CRIPPLING OF AMERICA: LIVING ENABLED OR LIVING DISABLED

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Abstract

Disability is a tragic and largely preventable epidemic; often disability in the workers compensation, disability (governmental and private systems), and personal injury arenas results from archaic concepts and self-serving behavior of participants, particularly physicians and attorneys. Many people who believe they are disabled are not; they can live empowered, useful lives. Our perceptions mold our realities and those same perceptions may be intentionally or unintentionally manipulated by others. Disability costs, both human and financial, create an unacceptable drain of resources and potential from our society. Those who pander to the increasing expectation that injury inevitably leads to disability often fail to recognize the dynamics of human potential, and the healthy effects of work. Individuals who perceive, or come to perceive, themselves as "victims" are unwittingly contributing to the creation of a dismal future for themselves. Physicians, therapists, lawyers, support groups and media who needlessly tell people they are injured, ill and are disabled are complicit in diminishing and limiting lives. They create expectations about the future course of life after injury that are based upon the way that they were trained to practice their profession, their ability to treat the presenting injury, their view of the proper remedy for injury and their pursuit of personal and/or financial agendas. Those expectations have the power to change the lives of injured persons. Employers and systems that establish barriers in staying at work or return to work create disability.

Physicians often label patients with diagnoses, not understanding that the labeling is an act that has lasting psychological significance. Sometimes the diagnosis is one of exclusion, after needless diagnostic testing and treatment, which increases the potential for disability by conditioning the injured person to think of them as profoundly damaged. Lawyers supposedly representing their clients may instead use their clients for their own personal financial gain by reducing every injury into the quest for the largest possible monetary award. Injured people are conditioned to demonstrate disabled behavior for the purpose of increasing the value of the case, creating needless disability. Employers and insurance adjusters who perceive that claimants are all problematic force injured people to justify their disability behavior, habituating it and creating that reality. Even where these pernicious influences are not present, well-meaning professionals may still "enable" the disabled behavior of their clients and contribute to their dysfunction unwittingly. By treating the perception of disability already exhibited by the client as an established fact, and helping the client organize their life responses and remedies with that assumption in mind, professionals sometimes assist the client in closing off the broader possibilities that are, in fact, available.

Solutions that empower, not disable, include creating positive realities, gratitude, traditions of strength, new paradigms rewarding recovery, disarming diagnoses, creating new expectations concerning the legal system and redirecting individuals toward healthy self-identify. People are able to live beyond assigned labels and be exceptional and productive. The ultimate responsibility for our actions, choices, and realities remains with each of us. Changing our state of mind changes our reality, both for ourselves and for those around us.

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Introduction

Our society is becoming crippled by needless creation of disability and the associated human and financial costs. The needless disabling results from ill-conceived belief systems, ignorance and self-serving behavior of an array of participants. Far too many individuals become attached to symptoms common to the human experience, identify with diagnostic labels assigned to them and perceive themselves as being disabled. Needless disabling may result from confusing experiences of life with symptoms of illness, excessive worry, inability to cope with the cumulative effects of multiple stressors, and failure to grasp the necessity of assuming self-responsibility for our own health and level of functioning.

The purpose of this paper is to provide a high level conceptual framework to explore issues about the disabling process and to pose questions to stimulate discussion and provide answers. We will focus on litigation as an example of the disabling process.

The Disabling Process

Acquired Disability Behavior and Neuroplasticity

To understand acquired disability behavior and the needless disabling that results, it is important to understand the mechanism by which the mind incorporates experience into the literal structure of the brain. The mechanism relies on the ability of the brain to alter the organization of its neural networks based upon experience, a phenomenon known as brain plasticity or neuroplasticity.[1] [2] [3]

