

## We Emperors Need More Clothes

Conventional medical training  
has not prepared us to help  
a critical subset of worker-patients

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Webility Corporation  
at

Impairment Without Disability 2018

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## My goal: a quiet DEEPENING of

- Your compassion for people who are stuck and your awareness of what they are dealing with.
- Your respect for the power of:
  - Your language (choice of words)
  - Your interactions / behaviors
  - The tone you set in your relationships
- Your view of:
  - What constitutes treatment
  - How you can help get stuck cases moving forward again
  - Your continuing education plans

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## Conflict of Interest

- Jennifer Christian, MD, MPH is an officer and majority stockholder in Webility Corporation.
- In addition to its consulting services, Webility develops and sells continuing professional education courses for clinicians, case managers, claims adjusters and workplace supervisors.

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## Roots of this presentation

- Conversation with an internist from New York
- Maze-Masters Program for “stuck cases”
- Following the literature, especially biopsychosocial model of sickness & disability, chronic pain, work disability prevention, outcome improvement, etc.
- Developing continuing education programs for physicians
  1. 2016 - 3 hr session: “Managing Heartsink Patients with MUPS”
  2. 2017 – 8 hr course: “Getting Difficult Cases Unstuck: Strategies & Tactics for Stalled Recovery & Prolonged Work Disability”
  3. 2018 - Cutting Edge Techniques in Work Disability Prevention: Identification and Early Intervention in High Risk Cases

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## Today’s Questions

- What is a “stuck case”?
- Who treats “stuck” cases?
- What got them stuck?
- How can they get unstuck? What works?
- Are they getting that now? If not, why not?
- Where is the cutting edge with regard to stuck cases?

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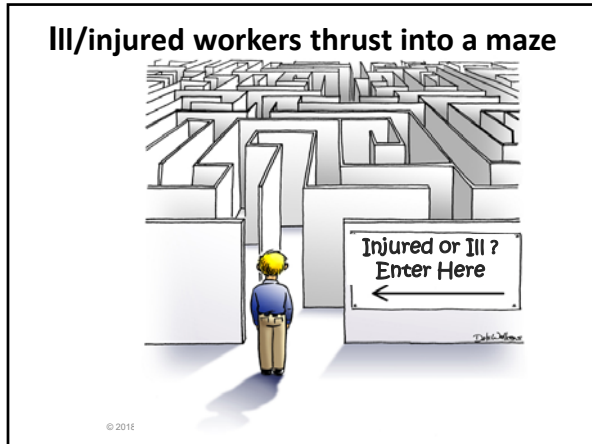
## Vocabulary: “Stuck Cases”

- Patients/people who:
  - Have failed to recover as expected
  - Have not been able to get better
  - Have been left with unexpectedly poor outcomes
  - Are living with persistent distress, chronic pain, and functional impairment out of proportion to objective medical findings
  - Have disabling symptoms but no objective medical findings
  - See suffering / symptoms as a major / the main focus of their life
- “Heartsink patients” “Whiners/Complainers” “Problem Children” “Frequent Fliers” “Train Wrecks” “Psych Overlay” “Creeping Catastrophes”

NOTE: This does NOT include everyone who is living with:

- Chronic or persistent pain
- Serious or progressive diseases
- Residual and irreversible effects of injuries / illnesses

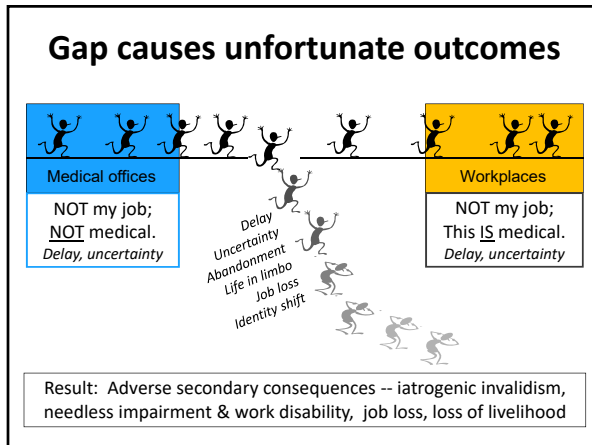
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### Take a quick look at the diagram

*Things that happen during the unfolding of an illness or injury episode drive it towards a good or poor outcome*

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### Unacknowledged and unmanaged consequences of variability → poor outcomes

- Workers with seemingly identical biology **at the start** will have wildly different outcomes.
- Patients vary: Educational/skill level, personality, past history, overall health status, world view, intentions, etc.
- Physicians/healthcare professionals vary: Competence, philosophy, attitude, interpersonal skills, outcomes, etc.
- Employers vary: Response to injury, tangible and intangible workplace environment, willingness to support recovery, sophistication, etc.
- Claims payers and legal systems vary: Skill, availability, philosophy, aligned vs. misaligned incentives, etc.
- Events that occur as episodes unfold vary.

