Iatrogenic Disability

Avoiding Needless Illness Behavior and Dis/ability - Focusing on Function

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What is your estimate of the percentage of individuals who currently receive long-term disability benefits that are truly disabled and unable to carry out meaningful work?

40%

Not truly disabled

Truly disabled

Impact

What are 10 key questions?

1. Why do some people become disabled, and others do not?
2. Why do some people with the same extent of impairment achieve high levels of performance, and others do not?
3. What are the risk factors for illness behavior and delayed recovery?
4. How do we hold people and systems accountable?
5. How do we support self-responsibility?
6. How do we deal with systems which demand proof of illness?
7. How do we avoid blaming the “victim” of dysfunctional “systems”?

8. What is the potential value of work?
   - Transcends the remuneration received
   - Provides a skill, an identity, and a sense of accomplishment
   - Key determinant of how one perceives one’s health

According to a 2001 survey of 235 physicians involved in disability evaluation

According to a 1998 survey of Occupational Medicine Physicians

Up to 80% of paid indemnity expense is unnecessary ...

Managed Comp Survey - April 1998
9. Why do we tolerate a society which appears often to foster disability?

10. Why do we tolerate a medical system which, from time to time, creates disability?

Key Questions

Learner’s Objectives

1. Identify characteristics that distinguish high-performers from those needlessly disabled
2. Explain the concepts of iatrogenic disability, delayed recovery, illness behavior and somatization
3. Describe how to avoid iatrogenic disability
4. Demonstrate the ability to empower patients

What are 10 key questions?

“I seem to have been only a boy playing on the seashore, and diverting myself in now and then finding a smoother pebble or prettier shell than ordinary, whilst the great ocean of truth lay all undiscovered before me.”
(Sir Isaac Newton)

“Needlessly disabled

Pain

Impairment

Disability

Definitions

Impairment vs. Disability

- Impairment
  - “Loss of, loss of use of, or derangement of body part, system, or function” – a medical determination (often determined by the AMA Guides to the Evaluation of Permanent Impairment)

- Disability
  - Subjective impact of the impairment on a person’s ability to function in life activities.
  - Gap: what one needs to do ……what one can do (or willing to do)

Contrast

- Needlessly disabled
  - Individual perceives themselves as disabled, despite minimal impairment(s)

- Exceptionally capable
  - Individual is dynamic and productive with his / her life, despite significant impairment(s)
Definitions are needed to permit a common language – prior to exploring these issues.

Our traditional medical training often has not provided an adequate conceptual basis or means to communicate about illness behavior or understand iatrogenic disability.

**Illness behavior**

- Adoption of the “sick role”
- “the manner in which individuals monitor their bodies, define and interpret symptoms, take remedial action, and utilize sources of help”

**Illness behavior: a spectrum**

- Unconscious Symptom Exaggeration
- Psychiatric Disorders and Malingering

**Symptom magnification**

- Increased expression of symptoms in excess of that expected; (cry for help)

“A conscious or unconscious self-destructive socially reinforced behavioral response pattern consisting of reports or displays of symptoms which function to control the life circumstances of the sufferer.”

Learned pattern of illness behavior

- Refugee
- Game player
- Identified patient

**Malingering**

- Intentional claims of false or grossly exaggerated symptoms for financial gain, avoidance of military duty, work or criminal prosecution or obtaining drugs

- Co-malingering

- Cooperative manipulation and subversion of private or public disability system; not always intentional, supported by the system it seeks to deceive
- A function of conflicting self-interests, labor relations, and gaps in disability management
### Comparison of Features

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<td>Identified Patient</td>
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### Definitions

**Distortion, Deception, Misattribution**

- **Distortion**
  - Unintentional or intentional misrepresentation of events.
- **Deception**
  - Inducing a false belief in another.
  - Conscious distortion of behaviors or self-report.
- **Misattribution**
  - Claim deficit due to false cause rather than true cause.

**Faking bad**

- Malingering, false imputation, simulation.
- Exaggeration or fabrication of symptoms and negative features.
- Denial and/or minimization of positive traits.
- Misattribution of deficit to false cause.
- Always involves looking worse, more dangerous, sick, or negative than one is to achieve a desired outcome.
- Vs. Faking Good

**Secondary gain**

- Contributes to illness behavior
  - Manipulation of relationships
  - Privileges of the sick role (sanctioned dependency)
  - Financial gain
  - Communication of ideas or feelings that are blocked
  - Intrapsychic defense mechanisms
  - Attention of health care providers, access to passive, “feel good” modalities
  - Relief from occupational and home responsibilities

### Personality Disorders

- Enduring patterns of inner experience and behavior that deviate from those expected by the individual's culture
- Commonly seen in the IME setting, particularly with cases of “delayed recovery:
- Ten personality disorders are divided into three clusters