Notwithstanding the old idiom "you cannot teach an old dog new tricks", neuroplasticity continues throughout life, and is the mechanism for all kinds of adaptive behavior. Repetitive experience creates connections between parts of the brain, facilitating responses in the presence of certain stimuli. The mechanisms for repetition include both repeating external stimuli and circumstances of prolonged stimulation, where the mind's focus on the stimulus creates the equivalent of repetition during the focus period. The phenomenon is variously associated with repair by the brain of certain kinds of organic damage, such as stroke, habit and addiction formation, creation of muscle memory in athletes, enhanced playing ability in musicians, and the acquisition of a wide array of useful and not-so-useful behaviors. Dr. Norman Doidge coined the phrase most often used to describe the phenomenon; "Neurons that fire together, wire together".[4]

The significance of this new understanding of brain function is that it explains a lot about the formation of the link between ideas, emotions and physical sensations. When an injured person feels pain and a

doctor tells them that he or she has a permanent condition, the feeling of pain becomes associated, over time, with the diagnosis, the emotional response to the diagnosis and factors associated with the diagnosis.[5 6 7 8 9 10] This is particularly true when the injured person has to validate and/or defend, over and over, their non-working status by disclosing their diagnosis to others, defending their status in court, and brooding over their status during the period any dispute resolution process is pending.[11] With this repetition of the association, the synapses adapt to make the connection between sensation and diagnosis more automatic. The diagnosis also becomes associated with various emotions: helplessness, fear, anger and overwhelming stress. Moreover the language that we use to describe various stages of the process may have similar impact. For example, the phrase "maximum medical improvement" used in many U.S. jurisdictions to describe the point at which further medical treatment is not medically likely to result in further improvement in physical condition. The phrase, to the uninitiated, has the ominous ring of a life sentence. Without further explanation, a worker is likely to understand this as a judgment that he or she has reached the highest potential for recovery that will be achieved, when that is often not the case.

For the worker confronted by an overwhelming array of new and poorly understood stimuli, the physical sensations, reminder of diagnosis, the emotions associated with the situation and any situation invoking the victim's role may get associated in a new neural network, through repetition and duration. Each of these stimuli acquires the power to independently trigger an experience of the other emotions, sensations and ideas, and the creation of a disabling pattern is complete. The injured person has adapted to the role of the victim. As repetitions of this cycle continue to build, while the claim for benefits awaits resolution, the worker sinks deeper into the role of the victim, the neural network of associations becomes stronger and with it the role becomes harder to break. It is no wonder that the literature is rich with studies showing that when a worker is off from work for a period of time the probability of their eventual return to work decreases. Most of these studies suggest that if a worker has not returned to work in 12 - 24 weeks, the probability of their eventual return is cut in half.[12 13 14]

Psychosocial factors likely have a role in this process. Some people feel despair when additional stressors (like the rigors of recovery and dispute resolution) are added to their life, where others are able to shrug off the additional load. The degree to which someone is resistant to an emotional reaction to additional stressors is likely influenced by the nature and cumulative impact of the other stressors in their life. Collectively, we call these other stressors "psychosocial factors" and note that a high level of those kinds of stimuli correlates with the acquisition of the complex of physical sensation, emotion and ideas that we call "learned victimization", or "learned helplessness".[15 16 17]It is important to remember, however, that the correlation is not necessarily reflective of causation, and individual workers may be more or less susceptible.

Once we understand that the way the human brain processes information is adaptive and facilitates connections that render connections between sensations thoughts and emotions habitual, the connection between delay and repetition of behaviors modeling disability during the dispute resolution process, and poor outcomes for some of those utilizing the process becomes understandable. Time spent directing the attention of the injured worker to the diagnosis, circumstances of injury, current physical sensations and prognosis all tend to focus the injured party on his or her disability, and render it habitual. Repetition of behaviors associated with the disability also causes habituation, through exactly the same mechanism. Therefore, when avoidance of acquired disability is the goal, time in the disadvantaged state and repetitions of the disabled behavior patterns are the enemy. Unfortunately, the processes used in the U.S. to resolve disputes over workers' compensation claims generally do not incorporate this understanding, and therefore rationally must be considered a potential source of iatrogenic (system caused), and therefore unnecessary, disability.