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### Confirmed:

Poor outcomes are rare, but very costly, and often preventable

- 90% of total system costs arise out of 10% of all WC claims (data from Washington State)
- Many / most of those expensive claims are due to potentially preventable "adverse secondary consequences" of routine MSK injuries. (Washington and Colorado state medical directors of work comp systems)

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### Small sub-groups of special interest

**“Classic” Catastrophes**

- Look serious from day 1
- Obvious immediate or imminent anatomical or functional destruction or multi-system insult -- often irreversible loss.
- Can be congenital issue, devastating illness, major trauma, etc.
- More likely to receive outpouring of support and encouragement for fullest possible recovery.

**“Creeping Catastrophes”**

- **Start out looking like common health problems**
- **Recovery stalls; nothing works; illness > disease**
- **Desperation drives search for expensive / destructive measures**
- **Go downhill over time**
- **Life has been ruined**
- **“Lost causes” leave the workforce, stay on disability**
- **PREVENTABLE over-impairment and worklessness**

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### Heartsink patients’ diagnoses\*

- Tension headaches, migraine headaches, neck pain, whiplash TMJ syndrome, back pain, herniated disc, failed back surgery syndrome, chronic pain syndrome, fibromyalgia, RSD/CRPS
- Palpitations, atypical chest pain, abdominal pain, irritable bowel syndrome, interstitial cystitis, chronic abdominal or pelvic pain
- Insomnia, dizziness, tinnitus, numbness/tingling, carpal tunnel syndrome, postural orthostatic tachycardia (POTS) syndrome; chronic fatigue syndrome, multiple chemical sensitivities, “allergies”, panic attacks, eating disorders, anxiety, depression
- Obesity, tobacco, alcohol, or drug abuse/addiction

*\* Heartsink patients tend to have >1 of these diagnoses – strengthens the possibility of a common root cause*

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### Creeping Catastrophes = Heartsink Patients

- A small yet resource-consuming sub-group.
- People living with major life disruption due to unexpectedly poor outcomes of illnesses or injuries:
  - Conditions that usually result in minimal life disruption or a satisfactory recovery on a predictable timeline; or
  - Unfortunate outcomes, e.g. iatrogenic harm or other negative results of surgery or other treatments.
- They have persistent distressing symptoms that have continued to interfere with full participation in everyday life activities for a prolonged period – at least 90 days and up to several years.
- Most doctors wish they could / try to avoid them. Others prey on them. A few take pity on them.

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### They may be VERY hard to deal with

- Disappointed, betrayed by system, iatrogenic harm
- Tired of being treated like a pawn, shoved around
- Skeptical, untrusting, stand-offish, evasive, closed
- Angry, hostile, lay blame, hold grudges, adversarial
- Demanding, manipulative, unreasonable expectations
- Hopeless, depressed, unhappy
- Passive, lack curiosity, low energy, inept, spacey
- Poor treatment adherence / “nothing works”
- Complainers, whiners, full of excuses
- Ignore or resist suggestions
- **Anything else?**

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### At the cutting edge,

We are beginning to distinguish and articulate some concepts, create some shared language, revise and expand traditional medical treatment models, in order to achieve better outcomes for:

- Newly injured or ill patients who are increased risk of prolonged recovery, iatrogenic impairment, and/or unnecessary work disability and job loss.
- Patients who are stuck: whose recoveries have already stalled out or been compromised by risks that were not detected, acknowledged, or attended to.**

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### If Not You, Who?

Firefighters are trained to run towards danger.  
Will you run away from Stuck Cases  
– or towards them?