**Cluster A Personality Disorders**

- **Paranoid Personality Disorder**
  - Person suspects, without sufficient basis, that others are exploitive, harmful or deceitful, is probably the most common in the legal arena.
- **Schizoid Personality Disorder**
- **Schizotypal Personality Disorder**
Cluster B Personality Disorders

- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder

Cluster C Personality Disorders

- Avoidant
- Dependent
- Obsessive-Compulsive

Negative affectivity

- Tendency to report a wide range of psychological symptoms and emotional distress: low self-esteem, guilt, anger, self-consciousness, anxiety, and hostility
- Correlated with negative appraisal of one’s physical health

Hysteria

- Behavior that produces the appearance of disease
- Mimics culturally permissible expressions of distress – great pressure on the unconscious mind to produce only legitimate symptoms
- Universal human response to emotional conflict

Hysterical epidemics

- Physician enthusiasts and theorists
- Unhappy, vulnerable patients
- Supportive cultural environments
- Interactive and evolving process

Somatization disorder

- “Conscious or unconscious use of symptoms for psychological purposes or personal gain”
- Propensity to:
  - experience and report somatic symptoms that have no pathophysiologic explanation,
  - misattribute them to disease, and
  - seek medical attention for them
Effects of Somatization
- Estimated to represent 5 – 40% of patient visits
  - Make greater resource use
  - Assume sick role
- Physicians often ignore psychosocial influences
  - Specialists especially
  - Also providers who benefit from providing unneeded services
    • passive interventions; unneeded modalities, manipulations, and surgeries

Common Somatic Complaints
- Complaints
  - Low back pain
  - Neck pain
  - Shoulder pain
  - Hand/wrist pain
  - Headache
  - Tinnitus
  - Pelvic pain
  - Dizziness
- Syndromes
  - Fibromyalgia
  - Chronic Fatigue
  - Multiple Chemical Sensitivity
  - Toxic Mold

Determinants of Perceived Health Status
- Study of medical outpatients screened for hypochondriasis
- Self-rating of health status correlated with:
  1. Hypochondriacal attitudes ($r = 0.79$)
  2. Tendency to somatize ($r = 0.77$)
  3. Functional disability (reported) ($r = 0.62$)
  4. Psychiatric morbidity ($r = 0.48$)
  5. Aggregate medical morbidity ($r = 0.36$)

The Effects of Medicalization of Complaints and ‘ Syndromes’
1. Amplifies distress and concern
2. Fosters somatization
3. Declining tolerance, threshold for self-limiting symptoms
4. Functional somatic syndromes amplified by the media
Illness behavior

- Mistaken beliefs
- Refusal to consider alternative explanations of symptoms
- Misattribution of symptoms
- Falsification of information
- Fabrication of complaints
- Manufactured disease
- Exaggeration for profit or revenge

Determined by multiple factors:

- Systems context:
  - Disability systems
  - Litigation and Workers' Compensation
- Cultural context
- Social Network
- Personality and life experience
- Response of the health care system

Iatrogenic disability

Disability caused by the health care system, as a result of:

- Incorrect or incomplete clinical assessment (physical, behavioral, psychosocial and psychological)
- False attribution to the etiology of the problems
- Failing to recognize and reinforcing dysfunction behavior

– Inappropriate diagnostic and treatment interventions
– Failure to promote function and effective return to work

Medicalization

- Invocation of a medical diagnosis to explain physical discomfort that is not caused by disease
- Application of a medical intervention to treat it
- Examples range from labeling of pain disorders to functional somatic syndromes (fibromyalgia, chronic fatigue syndrome, multiple chemical sensitivity, toxic mold)

Delayed Recovery

1. Attitude: challenge, positivity / catastrophe
2. Beliefs, expectations, perceived demands
3. Locus of control
   - Perceived by individual - Internal vs. External
   - Actual control
4. Mood
5. Coping style, capacity, and skills
6. Sum of stressors
Predictors of Chronic Disability in Injured Workers

- Older age
- Greater reported baseline pain and functional disability
- Perception of inability to return to work
- Dysfunctional personality traits / disorders and psychological problems
- With back pain, a specific dx (“disc disease”) vs. dx of “nonspecific back pain”

Occupational and Psychological Profiles of People Disabled by Soft Tissue Injuries – Low Back Pain (Colledge)

- Job dissatisfaction, monotony and stress
- Depression, anxiety, hypochondriasis, hysteria
- Legal entanglement

When we assess overall what typically occurs in the “care” of spinal pain, would patients have better functional results if they did not access the “health care” system?

Hippocrates 350 BC

*Primum non nocere.*
(First, do no harm.)

Need to:

Explore dis/ability within the context of the illness experience and individual vulnerability and socioeconomic influence

Understand what promotes performance and facilitate the development of full potential of the individual.
Develop a society which encourages performance and prevents dis/ability, not one which creates and reinforces disability.

Make a difference.

Create empowered individuals who achieve their dreams.

What steps will you take to accomplish this vision?