Disability – Perceptions vs. Reality

Impairment and disability are not synonymous.[18]"Disability" is a term that refers to a person's inability to work. "Impairment" is a medical term that refers to any physical or functional loss or anomaly; not all conditions and diseases result in impairment. The experience of being disabled more reflects the perception of the individual and those interacting with the individual.[19]

People who are impaired are not necessarily disabled if they are motivated and their impairments do not preclude them from being able to carry out their job responsibilities, and others are willing to accommodate their physical, mental or behavioral challenges. However, there is great inconsistency among physicians' ratings of impairment and definitions of functional ability, so people are often inappropriately labeled as being disabled. The context of "acceptable" disabling disorders often informs the way in which individuals choose to be well or to embrace the sick role.

There are many complex and inter-relating factors that play into the disabling process, including that of mind, body and spirit. The powerful influence of the mind includes personality structure, psychological hardiness, coping skills, acceptance of symptoms of live (such as discomfort and fatigue), ability to deal with stress (both stress associated with daily life problems and stress resulting from major life changes), level of satisfaction with work, experiences of others with disability, and previous experiences with injury, illness and disability. Issues of the body include the presence or absence of disease, physical hardiness, nutrition, and life-style choices (tobacco, alcohol, and drugs). The spirit is all encompassing, including empowerment, having a purpose driven life, and faith.

Aspects often seen with individuals who are "needlessly disabled" (e.g. perceive or report to be disabled, yet there is inadequate objective basis to support their disability) are contrasted to those "exceptionally able" (e.g. inspiring to others and achieving their potential despite impairments[20]) in Table 1.

Table 1. Needless Disabled vs Exceptionally Able

	Needless Disabled	**Exceptionally Able**
Impairment and Disability	Impairment < Disability	Impairment > Disability
Perspective	Negative (Pessimistic)	Positive (Optimistic)
Emphasis	Weakness	Strength
Problems	Barriers	Challenges / Opportunities
Responsibility	Others (Blame, Entitled)	Self
Reaction	Revenge, Obsession	Forgiveness
Relationship	Dependent	Independent
Physical	Inactive	Active
Feelings	Anger	Gratitude
Affect	Depressed	Joyful
Focus	Adversarial	Health (Function)

Victimization and the Sick Role

Individuals more vulnerable to symptom amplification and dysfunctional behavior are more likely to complain and assume a victim role.[21 22] When a people are prone to disablement, several forces may work in tandem to validate their concerns about illness. For example, through tremendous advertising efforts, pharmaceutical companies suggest that aches and pains, anxious or depressed feelings, or difficulty sleeping are not normal aspects of the human condition. They encourage people to see a physician in order to receive a diagnosis (and a label) and their drug. This approach reaffirms that something is wrong and poses more potential problems such as side effects or addiction. Psychologists also identify feelings of distress as problems that require ongoing treatment. The approach also contributes to the perception that medical intervention is a passive mechanism – that for every ailment there is a magic pill or operation, which once received from the health care professional, will remove the offending signs or symptoms.

People who embrace these unfounded theories and take on the mantra of the victim – "I am not responsible; it's not my fault, there is nothing I can do and I am not in control. They may become enmeshed in a system that shapes the world to their "benefit." However, they often overlook the fact that victimization results from reinforcement of the negative aspects of the condition, rather than on a person's potential. The end result is a downhill spiral that is reinforced by other victims and those who benefit from them; i.e., health care providers and attorneys.

The sick role is a medical sociology concept created by American sociologists Talcott Parsons in 1951.[23] He noted that the sick should not be held responsible for their illness; they should be cared for and be exempt from normal obligations until they are well; and they should want to get well and seek and cooperate with professional help in order to do so. Although Parsons was referring to acute illness, his definition of the sick role is now being applied to increasingly prevalent chronic illnesses and disabilities. The "sick role" has morphed into "the impaired role," whereby individuals believe their condition is not likely to improve and accept the condition and resulting dependency as permanent.