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**Mismatch:**  
Heartsink cases and traditional  
bio-medical model of disease

Mind-body split since 1600's  
"Scientific" medicine adopted in 1911  
Silo-ing within health care industry:  
Separation of mental vs. physical health  
Weak mental health training for physicians  
Overly narrow definition of medical "science"

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**Most physicians / clinicians are unprepared  
to diagnose and treat MUPS**

- MUPS = medically-unexplained physical symptoms
  - Also known as MUS, functional syndromes/ disorders, somatization, somatic symptom disorder, bodily distress disorder, etc.
  - Not primarily a psychiatric issue
    - 20% of patients with single MUPS diagnosed with concurrent psychological condition (Fink 1999)
    - Many patients do not have psychiatric comorbidity (Gureje 2008)

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**Illness is DISTINCT from disease**

- Illness = symptoms / distress / life impact
  - Symptoms can occur in the absence of demonstrable disease
- Disease = tissue pathology / anatomical change
  - "Silent" disease can occur without symptoms
- Symptoms associated with IDENTICAL pathology or pathophysiology vary A LOT.

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**ALL HUMAN BEINGS have MUPS:**  
brain-generated, benign bodily sensations and reactions

- When embarrassed, scared, tense, nervous, overtired, sleep-deprived, angry, worried, sad, heartbroken, grieving – or infatuated, joyous, exhilarated, excited, or surprised.
- Blushing, flushing, sweating, trembling, fainting, "butterflies" in chest or stomach, stomach ache, nausea, vomiting, diarrhea, constipation, shortness of breath, chest pain, dizziness, ringing in ears, loss of balance, weakness, fatigue, etc.
- Sharp sudden pains in ribs, abdomen, head; muscle spasms and aches, arms/legs "going to sleep"; aches in hands, feet, elbows, knees, hips, pelvis, back, neck, head.

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**Important scientific advances are not (yet) part  
of clinical training, and "Evidence-based Medicine"**

Human behavior, psychology, social psychology

- Interpersonal dynamics, especially impact of therapeutic interactions
- How humans make decisions, behavior modulation
- Anthropology of health care – social roles of healer and patient

Sociology and behavioral economics research

- Impact of culture, personal beliefs, competing priorities/ predicaments
- Incentives that most strongly drive behavior (hint: NOT money)

Neuroscience:

- Neuroplasticity; brain as source (modulator/generator) of all life experience
- Inter-relationship between brain/mental processes and bodily symptoms

Healthcare delivery system research

- Care process, timing, contents of clinical encounters, communications, coordination, patient choice/satisfaction

Paradigms: What is illness? What is disease? What causes/cures them?

- The bio-medical model vs. bio-psycho-socio-economic model (BPSE)

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**MUPS Prevalence – Primary Care**

- **16-53% of new complaints** in multiple studies in developed countries (Burton 2003; Creed 2011; Kroenke 2014)
- ICD-9 780-789 "Symptoms, signs, and ill-defined conditions"
  - 4<sup>th</sup> most common cause of visit in the UK
  - 5<sup>th</sup> most common cause of visit in the US after respiratory, nervous, circulatory, and musculoskeletal conditions (Cherry 2005)
- Patients with **chronic MUPS** accounted for **3% of all primary care visits** in a recent Norway study
  - Equivalent in volume to COPD, CHF, diabetes visits

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### MUPS Prevalence – Secondary Care

- Several studies (thousands of patients, some studies with chart reviews) between 1996 and 2011
- Symptoms without /poorly corresponding to objective pathology (MUS) were the presenting problem for **26-52%** of new outpatients at cardiology, neurology, GI, rheumatology & orthopedics clinics in US and UK.
- **For low back pain, MUPS prevalence in orthopedic specialty clinics was 67%**
- Examples: (Creed 2011) (Reid 2001) (Maiden 2003) (Stone 2009)

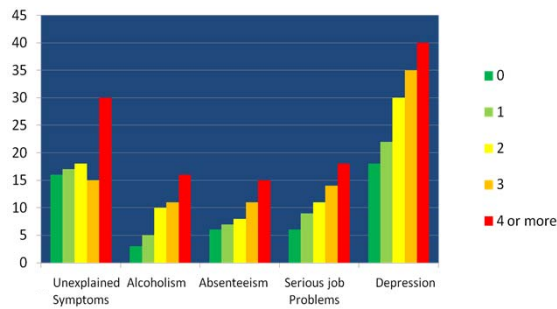
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### Many of us have never heard of ACEs, much less know what to do about it

- A history of adverse childhood experiences (ACEs) is a hidden cause of variability in outcomes
- Yet, the ACE score is the strongest known predictor of adult health status (per CDC)
- Roughly 8-10% of US population has a high ACE score (per CDC)
- People with high ACE scores have (a) had their nervous & immune systems permanently altered; (b) may not have been taught how to cope well with adversity.

