



## “Ask Dr. J”



The “Ask Dr. J” columns are authored monthly by Jennifer Christian, MD, MPH, President of Webility Corporation. See previous columns at [www.webility.md](http://www.webility.md).

Dr. J’s columns also appear in the monthly Bulletin of the Disability Management Employer Coalition (DMEC). To purchase a book of Dr. J’s collected columns, go to [www.dmec.org](http://www.dmec.org).

The columns often summarize issues discussed by the Work Fitness and Disability Roundtable, a free, multi-disciplinary e-mail discussion group moderated by Dr. Christian. Apply to join the Roundtable at [www.webility.md](http://www.webility.md).

### December 2005 – Evidence-based Clinical Decision-making in Return to Work

Dear Dr. J:

If doctors should practice evidence-based medicine, shouldn’t they also write evidence-based return to work notes?

Louis in Lafayette

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#### **Answer – Part II:**

**See Part I of the answer in November’s bulletin!**

Still here, Louis? Last month I said that I agree with you, but that we ought to take a few minutes to make sure we’re talking about the same thing. Here are a few more thoughts I’d like to share with you.

As you recall, there are actually two different kinds of “evidence” to talk about in the area of return-to-work decision-making:

- The evidence produced by scientific research on HOW the physician should go about formulating his/her guidance to the patient / employer / insurer / court.
- The data upon which the physician bases that guidance.

I have a beef with people who talk about “quality” in scientific evidence as though randomized controlled trials are the only evidence that’s “good enough.” Some evidence is better than nothing. One of the silliest ways to make a decision is to rely on someone’s strong opinion buttressed by no observable facts whatsoever. And, decisions must be made.

There’s nothing new or unusual here. The uncomfortable but universal fact is that, in life, people have to make decisions all the time about what to do using the data that is actually currently available to them – which is usually incomplete and based on insufficient and imperfect

knowledge or research. Heck, I even have trouble feeling that I know enough to vote for God's sake! Wouldn't life be a lot easier if we COULD see the future or "the truth"?

Professionals in different sectors of the economy must rely on fragments of information and incidental observations to come up with recommendations for action now: For example, stockbrokers, insurance actuaries, election results forecasters, Alan Greenspan of the Federal Reserve, the director of the CIA, the President of the United States, and so on: Another example is physicians who have to make decisions in the return to work setting.

Table 1, below, shows the continuum of evidence that might actually be available to a physician faced with a patient who needs guidance. Let's go back to a key part of that definition of evidence based medicine from Dr. Sackett: "Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. . . ." A doctor who's trying to do the right thing will use the best available evidence. The sad thing is that today, the best available frequently isn't very good. (SWAG's by the way are scientific wild [fill in the blank] guesses; WAGs are just plain wild guesses.)

| <b>Table 1</b><br><b>Forms of "Best Available" Evidence for RTW Decisions</b><br><b>(in descending order of fanciness)</b> |  |
|--|--|
| •  | Many / solid scientific / medical research                     |
| •  | Some / weaker scientific / medical research                    |
| •  | Consensus expert knowledge / opinion                           |
| •  | Databases of "scrubbed" objective information                  |
| •  | Objective measurements and descriptions                        |
| •  | Documented factual observations                                |
| •  | Incidental observations/ data recorded in past medical records |
| •  | SWAGs, patient report, WAGs                                    |

As I mentioned last month, the state of the science in return to work is primitive – the topic has not been subjected to much research effort at all compared to other medical issues. In addition, more often than not, NO objective information at all is provided to the physician to buttress his or her decision-making. And, the accuracy and predictive ability of the methods used to obtain the supposedly-objective data that is sometimes provided to the doctor have themselves not been subjected to rigorous scientific scrutiny. So, since the doctors have to make decisions, they do the best they can under the circumstances.

Table 2, below, is excerpted from a new report entitled *Preventing Needless Disability by Helping People Stay Employed*. I chaired the committee that wrote the report; it was adopted this month by the American College of Occupational & Environmental Medicine. The full report isn't available quite yet, but this will give you a little taste (a sneak preview). The table's three columns compare the ways that doctors amass the information they need in order to formulate their advice to patients and employers about whether and when to return to work, and if so, doing what. The first column shows the issue the doctor must consider. The second column shows the quickest / simplest / and lowest cost methods in common use to answer that question. The third column shows the most complex / slowest / more expensive methods that are widely available.