There are various expressions of belief that one is disabled when there are no objective disease findings, including hysteria, somatization, hypochondriasis, and malingering.[24 25 26 27] Hysteria is a behavior that produces the appearance of disease; it is a universal human response to emotional conflict that mimics culturally permissible expressions of distress.[28] Over time, terminology has changed; however, patients have not. What used to be called hysteria now is reflected in the concepts of somatization and hypochondriasis.[29 30 31]Somatization is a person's conscious or unconscious use of bodily symptoms for psychological gain. People who experience somatic symptoms usually misattribute them to disease and seek medical attention for them, even though these symptoms have no physical explanation. Somatization can be acute or chronic and may accompany an identifiable physical illness, an underlying psychiatric condition, a personality disorder, or a significant psychosocial stressor. Physicians who provide unproven medical diagnoses for patients with somatization issues contribute to their disability by feeding their conviction that they are permanently disabled.

The human psyche is complex and often not well understood, and includes intriguing areas of personality structure and disorders, co-dependency, and dysfunctional relationships. Personality disorders represent enduring patterns of inner experience and behavior that deviate from those expected by the individual's culture. These inflexible and pervasive patterns are very common among individuals who are needlessly disabled. These patterns reflect problems with cognition, affectivity, interpersonal relationships, and

impulse control. By their very nature, personality disorders are often unrecognized by those who suffer from them, and these individuals tend to blame others for their problems. Health care providers often fail to diagnose these disorders.

Work

The healthy effects of work and the health risks of unemployment are now well recognized.[32 33 34 35] There is clear evidence that working can be good for your health, well-being, and recovery from illness. This has been demonstrated by an innovative cross-government initiative in the United Kingdom. Waddell and Burton performed an extensive review of the literature and found strong evidence showing that work is generally good for physical and mental health and well-being. Not working is associated with poorer physical and mental health. Work can reverse adverse health effects of unemployment. People who are employed are at less risk of health problems than those who are unemployed. Work defines purpose and creates a focus for life.

An article by Harris[36] reconfirmed that workers receiving disability benefits recover less quickly and have poorer clinical outcomes than those with the same medical conditions who don't receive disability benefits. People who are long-term unemployed or who have never worked are between two to three times more likely to have poor health than those in work. Disability is diminished when a patient works in a positive work environment and performs a satisfying job.

The Canadian Medical Association issued a policy entitled "The Physician' Role in Helping Patients Return to Work After Illness or Injury" stating "prolonged absence from the workplace is detrimental to a person' mental, physical, and social well being. Physician should therefore encourage a patient's return to function and work as soon as possible."[37].

The Players

There are multiple participants in the disabling process, including the individual, families, friends, communities, health care providers, attorneys (plaintiff and defense), pharmaceutical and device manufacturers, attorneys, disability benefit systems (including private and governmental entities), employers, advocacy groups, and media. Each of these players may contribute to the disabling process.

The individual with the experience of disability is central stage; however, this person is surrounded by influencers.[38] In this paper we will briefly review the contributions of each, and focus on the impact of litigation, particularly in the workers' compensation arena.

Health Care Providers

Physicians and other health care providers appear to often ignore the moral basis of medicine--the Hippocratic entreaty to "first, do no harm." As a consequence, a person's reported concerns and suffering

can be falsely diagnosed and result in unneeded and sometimes harmful and expensive treatments and needless disability.[39 40 41 42 43 44 45]

