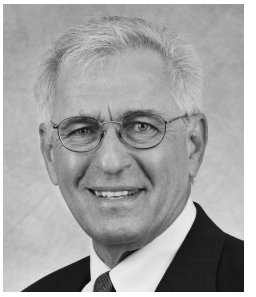
Editorial

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, Canada[1]. 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[2].

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[3]. 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 disability[2]. It has been joined with the various forms of regional upper extremity musculoskeletal disorders[4] 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, predominated[5]. When Canadian generalists, orthopedists, physiatrists, and rheumatologists were surveyed, only rheumatologists were likely to countenance the posttraumatic inference[6]. 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 narrative[14]. FM today is but a narrative of distress[15]. 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 1913[16]. 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 determination[18]. 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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REFERENCES

1. Fitzcharles M-A, Ste-Marie P, Shir Y. A medicolegal analysis of worker appeals for fibromyalgia as a compensable condition following workplace soft-tissue injury. J Rheumatol 2013;40:323.
2. Hadler NM. Stabbed in the back. Confronting back pain in an overtreated society. Chapel Hill: UNC Press; 2009:1-204. French edition, Poignardé dans le dos. Québec: Les Presses de l'Université Laval/Les Éditions de l'IQRC; 2011:1-240.
3. Dembe AE. Occupation and disease. New Haven: Yale University Press; 1996:24-101.
4. Hadler NM. Occupational musculoskeletal disorders. 3rd ed. Philadelphia: Lippincott Williams & Wilkins; 2005:1-339.
5. Neerinckx J, van Houdenhove B, Lysens R, Vertommen H, Onghena P. Attributions in chronic fatigue syndrome and fibromyalgia syndrome in tertiary care. J Rheumatol 2000; 27:1051-5.
6. White KP, Østbye T, Harth M, Nielson W, Speechley M, Teasell R, et al. Perspectives on posttraumatic fibromyalgia: a random survey of Canadian general practitioners, orthopedists, physiatrists, and rheumatologists. J Rheumatol 2000;27:790-6.

7. McBeth J, Harkness EF, Silman AJ, Macfarlane GJ. The role of workplace low-level mechanical trauma, posture and environment in the onset of chronic widespread pain. Rheumatology 2003;42:1486-94.
8. Tishler M, Levy O, Maslakov I, Bar-Chaim S, Amit-Vazina M. Neck injury and fibromyalgia — are they really associated? J Rheumatol 2006;33:1183-5.
9. Russell A, Ferrari R. Whiplash: social interventions and solutions. J Rheumatol 2008;35:2300-2.
10. Carragee EJ. Great expectations. J Rheumatol 2009;36:869-71.
11. Wynne-Jones G, Macfarlane GJ, Silman AJ, Jones GT. Does physical trauma lead to an increase in the risk of new onset widespread pain? Ann Rheum Dis 2006;65:391-3.
12. Jones GT, Nicholl BI, McBeth J, Davies KA, Morriss RK, Dickens C, et al. Role of road traffic accidents and other traumatic events in the onset of chronic widespread pain: results from a population-based prospective study. Arthritis Care Res 2011;63:696-701.
13. Gordon DA. Fibromyalgia syndrome. Toronto: Ontario Workplace Safety and Insurance Appeals Tribunal; 2003. [Internet. Accessed December 18, 2012.] Available from: http://www.wsiat.on.ca/english/mlo/fibromyalgia.htm
14. Wolfe F, Clauw DJ, Fitzcharles MA, Goldenberg DL, Katz RS, Mease P, et al. The American College of Rheumatology preliminary diagnostic criteria for fibromyalgia and measurement of symptom severity. Arthritis Care Res 2010;62:600-10.
15. Hadler NM, Greenhalgh S. Labeling woefulness: the social construction of fibromyalgia. Spine 2005;30:1-4.
16. Brod M. Franz Kafka: a biography. New York: Schockian; 1947:84.
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.
18. Hadler NM, Ehrlich GE. Fibromyalgia and the conundrum of disability determination. J Occup Environ Med 2003;45:1030-3.