 weeks to recover from. She then started a Pain Management Program and in mid January of 2011 she began her third Graduated Return to work.

What else would you want to know that might help you better determine whether features of chronic pain syndrome (pain disorder?) were present and/or in need of attention?

Sample answer:
Sleep patterns, reliance on medications, mood, social isolation, expectations for recovery, claims concerns, catastrophizing/anxiety presentation, work environment/relationships, past injury history, past social history.

Further information: Over the course of treatment the following pieces of information were obtained or observed.

Trauma history
Significant obesity
Relational Concerns
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Would having this information about Ms. Johnson change your approach for treatment? If so, how?

Sample answer:
Knowing the history would highlight red flags that there could be a higher risk of condition becoming chronic. Working on more “chronic” approaches earlier in the treatment plan, even if still “acute” may be beneficial.

Positives for this case

1. Ms. Johnson remained connected to her workplace. This was important as it allowed her to maintain several supportive relationships and led to ongoing joint expectations for return to work. Essential, especially after ‘unsuccessful’ GRTWs.
2. Thorough and timely medical investigation. This prevents the common pattern of diagnostic uncertainty or delay perpetuating avoidance behaviours, deconditioning and disproportionate focus on pain symptoms.

Setbacks or Down Sides

1. Significant delay before Ms. Johnson was exposed to central principles and practices of managing chronic pain symptoms.
2. Depressive symptoms had become entrenched and were in need of pharmacological and psychological response.
3. Social support structure had not adapted well – this relates in part to change in family dynamics, role clarity and lack of awareness about chronic pain and how to manage it within the family context.
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Case Study 2:

When is a Disability Medically Required, Medically Discretionary, or Medically Unnecessary?

(Source: ACOEM Practice Guidelines, 2nd edition, Chapter 5, Cornerstones of Disability Prevention and Management, pp 80-82)

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<td>Absence is medically required when:</td>
<td>Medically discretionary disability is time away from work at the discretion of a patient or employer that is:</td>
<td>Medically unnecessary disability occurs whenever a person stays away from work because of non-medical issues such as:</td>
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<td>• Attendance is required at a place of care (hospital, physician’s office, physical therapy).</td>
<td>• Associated with a diagnosable medical condition that may have created some functional impairment but left other functional abilities still intact.</td>
<td>• The perception that a diagnosis alone (without demonstrable functional impairment) justifies work absence.</td>
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<td>• Recovery (or quarantine) requires confinement to bed or home.</td>
<td>• Most commonly due to a patient’s or employer’s decision not to make the extra effort required to find a way for the patient to stay at work during illness or recovery.</td>
<td>• Other problems that masquerade as medical issues, e.g., job dissatisfaction, anger, fear, or other psychosocial factors.</td>
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<td>• Being in the workplace or traveling to work is medically contra-indicated (poses a specific hazard to the public, coworkers, or to the worker personally, i.e., risks damage to tissues or delays healing).</td>
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<td>• Poor information flow or inadequate communications.</td>
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<td>• Administrative or procedural delay.</td>
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Parm Sidhu, 36-year-old truck driver, drove his 16-wheel truck into the ditch to avoid hitting an unobservant driver. He is a non-English speaking man who lives with his wife’s parents, his wife and his three sons aged 16, 14 and 9. He reports having a “very sore back” and had an unsuccessful 6 week stint with physiotherapy. The initial diagnosis was of an uncomplicated low back-strain (no radiating/neurological symptoms). Due to ongoing pain, Mr. Sidhu was referred for an MRI by his family physician to rule out discogenic concerns. His pain reporting had begun to include reports that “the pain is moving around.” He also had begun to report a symptom of “heaviness across his forehead” which he connected to his back pain. The MRI review (no specific findings on MRI) recommended non-surgical, conservative interventions a exercise.

Based on findings, Mr. Sidhu was referred by WorkSafeBC to an Occupational Rehabilitation 2 Program. Mr. Sidhu attended 18 out of 20 days of the OR2 program, a Job Site Visit was conducted and it was agreed with the employer that Mr. Sidhu could return to work as an extra driver with modified duties. After 4 weeks of the program, it was determined that he was functioning at a level that would enable him to begin a GRTW. A day prior to the GRTW Mr. Sidhu called his employer, stated that wasn’t ready to come back because of too much pain.
Around this time Mr. Sidhu returned to his family doctor and reported that he was unable to follow the prescribed return to work plan because of “too much pain.” Mr. Sidhu also recalled the recent conversation with his employer in which he stated “my boss says I can’t come back now until I’m 100%!” Mr. Sidhu became angry and began to assert that “there must be something still wrong with me or I would be better by now. I have done everything asked of me. I’m doing my best! Why aren’t you helping me?”

Mr. Sidhu’s Case Manager referred him to the Pain Management Program which he started but stopped after four days due to too much pain. He is reporting to his family physician that there must still be something wrong. His Case Manager has suspended his claim.

Mr. Sidhu is experiencing significant financial strain, reports sleeping three hours per night and has begun to drink 5-6 alcoholic beverages per day as a way to “deal with the stress.”

**Discuss the following questions.**

1. **Where would you locate Mr. Sidhu on the above table?**
2. **At what point does Mr. Sidhu move from column 1 to column 2? From 2 to 3?**
3. **What are the indicators that he is moving from column 1 to 2, and 2 to 3?**
4. **Where to from here? What other problems could develop here with Mr. Sidhu?**
5. **What interventions might have prevented a worsening picture?**

**Sample answer**

1. Column 3
2. Return to work attempt would be ideal after 4 weeks of community physiotherapy, therefore move to column 2 at this time, move the column 3 following return to Family Physician with complaints of pain and argument with employer.
3. Column 1-2: no progress with physiotherapy, no exploration of return to work by patient/therapist/WSBC/employer/Family Physician, new investigations looking for medical fix. OR2 program GRTW- not completed due to patient report of pain. Employer has modified duties available at this point. Column 2-3: not attending Pain Management Program but it was known from OR2 program that function is sufficient to commence a GRTW, argument with employer, use of alcohol, communication difficulties, belief of no medical closure, financial stress, family stress, claim suspended.
4. Requires more “chronic” approaches with holistic approach looking at case through a biopsychosocial lens. Alcohol use could continue to increase. Medication use could increase, family breakdown, worsening financial picture, deconditioning, pain increase.
5. Interventions (not an exhaustive list)
   - education regarding pain physiology and pain vs. damage
   - education around low back pain
   - instruction from health care providers (physio, OR2 program and Family Physician) that exercise/participation in rehabilitation is best treatment
   - return to work discussion early on ?first visit?
   - discuss expectations of patient