It is common for patients to visits to their physicians over concerns about experiences of fatigue and pain; in the majority of these case the doctor cannot find objective physical evidence of organic disease, i.e., their presenting symptoms are not consistent with any demonstrable tissue changes. [46] Yet the physician must assign a diagnosis to obtain payment for their services from the current medical insurance system. These symptoms may be assigned labels which lack a known pathophysiological basis and these labels become the identity of the patient. Because many people with these conditions have gotten little relief from conventional medicine, new fields specializing in the diagnosis and treatment of syndromes not associated with any known disease or disability process have appeared in the past 20 years. These range from respected academic researchers who have created a branch of medicine labeled functional medicine, to quacks and charlatans who prey upon the frustration and suffering of these patients, with a range of well-intended but not necessarily well-informed practitioners in between. Often these conditions are associated with underlying emotional issues such as fear, depression, unresolved grief, or panic disorder. Unfortunately, many of these visits are brief and physicians, who are trained to identify physical disease, overlook the potential psychosocial and psychological components of the problem and instead order unnecessary tests and make unnecessary referrals to specialists. These expensive efforts can lead to an endless cycle of repeat visits, repeat tests, and further time spent with specialists in search of the root of the problem within their realm of interest. Even if physicians do make referrals to mental health professionals, many patients will not follow through because of a fear of the stigma of being labeled with a mental disorder. In the meantime, the repetition associated with the seemingly endless testing and specialist referrals contributes to the formation of the neural networks associating sensation, emotion and beliefs, and contribute to the formation of the disabled persona.

Many physicians are not comfortable with disability assessments and their assessments can be highly variable.[47 48 49] Physician recommendations limiting activity and work after injury are highly variable, often reflecting their own pain attitudes and beliefs. Patients' desires strongly predict disability recommendations (i.e., physicians often acquiesce to patients' requests).[50] The simple request for a sick note can disguise important medical, psychological or social issues.[51] One study of ethical aspects of disability determinations found 39% of random sample physicians willing to exaggerate clinical data to help a patient he/she thought was deserving of disability and 56% of neighborhood health centers.[52] The majority of the physicians in this study felt that filling out disability forms compromised the physician patient relationship, that filling our disability forms was a conflict of interest for the physician and it would be better if an independent physician determined disability. Another study found that 41% of family physicians felt pressured to write unwarranted work excuses and felt manipulated by their patients. [53] A Swedish study found in 87% of cases in which primary care physicians could not justify "sick listing" certification, a certificate was issued anyway.[54]

Physicians encounter difficulties in determining when disability is medically required, discretionary, or unnecessary. Three factors in determining return to work are: capacity (physical ability based on the injury and the current medical condition), risk (possibility of reinjury or worsening of the medical condition) and 3) tolerance (decision by the patient to endure the pain in exchange for the benefits of returning to work (modified by education and communication). For the physician the typical order is:1) capacity, 2) risk and 3) tolerance and the patient it is: 1) tolerance, 2) risk and 3) capacity.

Ignorance and greed may also play into this process, engendering a dependent patient-doctor relationship that creates a recurring source of revenue for the physician. Medical training and reimbursement systems pressure physicians to quickly "label" the patient with a diagnosis. This label may then become the focus

for the patient and others involved in the disabling process. In a medical system driven by managed care, short visits with patients can lead to the hasty application of inappropriate diagnostic labels, unnecessary diagnostic testing, prescriptions for inappropriate medications (including narcotics), unnecessary therapeutic procedures and a failure to address core psychosocial, behavioral, personality, and psychological issues. Attempts by the health care professional to treat certain somatic syndromes as a physical illness will often do more harm than good, and may reinforce dysfunctional illness behavior.

Physicians are driven by market forces and have a vested interest in developing a referral base,; this is reinforced by providing care for "popular" diagnoses often associated with the perception of disability, i.e. chronic back pain[55 56], fibromyalgia, whiplash[57], and somatic syndromes, such as multiple chemical sensitivity and chronic fatigue syndrome.[58 59]

Pharmaceutical companies also exert pressure on physicians to purchase durable supplies and equipment (for example, injection or surgical devices for treating back pain) and to prescribe drugs that may not be best for the patient. Treatment can also be driven by payment; for instance, the most common procedures paid for by automobile insurers are hot packs and electrical stimulation, even though these treatments often are not helpful. Well- credentialed health care providers are not immune from this type of unintentional propagation of poor medical and behavioral health practices.