With the exception of disability duration guidelines based on databases of actual work disability episodes, the irony is that today's most complex and expensive tools and methods are not necessary more accurate or effective than the simpler ones. Most of the fancy tools and methods are pretty good at detecting which people who want to work really can't. They are not as good for detecting people who could work but don't think they can or don't want to. In fact, most of the time, the parties have resorted to the elaborate type of data-gathering and decision-making because that second question is at issue. And, the situation has already become so adversarial, inauthentic and ritualized that the results are distorted and the expense and effort of using the tools goes for naught.

| <p align="center"><b>Table 2</b><br/> <b>ISSUES THAT PHYSICIANS MUST ADDRESS IN ORDER TO FORMULATE WORK/ACTIVITY PRESCRIPTIONS – AND THE METHODS USED TO ADDRESS THEM</b></p> |   |   |
|---|---|---|
| <p align="center"><b>Question / Issue To Be Addressed</b></p>   | <p align="center"><b>Low-Cost and/or Simple Method</b></p>  | <p align="center"><b>High-Cost and/or Complex Method</b></p>  |
| <p>What are the functional demands of the worker's usual job?</p>   | <p>Doctor asks the worker what he / she usually does at work.</p>   | <p>Doctor relies on data from a job analysis. Doctor reads a multi-page comprehensive functional job description possibly with digital photos/video. The report has been prepared by a trained expert hired by the employer or insurer. The expert did a formal job analysis including making actual measurements at the worksite.</p>  |
| <p>What is the worker's current work capacity and functional limitations?</p>   | <p>Doctor asks what the worker can't do; observes the worker's behavior in the exam room; performs a physical exam – and then mentally projects those answers and observations into likely workplace activities</p>             | <p>Use data from tests such as treadmill testing (aerobic exercise capacity), functional capacity evaluation (musculo-skeletal work capacity) or neuro-psychological testing (cognitive ability). Tests of other capacities are available but much more rarely used. Doctor reads a report of the worker's visit to a special testing facility, in which he/she performed a set of maneuvers to ascertain the worker's maximum work capacity.</p> |
| <p>Is there a medical reason why the worker should be removed from work? Is there any specific activity / exposure the worker should avoid for medical reasons?</p>           | <p>Doctor uses his/her own knowledge of workplaces and jobs, then thinks about potential situations that might pose a risk to the health / safety of the worker or others -- and writes medical restrictions to avoid them.</p> | <p>Other than disability duration guidelines that specify the length of time people are typically absent from work for various conditions, no clinical resource is available. We are unaware of any reference that systematically reviews the occupational implications (medical concerns and functional issues) of various medical conditions. Neither a consensus-based encyclopedic</p>  |

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|--|---|--|
|  |   | reference nor a systematic and comprehensive review of evidence-based medical literature exists yet.   |
| Can this worker with this functional capacity and these medical restrictions do this particular job? | Make an informed guess. The doctor uses whatever information is available to decide whether the worker's current capabilities match with the job demands.<br><br>OR<br><br>The employer or insurer looks for a match. They compare the employee's abilities as portrayed in a doctor's note with the demands of available jobs. | Doctor relies on data from functional testing. Using information about a particular job, a testing facility devises a set of maneuvers that duplicate the maximum functional demands required by the tasks of that particular job. Then the worker attempts to perform those critical tasks. The areas of mismatch are the tasks that the worker cannot perform. |
| Ways of modifying jobs / making accommodations   | The doctor makes a suggestion based on his/her previous life and practice experience. The employer may seek advice from a consulting physician with occupational medicine expertise.  | Doctor relies on data in a report written by a vocational counselor or similarly trained and qualified professional who has evaluated the situation in detail and made recommendations.  |

Scientific insiders have always known that the scientific method is a rather crude attempt to pin down the messy thing we call reality and put it in a neat little box. Scientists take scientific "facts" with a grain of salt – they know that today's "facts" are temporary by definition – that what appears to be true today can and will be blown away tomorrow – or ten or a hundred years from now. When I went to medical school, we were taught that 50% of what medical science knew as truth then would have been proven false or inadequate within 10 or 20 years. It's best to think of it as a series of successive approximations or models of "reality", each more accurate than its predecessor, but each in turn being replaced by another still more accurate model of "reality."

The wavefront of science is continually moving forward. I think of the progress of science like the ocean lapping the beach during an incoming tide. There are waves crashing and rushing up and down on the sand – the latest scientific findings that often seem to contradict each other or are proven wrong the next year (the bad/protective effects of coffee/tea/caffeine and hormone replacement therapy, for example). There are also the great new drugs that a few years later are recognized to have horrible side effects (vioxx, phen-fen, thalidomide). There's no surprise that this area is in constant flux and is unstable – it's the breaking surf of science.

But hidden by the surf, the ocean itself is creeping up the beach – there is progress being made, and areas that used to be the surf are now calm water. There is little dispute or uncertainty these days about whether smoking cigarettes causes cancer, or that seatbelts save lives, or what causes AIDS, or whether laparoscopic surgery leads to faster recovery than does a conventional surgery with open incision. I remember when each of these topics was still being debated.

Investments in better tools and methods – like teaching cases, reference materials, validated and reliable ways to accurately predict what functional ability a person actually has, and efficient and accurate ways to determine functional demands of jobs and give key information about jobs to doctors both quickly and accurately – should be high on the agenda of organizations for whom the financial and human consequences of poor RTW decision-making are high. It won't

all happen over night, but we can make a lot of progress by simply acknowledging what needs to be done, and taking a more systematic and united approach.

The day will come when we will look back on the crude and non-standard methodologies we are using in the return-to-work process today and say to each other “Wow, we sure were hurting people and wasting money in the old days, weren’t we? I’m very glad that we invested in research and infrastructure improvements that have made today’s decisions soooooooooooooo much better.”

Smiling,  
Dr. J

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