Workers' Compensation, Fibromyalgia, and Kafka

In this issue of *The Journal* Mary-Ann Fitzcharles and colleagues present statistics describing the appeals process for patients with “fibromyalgia” (FM) whose indemnity claim for workers’ compensation had been denied by the Workplace Safety and Insurance Board (WSIB) of Ontario, Canada¹. No doubt these descriptive statistics will be of interest to and even have use for those involved in this process in Ontario. They may even be relevant to actuaries and policy-makers in other jurisdictions. But are they of interest to anyone else? In particular, are they of interest to rheumatologists who are not involved in the workers’ compensation indemnity scheme of Ontario?

I will argue the affirmative; this process is a window on the social construction of illness and on the role of the physician in determination of disability. I have a personal bias in that this fascination has captured a great deal of my scholarly efforts for many decades. A recent monograph bears witness and hopefully can imbue the reader with a similar level of interest².

Workers’ compensation indemnity schemes made landfall in North America almost exactly a century ago. However, unlike the Prussian precedent that swept Europe country by country, this species of social legislation was met with a politic that resulted in distinctive programs in each Canadian province and American state. All these schemes were designed to serve a particular ethic: any worker who is injured in the course of working should not fear for loss of wages while recovering from the injury or after recovery.

The initial notion of “injury” was straightforward, the damage that resulted from a violent event. Injury of this nature still accounts for the vast majority of workers’ compensation claims in all jurisdictions. In response, the workers’ compensation establishment has underwritten a great number of important advances in trauma surgery and in rehabilitation medicine. Much progress has been made in an attempt to render the workplace safer in this regard. Today, most victims of violent accidents resulting in tissue damage recover and return to gainful employment; post-traumatic FM is not a concern.

It was not long before the reductionistic notion of “injury” was questioned. Insidious toxic exposures, such as the lead in paint, were recognized and indemnified separately as “occupational diseases.” “Telegraphist’s wrist” and “writer’s cramp” soon became rallying cries of the early British labor movement. Since discomfort likely reflects damage, shouldn’t one assume that discomfort occurring in the course of any activity is a symptom of an injury caused by that activity? These regional musculoskeletal disorders were added to the schedule of compensable injuries in 1908 despite a debate that culminated in the label “occupational neurosis” a decade later³. By 1935, regional low back pain was ensconced as a compensable “injury” and rapidly moved to center stage as the label most likely to denote longterm disability². It has been joined with the various forms of regional upper extremity musculoskeletal disorders⁴ to account for about 20% of claims but some 80% of cost of workers’ compensation schemes in nearly all jurisdictions.

Needless to say, the promulgation of the notion that regional back or arm pain should qualify as “injury” is contentious, in part because it is not clear that the worker who finds these symptoms incapacitating is advantaged often enough by recourse to workers’ compensation indemnity schemes. It’s also contentious as a semiotic. Would we consider a headache an injury if its onset is at work? Would we consider angina an injury if it precludes performance at work? Why don’t we consider the common cold an injury given the likelihood of exposure to infectious droplets in the workplace?

That brings us back to the report by Fitzcharles, *et al.* The cases under appeal had failed to satisfy one or more of the WSIB’s 5 criteria for considering FM a compensable injury: there was a work-related injury; FM was caused by the injury; pain persisted 6 or more months beyond the usual healing time of the injury; the degree of pain was inconsistent with organic findings; the chronic pain impairs earning capacity. The last 3 elements address the veracity of the claimant. The first 2 are an exercise in semiotics that begs scientific underpinning.

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THE CAUSAL INFERENCE

A decade ago the debate as to whether FM might be caused by “minor trauma” invoked little more than the casting of preconceptions. Patients with FM in tertiary centers often had attributional notions although “chemical imbalance” or “virus,” not trauma, predominated⁵. When Canadian generalists, orthopedists, physiatrists, and rheumatologists were surveyed, only rheumatologists were likely to countenance the posttraumatic inference⁶. A decade later, the debate is informed by systematic studies. The first addressed the issue in the workplace. McBeth, *et al*⁷ followed over 1000 workers for over a year. None had persistent widespread pain at inception of the cohort, although some had regional musculoskeletal pain and some manifested maladaptive illness behaviors. These personal attributes were associated with new-onset widespread pain during followup more than the content of their tasks. “Task content” denotes elements such as pushing/pulling and posture. It does not account for idiosyncrasies such as the occasional slip or for individual differences in biomechanics that might render an activity more or less forceful. Fortunately, we are advantaged by a corollary science that renders such explanations for new-onset FM untenable. Patients suffering “whip-lash-associated disorders” (WAD) or compensable chronic low back pain can qualify for the FM label in the absence of specific pathoanatomy. Most ascribe their illness to a discrete event, a “minor” motor vehicle accident in the first instance, materials handling in the second. Cohort studies quantifying the influence of these discrete events on the incidence of FM yield remarkably consistent results. Whether the consequent illness is labeled WAD^{8,9,10} or posttraumatic FM^{11,12}, the role of the minor motor vehicle accident is so overwhelmed by predisposing psychosocial attributes as to render the accident itself incidental. The corollary literature pertaining to compensable chronic low back pain is even more robust^{2,4}.

Rheumatologists who supported appeals before the Ontario Workplace Safety and Insurance Appeals Tribunal on causal grounds must have had little regard for contravening scientific evidence.

THE INJURED ASSERTION

The Ontario Workplace Safety and Insurance Appeals Tribunal has to decide the degree to which an appellant has been injured at work. In the case of FM, input from the testifying rheumatologist supplements a document titled “Fibromyalgia Syndrome,”¹³ which was prepared in 2003 and reviewed in 2010. The notion of FM has evolved considerably in that interval. Despite all sorts of preliminary data, there remains no “objective” finding that cements the diagnosis or quantifies its degree. The vaunted “tender points” add nothing to what one can glean from the patient’s narrative¹⁴. FM today is but a narrative of distress¹⁵. Quantifying the degree of distress is an exercise in listening

to and interpreting the appellant’s idioms. There is no reason to assume that an “expert” rheumatologist, or even the treating rheumatologist, is uniquely qualified for this task.

Because the precipitating event is irrelevant on scientific grounds and the validation of the idioms of distress purely a matter for judgment, why should any rheumatologist feel particularly competent in this setting? It is a setting that demands the appellant somehow prove illness. It is not a clinical setting where trust is prerequisite to a therapeutic relationship.

KAFKAESQUE

Before any rheumatologist chooses to enter this arena, I’d advise perusal of *The Trial* by Franz Kafka. It is the story of Josef K, a bank clerk, who is arrested and brought before a Tribunal to defend himself — only he knows not of what he was accused and is driven to madness by the process. Kafka was an attorney who died in 1924, at age 41, of tuberculosis. He could not write *The Trial* had he not worked in the Workers’ Accident Insurance Institute in Prague from 1908 to 1913¹⁶. Kafka’s Prussian Tribunal has left its mark on workers’ compensation tribunals ever since. As I said, many years ago, “If you have to prove you are ill, you can’t get well.”¹⁷ Compensable FM remains an object lesson in social iatrogenesis that calls for reform of the Western approach to disability determination¹⁸. Rather than “a medicolegal analysis of worker appeals for fibromyalgia as a compensable condition,” rheumatology is in need of some soul-searching.

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