Psychologists, psychiatrists and other mental health workers may reinforce a victim role and dependency, rather than focusing on function.[60 61 62 63] Needless disability also occurs when these professionals assume an inappropriate advocacy role in defining disability.[64]

In the haste to diagnose a physical cause for their patients' suffering, medical professionals often overlook the emotional and psychological issues that can masquerade as physical problems. Even when patients have a legitimate medical condition, untreated depression or other psychiatric conditions can worsen their outcome. In these instances mental health professionals should be involved in overall patient care. However, psychiatrists and psychologists can become complicit in keeping patients disabled if they treat the person's misery as a long-term source of revenue rather than as a discrete issue to be worked through and eventually resolved.

Attorneys and Legal System

Doctors who strive to help their patients recover from work- or accident-associated injuries are often viewed as adversaries by attorneys who would prefer to employ the patient's long-term disability and ongoing needs for medical care in order to reap a healthy financial settlement. In that the legal system often contributes to needless disabling, this area will be examined in depth.

Dispute Resolution in Workers' Compensation

Dispute resolution in Worker' Compensation in the United State is almost always a bewildering and counter-intuitive process for the injured worker. He or she is confronted by a claims adjuster who is often taxed by their case loading beyond the reasonable ability to respond to the worker with the same urgency as the worker attributes to their issues. The services of the treating physician may be questioned, and treatment delayed. The physician may not be the injured worker's choice of health care providers. Neither situation in health care is likely to be consistent with the common experience of the worker with

respect to the care received in other contexts. The terminology utilized in the process is unfamiliar to inexperienced claimants, and some terminology is used in ways that have industry specific meanings.

If there is a dispute, the mechanism(s) for resolution of the dispute may be unfamiliar. The rigors of presentation of a case for formal dispute resolution require an understanding of the rules of evidence and procedure in effect in that tribunal, an understanding of the specific facts that must be proven to prevail and the ability to present the case, examine necessary witnesses, solicit supporting documentation and successfully argue their position. These demands are often beyond the ability of someone who has other stressors, including the injury itself, already taxing their resources.

While the worker is recovering from their injuries, they are subjected to lawyer advertising and the advice of friends, both tending to create fear of attempting to handle the requirements of the system without help and concurrently creating an expectation concerning the monetary rewards that are expected at the end of the process. During the pendency of the dispute the worker may feel cut off from the support systems he or she has developed at work, and their identity as a productive person and family bread winner is likely to be shaken. He or she may feel alienation from his or her employer, friends and family. The worker may, with the reduction of income suffered during time off from work, experience financial pressures, especially if their claim has been denied. These stressors, separately or in combination, may push the worker into seeking the aid of an attorney to assist in the collection of their claim.

Dispute resolution processes vary considerably from jurisdiction to jurisdiction. Some systems utilize some form of alternative dispute resolution mechanism. Models range from true meditation (e. g. the Navajo Nation[3]) to mandatory non-binding arbitration (e.g. New Mexico[4]) to voluntary arbitration (e.g. Mississippi[65]). Whether or not there is a mechanism for alternative dispute resolution available, the majority of jurisdictions have a captive first level formal dispute resolution mechanism. These include internal administrative law judges[5] and internal boards or commissions.[6] In all U.S. jurisdictions there is eventual access to the civil court system, at least for access to the appellate process.

The Role of Attorneys in Workers' Compensation Cases

Plaintiff's Attorneys

The most common model for representation of claimants is through the efforts of private counsel, who often specialize in representing injured workers before workers' compensation (and sometime Social Security) tribunals. Although a few states[7] have publicly employed, salaried attorneys available for the representation of injured workers, that arrangement is not common, and most "legal aid" organizations will not accept cases for which the award of monetary compensation is an appropriate remedy. The private plaintiff's lawyer is generally compensated, in part or whole, by the plaintiff, most often out of the proceeds of the recovery from the case. The private attorney works for the claimant, and owes ethical allegiance to him or her alone.