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### ACEs: Dose-response relationships



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### Where are these known risk factors located?

- Lack of “system” knowledge (rights, responsibilities, roles)
- Health illiteracy / ignorance
- Negative expectations
- Residual of past experiences, especially ACEs & traumas
- Distrust
- Passivity
- Low self-confidence / self-efficacy
- Lack of coping skills / resiliencyCatastrophic thinking
- Lack of life skills
- Fear avoidance
- Perceived injustice

### 10 point ACE Score

- 1 Raised by single parent
- 2 Witnessed physical abuse of mother
- Someone in household
  - 3 In jail
  - 4 Drug addict / alcoholic
  - 5 Mentally ill / suicide
- Neglect, whether 6 emotional or 7 physical
- Repeated abuse, whether 8 emotional, 9 physical, or 10 sexual.

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### Where are these obstacles located?

- Refusal to authorize needed (indicated and effective) treatment
- Prolonged time away from work because:
  - “We can’t find work within the restrictions / limitations.”
  - “Sorry, we can’t think of any modified work for her to do.”
  - “Sorry, we don’t allow more than 90 days of light duty.”
  - “No, we don’t have a return to work program.”

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**And THESE obstacles?**

- Inadequate / ineffective medical treatment
- Excessive treatment
- Potentially harmful treatment
  - Surgery
  - Continued opioid prescription or polypharmacy
- “He told me he can only lift 10 pounds and work half days.”
- “I don’t want her to wreck my surgical result; I want to wait to return her to work until everything is fully healed.”

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**Words**

- Educate (transfer factual information)
- Reassure – or frighten
- Signal interest / empathy – or not
- Build trust / confidence – or distrust/insecurity
- Create expectations – positive or negative
- Grow relationships – or alienation
- Empower – or undermine
- Heal – or harm

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**Dr. J’s Super Simplified Summary:  
Effect of Words on the Brain**

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↑ **Trust** = ↑ **Speed** ↓ **Cost**  
 ↓ **Trust** = ↓ **Speed** ↑ **Cost**

Source: Jason Parker, Centrix Disability Management Services

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**Rider = Frontal Lobe  
Elephant = Limbic System**



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**So what do we do with this?**

- What are the implications for clinicians?
- What are the implications for everyone who interacts with “stuck cases”?

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**A New Way to Look at Words:**  
 A powerful therapeutic tool / technique  
 that changes brains  
 which affects outcomes

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“Information is an important mediator  
 of the variability in the relationship  
 between disease and symptoms.”

from “The Iatrogenic Potential of the  
 Physician’s Words”  
 Arthur Barsky, MD NEJM 2017

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**WORDS**

- Words will persuade or alienate other parties whose buy-in or collaboration will help your treatment succeed
- Words will be part of the treatment, whether intentionally or unintentionally
  - Establish human relationship (empathy, respect)
  - Negotiate therapeutic alliance
  - Healing / harming words: Placebo and nocebo
  - Information transfer

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Your words will have a more  
 powerful & positive **IMPACT** when:

A. The listener **perceives you** as a “credible authority”:

- benevolent
- trustworthy
- expert in the matter at hand

B. The listener believes that you are familiar with and understand their **specific situation**:

- who they are as a person
- what has happened so far
- what their reasonable needs & concerns are
- what they want to accomplish.

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Nocebo → “Viscerosomatic Amplification” of  
 Sensations and Symptoms


<p style="text-align: center; color: red; font-weight: bold;">NOT THIS ☹️</p> <ul style="list-style-type: none"> <li>• Enumerate most common side effects of a med                             <ul style="list-style-type: none"> <li>– 38% ED with info; 13% no info (β blockers for HTN)</li> </ul> </li> <li>• Order imaging to reassure                             <ul style="list-style-type: none"> <li>– Worse status at 90 days w/ imaging (RCT in acute LBP)</li> </ul> </li> <li>• Predict future pain or describe existing pain in dramatic terms                             <ul style="list-style-type: none"> <li>– Many nocebo studies</li> </ul> </li> </ul>	<p style="text-align: center; color: green; font-weight: bold;">THIS 😊</p> <ul style="list-style-type: none"> <li>• Predict no problems; mention only serious side effects</li> <li>• Order imaging sparingly for clear clinical indications</li> <li>• “Maybe a bit of discomfort but most likely you will be quite comfortable and able to manage.”</li> </ul>
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**THE CUTTING EDGE**

