CLINICAL PRACTICE

How to Determine Whether Our Patients Can Function in the Workplace: A Missed Opportunity in Medical Training Programs

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ABSTRACT

Patients often hand their physicians disability forms, and physicians too often struggle to complete them. Many physicians lack the training to complete these forms. This article aims to provide a clear understanding of impairment, limitations, restrictions, and disability. It explains how physicians can use skills they already possess to appropriately assess limitations, restrictions, and functional capacity, and it explains why accurate determinations are a vital part of good patient care.

INTRODUCTION

A 41-year-old warehouse worker arrives in your office with a complaint of chronic low back pain and requests that you complete a disability form.

Three open questions are posed to all practicing physicians and to physicians in training:

1. How comfortable are you addressing medical questions in the assessment of disability of your patients?
2. Have you had, or are you receiving, the appropriate medical training to adequately address medical questions on the limitations and/or restrictions that your patients may have because of their medical conditions?
3. Do you see this type of medical assessment as more of a nuisance that takes you away from providing your patients with the level of care that they need; or do you see this as an important part of the medical care that you provide for your patients?

It is not surprising that many physicians feel uncomfortable addressing medical questions in the assessment of disability for their patients. Physicians want their patients to be pleased with their care; they work to avoid discord with their patients; and they view themselves as advocates for their patients. But does being an advocate for your patient mean doing what your patient wants, or does it mean doing what is medically best for your patient?

DEFINING DISABILITY

The terms used in making a disability determination are *impairment, limitations, restrictions,* and *disability. Impairment* is the loss of structure or function, physically or mentally, because of disease or injury. A *limitation* is an activity that a person would be physically or mentally incapable of performing, even if s/he wanted to perform it, because of an impairment. A *restriction* is an activity that you would not allow a patient to perform, even if that patient were capable of performing it, because of an unacceptable risk resulting from that patient's impairment. The same restrictions should apply to all individuals with the same level of impairment.[1] For example, during a grand mal seizure, a patient would be limited from driving a car, but after the seizure is over, that patient would also be restricted from driving until seizure free for a time interval according to state law.

Disability is a determination usually made with medical, vocational, and legal input. For physicians to be comfortable and confident in their assessment of disability, they must focus on their medical assessment of impairment, limitations, and restrictions—what we term the medical aspects of disability—and avoid involving themselves in the vocational or legal aspects of disability.

The definition of disability depends on the organization defining it. The World Health Organization, the United Nations, the Americans with Disabilities Act, the Social Security Administration, and private insurance companies may all define disability differently. For private disability companies, the definition of disability may vary among insurers and may even vary between policies issued by the same insurer.

If the practicing physician stays within the role of addressing functional ability by accurately describing limitations and/or restrictions, it should not matter (to the physician) who is defining disability. If the medical record documents the appropriate limitations and/or restrictions that a patient needs to follow because of impairment, and the physician recommends medical accommodations or assistive devices that would improve safety and maximize functional ability or resiliency, then patient care would improve and the documentation in the medical records might eliminate the need for disability forms as currently written.[1-3]

GAPS IN TRAINING

A review of the literature reveals a paucity of studies as to whether medical training programs in the US provide structured training for residents and fellows on the medical aspects of disability. We have encountered widespread physician discomfort and inconsistent training when it comes to disability applications and assessing patients' functional ability. Many physicians view completing disability forms for private insurance companies or the Social Security Administration as a tedious exercise. In the absence of effective training, physicians may not view medical assessments of disability as their role and may fail to appreciate why such assessments are an important part of their patients' medical care.

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In a 2013 study, a clinically integrated postgraduate training program in evidence-based medicine was shown in the interventional group to result in more evidence-based disability evaluations than in the control group.[4] These findings demonstrate the ability of an educational program using multiple methods in a supportive professional context to change physician behavior.[4] A good clinical assessment of function is a valuable clinical skill to cultivate for all physicians. Disability forms should not detract us from the important medical decisions that must be accurately and appropriately made to provide our patients with the level of care and services they deserve.