Where available, the publicly employed attorney is paid a salary by an entity for which he or she works, and provides services to the plaintiff without expectation of compensation from the plaintiff. The public

[3] 5 NNC 1010
[4] Section 52-5-5 NMSA 1978
[5] For example, in California and New Mexico
[6] For example, in Arizona and Arkansas
[7] Nevada, for instance

plaintiff's attorney still owes ethical allegiance to the claimant, but also is subject to certain controls, formal and informal, within their employing entity. Regardless of the role and source of compensation, the role of the plaintiff's lawyer is to win the case before him. The lawsuit is, to the plaintiff's attorney, a classic "zero sum" game where one party wins and the other loses.

A variety of different considerations come into play in the decision of the private plaintiff's attorney to accept or reject a case. Most plaintiff's attorneys are paid upon a contingent fee arrangement, and therefore only obtain remuneration for their work upon obtaining a positive outcome for the injured party. Therefore the plaintiff's attorney will often make an economic decision concerning the viability of the case, both in terms of its probability of success and in terms of the economic potential for fee generation under the applicable standards controlling attorney compensation. This can make it hard for worker with a case in which there is a small dollar value in controversy to get representation, even if the issue is of great significance to the worker, because the amount of attorney work to prevail may be too great to balance the fee obtained at the end of the process. This is particularly true in cases where only medical benefits are in dispute. One exception occurs when the case presents a possibility of creating precedent applicable to other cases. The notoriety and opportunity for future business attendant the creation of favorable precedent may provide sufficient motivation for the attorney to accept a case for which a substantial profit is unlikely.

After acceptance of the case, private plaintiff attorneys are often partially motivated by management of the caseload assigned to them. They may be tempted to utilize tactics to maximize the probability of a settlement of the case. Settlements are considered desirable, despite generally resulting is some reduction in compensation in the individual matter, because they allow the attorney to undertake representation of a larger number of clients over any period of time than the longer process of trial and appeal would allow. The trade then becomes resolution of more claims at a reduced level of compensation versus maximization of the return on a particular case. This settlement strategy also reduces the probability that a given case will go entirely uncompensated. Tactics utilized include the bringing of questionable claims, accompanied by a willingness to settle them at less than the cost of the defense of the claim, and the bringing of claims for excessive items and amounts of claimed benefits (particularly indemnity benefits) so that the claim will contain items that can be compromised to obtain a settlement. Ethical constraints (which are generally quite loose if the attorney can argue that he or she is seeking an "extension of the law") personal responsibility, and the widely varying oversight of administrative and civil courts act are factors limiting such behavior.

Public plaintiff's attorneys may also be motivated to settle cases due to the need to manage their caseload. They may be rewarded for processing more cases in a given period of time, or may be motivated simply by avoiding the sensation of being overwhelmed by their assigned cases, but there is no direct economic motivation to maximize the award for the worker. Public plaintiff's attorneys are often seen as of inferior quality, but that impression ignores the fact that such practitioners are among the most experienced members of the bar in their particular specialty, and that they usually do not have the distractions of the economics of law practice to cloud their judgment or divert their attention.

Defense Attorneys

The defense attorney most often is a member of a law firm that contracts with the payer to handle those claims that require services that are beyond the role of claims adjuster. Attorneys may be statutorily required for the representation of corporations. In such a model, the purchaser of the services is the either the claims adjuster on the case or someone in authority to make such decisions in the payer organization, and the attorney will very likely be mindful of the need to please the hiring entity to obtain further work.

If not a member of a law firm, the defense attorney may be an employee of either an insurance company or an employer that was authorized to assume its own risk of on the job injury. In such cases the attorney may have significant direct control over the positions taken on particular cases and the general style of case handling within that environment.