**3 SEPARATE TREATMENT PATHWAYS**

*Crossovers expected*



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### 3 Levels of risk justify 3 DIFFERENT pathways

<p><b>1. LOW RISK</b></p> <ul style="list-style-type: none"> <li>No known significant medical OR non-medical risks / obstacles to recovery</li> </ul>	<p><b>2. AT RISK</b></p> <p>Risks or obstacles identified</p> <p>2a. At some risk</p> <p>2b. At higher risk (severe risks, major obstacles, or new adverse events)</p>	<p><b>3. SALVAGE</b></p> <p>Long-term stalled recovery or persistent suffering &amp; life disruption</p>
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### EXPAND OUR REPERTOIRE OF TREATMENT OPTIONS

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### Generic course of treatment on the Salvage Pathway

- Conduct **multi-dimensional evaluation** of person's situation
  - Explicitly consider physical, mental-neural, human, and situational causes of distress / functional impairment simultaneously
  - Do basic rule out only of serious treatable disorders unless objective signs / findings are present /appear
- Persuasively educate** patient about nature of problem
- Establish **therapeutic alliance** with person
- Develop **multi-dimensional plan in collaboration with person** that addresses identified obstacles to recovery
- Provide regularly scheduled on-going support

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### Identify and address risk factors or obstacles to recovery in any dimension of life

<p><b>Environmental Factors</b></p> <ul style="list-style-type: none"> <li>Inappropriate / inadequate medical care</li> <li>Polypharmacy / opioids</li> <li>Workplace</li> <li>Claim process</li> <li>Financial stresses</li> <li>Family dynamics</li> <li>System incentives</li> <li>Employment options</li> </ul>	<p><b>Personal Factors</b></p> <ul style="list-style-type: none"> <li>Insomnia</li> <li>Physical &amp; mental deconditioning</li> <li>Ignorance:                             <ul style="list-style-type: none"> <li>Health / system illiteracy</li> <li>Lack of self-care / self-mgt skills</li> <li>Lack of life skills</li> <li>Lack of coping skills / resiliency</li> </ul> </li> <li>Emotions/beliefs/perspective                             <ul style="list-style-type: none"> <li>Negative expectations</li> <li>Distrust, fear, anxiety</li> <li>Perceived injustice (anger)</li> <li>Catastrophic thinking</li> <li>Fear avoidance behavior</li> </ul> </li> <li>No life goals drawing them forward</li> <li>Low self-confidence / self-efficacy</li> <li>Passivity</li> </ul>
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### REVISE ELEMENTS OF CLINIC VISIT AND TREATMENT PLAN

- Include / document patient's perspective, as an active participant
- Conduct therapeutic clinical interactions (which take time).
- Treatment plan = **TRACKS**
  - Typical medical treatments
  - Referrals
  - Activities for patient to do
  - Communication/coordination
  - Knowledge
  - Skills

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### THE HEALING POWER OF THERAPEUTIC INTERACTIONS

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### How “Therapeutic Interactions” aid healing

1. Human beings are of one piece; brain (not just mind) plus body.
2. Thoughts, feelings, beliefs, memories, and conditioned responses are neurochemical events.
3. Thoughts, feelings, beliefs, memories, and conditioned responses can cause physical sensations, symptoms, and physiological alterations.
4. Physical sensations, symptoms, and physiological alterations create thoughts, feelings, beliefs, memories and conditioned responses.
5. Symptoms of illness/distress are often relieved by:
  - Education and awareness (reducing worry, recognizing or resolving BPSE issues and conditioned responses)
  - Retraining the brain – remodeling neural circuitry via repetition

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### So what do we do with this?

- What are the implications for clinicians?
- What are the implications for everyone who interacts with “stuck cases”?

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### Why therapeutic interactions are powerful

- Patients imbue (endow) physicians with positive (*or sometimes negative*) powers based on their life experience.
  - “Positive transference” can increase the effectiveness of therapeutic interactions and other treatments.
- Much evidence re: impact of “physician-patient relationship”
  - Therapeutic alliance, trusted clinician, traditional healers, placebo/nocebo
- Certain words are “loaded” (have symbolic meaning) and convey larger implications.
  - Negative examples: “injury,” “injured worker” “diagnosis,” “prognosis,” “disability,” “work restrictions,” “degenerative changes,” “arthritis,” “disc herniation,” “bone on bone”