DETERMINING FUNCTION

An accurate medical determination of functional ability is essential for the physical and mental well-being of our patients and should be considered an aspect of high-quality health care. There is considerable literature demonstrating the association of adverse health outcomes with unemployment, the increased risk of death with unemployment, and that unemployment is a risk factor for poor health.[2,5-8] Such studies accentuate the need for physicians to make accurate determinations when assessing functional ability in the presence of an impairment, and when assessing limitations and restrictions for patients with impairments.

This can be accomplished only by taking an accurate medical history, conducting an adequate physical examination, appropriately interpreting test results, and recognizing the consistencies and inconsistencies between what is reported and what is observed. Only then is the physician able to make determinations on limitations and restrictions that reflect reality. When a patient reports that chronic low back pain prevents adequate focus and concentration when sitting at work, a physician should question whether the patient is able to focus and concentrate when driving. When a patient reports that severe shoulder or arm pain has precluded the lifting of more than 5 lbs on a long-term basis, a physician should look for signs of atrophy on examination and observe how the patient moves his/her arm in the physician's office.

ASSESSING LIMITATIONS AND RESTRICTIONS AS PART OF GOOD PATIENT CARE

Physicians must use the same skills in assessing limitations and restrictions that they use to make other accurate diagnoses: Correlating a patient's symptoms with astute observations and examination findings, recognizing consistencies and inconsistencies, and formulating opinions that reflect sound medical reasoning. When individuals are symptomatic from impairments, they turn to their trusted physicians not only for evaluation and treatment but also for guidance on rest, activities, and any needed restrictions. Patients' perceptions regarding recovery and coping with their impairments are influenced by their environment, including the workplace, family, and social networks. Patients can also be powerfully influenced by the attitude, approach, and style of the treating physician, especially in the early weeks and months of impairment.

A physician's care should focus on maximizing the functional ability and resiliency of his/her patients while appropriately advising patients on avoiding activities that greatly compromise their safety and well-being. Just because a patient has an impairment does not mean that a patient is unable to work. A physician should not agree to support disability simply because the patient feels that s/he should not have to work with an impairment, and a physician should not document limitations or restrictions before determining consistency with the patient's history, examination findings, test results, or activities observed by the physician.

Physicians should avoid inadvertently contributing to "iatrogenic disability." Examples include 1) disability caused by the inappropriate use of medication resulting in greater restrictions or limitations than the condition being treated, such as long-term narcotic therapy for nonmalignant chronic pain syndromes, or 2) inappropriate medical advice that further compromises the patient's well-being and functional ability, such as the inappropriate prescription of rest and inactivity for chronic lower back pain instead of a prescribed monitored graduated exercise program.

RECOMMENDATIONS

According to Talmage et al,[5] "The American Medical Association encourages physicians everywhere to advise patients to return to work at the earliest date compatible with health and safety and recognizes that physicians can, through their care, facilitate patients' return to work." Have physicians received the training needed to ensure that they are able to provide their patients with both the advice and the care needed to make the appropriate medical determinations to successfully meet the American Medical Association's recommendations? Do health care leaders and health care organizations have any interest in evaluating physician's performance relevant to the medical aspects of disability?

Because unemployment and disability are linked to adverse health and well-being, a sound medical assessment of disability is part of good medical care, and an inappropriate medical assessment of disability represents a failure of good patient care. Organizations such as the National Committee for Quality Assurance that develop clinical metrics for quality should be encouraged to develop similar metrics to assess medical certification for disability. Medical schools and postgraduate training programs should take responsibility to provide training on the medical aspects of disability, and state medical boards should advocate for periodic continuing education on this topic.

In the name of good patient care, let the training begin. ❖

Disclosure Statement

The author(s) have no conflicts of interest to disclose.

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Grappling

The problems of disease are more complicated and difficult than any others with which the trained mind has to grapple; the conditions in any given case may be unlike those in any other; each case, indeed may have its own problem.

— William Osler, MD, 1849-1919, physician, pathologist, teacher, diagnostician, bibliophile, historian, classicist, essayist, conservationalist, organizer, manager, and author