Workers' Compensation, Fibromyalgia, and Kafka

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*The Journal of Rheumatology* is a monthly international serial edited by Earl D. Silverman featuring research articles on clinical subjects from scientists working in rheumatology and related fields.
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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, Canada. 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 interest.

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 later. By 1935, regional low back pain was enconced as a compensable “injury” and rapidly moved to center stage as the label most likely to denote longterm disability. It has been joined with the various forms of regional upper extremity musculoskeletal disorders 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.

See Medicolegal analysis of worker appeals for fibromyalgia, page 323.
THE CAUSAL INERENCE
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, predominated. When Canadian generalists, orthopedists, physiatrists, and rheumatologists were surveyed, only rheumatologists were likely to countenance the posttraumatic inference. A decade later, the debate is informed by systematic studies. The first addressed the issue in the workplace. McBeth, et al 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 more or less forceful. Fortunately, we are advantaged by a corollary science that renders such explanations more or less forceful.

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,” 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 narrative. FM today is but a narrative of distress. 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.

REFERENCES


17. Hadler NM. If you have to prove you’re ill, you can’t get well. The object lesson of “fibromyalgia.” Spine 1996;21:2396-400.