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### Words

- Educate (transfer factual information)
- Reassure – or frighten
- Signal interest / empathy – or not
- Build trust / confidence – or distrust/insecurity
- Create expectations – positive or negative
- Grow relationships – or alienation
- Empower – or undermine
- Heal – or harm

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### Conduct “engineered therapeutic interactions”

#### Align:

- Increase cooperation / adherence
- Engage and activate the worker

#### Develop:

- Identify / correct knowledge or skill deficits

#### Guide:

- Deliver key messages that improve outcomes
- Shift their thinking

#### Push for progress:

- Identify and commit to next specific step forward

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### “Non-specific” things that heal

- Being understood
- Being respected
- Having someone be interested
- Being encouraged to face the difficulties and overcome them.
- Being accepted
- Being forgiven
- Regaining confidence and restoring hope (undoing demoralization and hopelessness)

### Common Communications Mistakes

- Failure to be curious and listen
- Assume authority without agreement
- Abdicate your role; fail to offer your expertise
- Failure to align worker’s goals with yours
- Imply goal of medical care is symptom relief.
- Imply that working is harmful or “too much”
  - Over-protect – create fear
  - Over-limit – underestimate capability
- Make negative predictions – destroy futures
- Use words that act as “nocebo” instead of “placebo”

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### Summary of Suggestions for Salvage Pathway

- Analyze situations using a BPSE (multi-dimensional) approach to find issues that might be mitigated / resolved.
- Broaden definition of / repertoire of interventions.
- Employ multi-dimensional management / treatment plans with active orchestration as necessary. Physicians develop and oversee them. Payers agreed to pay and help find resources.
- Engage all involved parties to support recovery.
- Build the worker-patient’s sense of ownership & control of the situation and solutions.
- Focus on strengthening / developing / restoring the worker-patient’s skills and confidence.
- Provide frequent and on-going emotional support, resources and guidance as worker-patient does their part of the work.

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### Avoid NOCEBO effect: Words can make things better – or worse

#### SAY THIS

- Your recovery process
- Getting life back to normal
- What progress have you made? What can you do now that you couldn't do last time we talked?
- Back ache / shoulder trouble
- Many people your age -- who don't have any symptoms at all -- have abnormal MRI's.
- Stay active; movement has been proven to be good. Walking will reduce your pain and improve your mood.
- Try not to let this get in the way of your life; you can probably find a way to do the things you care about.

#### NOT THIS

- Your injury, illness, diagnosis, condition
- Getting you back to work
- How's your pain-- from 1 to 10?
- Back injury / shoulder injury
- The findings on your MRI: bulging disc, disc protrusion; loss of cartilage; bone on bone.
- Avoid activity; get plenty of rest.
- You must follow your doctor's restrictions.

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But .....

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### Point out a positive path forward

- Challenges, difficulties and imperfections are part of every human life -- maybe even the design!
- ALL of us can find a pathway to wholeness, no matter what has happened.
  - Including those with medical problems
  - Including those with incurable chronic conditions, fixed disabilities and aging
- Find the opportunity to grow & develop yourself:
  - Cope successfully with whatever challenges life delivers
  - Keep participating as fully as possible in human life
  - People who stay engaged in purposeful and productive activity, whether paid or unpaid, are happier, live longer.

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### Most physicians / clinicians have never been taught and mastered the skills to:

1. Make an empathetic and genuine human connection.
2. Listen deeply to a person until we grasp the larger context in which their medical problem is occurring.
3. Deal with / heal patients with MUPS.
4. Assess the patient’s entire situation -- in medical as well as non-medical life domains -- in order to identify obstacles to recovery and actionable opportunities to resolve them.

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5. Create and maintain a therapeutic alliance.
6. Devise and orchestrate an evidence-informed & effective multi-dimensional treatment plan.
7. Communicate persuasively so that the person is more likely to accept and adopt our assessment, diagnosis, and treatment plan as the way to go.
8. Establish ourselves as a “credible authority” so the person **grants us** the healing power of a shaman (enables placebo / nocebo effects).
9. Use our words, key messages, and engineered interpersonal interactions as treatment modalities — as interventions in our therapeutic repertoire.

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Thank you for listening, and for  
being open to new ideas!

**Comments?**

**Questions?**

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### Start here to begin learning how!

- Barsky AJ – Iatrogenic Potential of the Physician’s Words, JAMA 2017
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- ACEs - US CDC - <https://www.cdc.gov/violenceprevention/acestudy/index.html>

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### Stay in touch!

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