The defense attorney often faces situations where the possibility of "winning" the case, by reducing the employer's liability to zero, is remote. In such cases, the creation of conditions where the case is settled at less than the maximum possible liability is considered a victory. A variety of strategies are utilized for that purpose, including delay of the case (to create economic pressure to settle), forcing the claimant to prove their case even when its merits are apparent (in hopes that the other side will make a mistake that can be exploited) or using "scorched earth" tactics - contesting every possible issue to the maximum extent - to raise the cost of prosecution of the case to the level where a settlement at a compromised level of liability becomes attractive. Countervailing pressures exist to hold down the use of these tactics. They include ethical constraints, personal beliefs, and the desire of the entity paying for defense services to strike a balance between aggressive defense and the cost of the defense in attorney fees and litigation related expenses.

The Role of Attorneys in the Creation of Disability

The impact that attorneys have, under the system of compensation of attorneys and resolution of disputes currently prevalent in the United States, in the creation of systemically induced disability is sufficiently unique, that it deserves its own term. For purposes of this Chapter, it will be referred to as "attorneyogenic" disability.[8]

Attorneys, as might be expected, are highly resistant to the notion that their activities might cause disability. To be sure, most attorneys have no idea that they are harming their clients, and would be concerned if they considered the implications of their practice. Some are sufficiently aware to avoid such harms.

The role of attorney fees in creating disability

In the United States, most attorneys accept workers' compensation and/or personal injury lawsuits on a contingent fee basis. That is, the attorney representing the injured person does not get paid for their services unless they are successful in obtaining a judgment for the injured party, and they take a percentage of that judgment as their fee. The percentages vary with local practices, but often run between 25% and 40% of the ultimate award for personal injury cases, depending on a variety of factors, including the extent of court proceedings in the case. In workers' compensation the practice of being paid on a contingent fee basis is often controlled by statute, and/or is subject to governmental approval of attorney fees.[9] However, in either case the principle remains the same – within limits, the attorney gets paid more the larger the size of the award received by the injured party. Since the injured party gets a larger award based upon measures of damages such as loss of wages, expectations of future

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[8] The term was coined by a physician, whose name was unfortunately not recorded, at the 2009 American Occupational Health Conference of the American College of Occupational and Environmental Medicine. It also appears in a chapter entitled "The Legal System and Behavioral Health" in Warren, P., editor, The Handbook of Behavioral Health Disability: Innovations in Prevention and Management, Springer Publishing, pending publication.

[9] Attorney fees must be approved by the court or administrative body in 37 states, according to "Workers' Compensation Laws, 2d edition – a Joint Publication of IAIABC and WCRI", June 2009

lost wages, degree of permanent physical impairment, pain and suffering (in personal injury, but not workers' compensation) and medical bill, it is literally true that the attorney gets paid more, the more disabled the injured party is found to be. Thus, the rational economic interest of the attorney representing the injured party is to present him or her to the world as disabled, helpless and without prospects of future improvement, so as to maximize the award.[10]

The impacts of such a system can be both overt and subtle. A worker who has returned to work cannot make a convincing case that they are too disabled to work, and deserving of a higher award on that basis. Workers report, not infrequently, that they were advised by their attorney not to return to work when they felt ready to do so, for fear of compromising the award that they would get at the end of the case.[11] Significant impact also occurs when the attorney publicly refers to the injured party as someone who is no longer able to work, seeks an award based upon the expectation that they will be dependent on others indefinitely, or coaches the client on how to appear at hearings, doctor visits and other occasions where the degree of their disability will be judged. As we have seen above, the modeling of a particular behavior over time can create associations that make neural connections between the behavior and a whole complex of beliefs and emotional responses. In common parlance we speak of "self-fulfilling prophecy" or the "Pygmalion effect" rather than speak in terms of the creation of neural pathways, but the outcome is the same regardless of the level of detail invested in the description of the mechanism – the injured party who is treated as if they are disabled, or counseled to act disabled, often becomes the story that is told to the outside world. Thus, some "attorneyogenic" disability arises as a result of the plaintiff's attorney seeking a larger award, and consequently, a larger fee.

Far from being seen as an inherent conflict of interest, the plaintiff's bar defends the practice of contingent fees on several grounds. First, it is asserted that the use of contingent fees is necessary so that economically challenged individuals can afford to pursue their claims without risking their own resources, already taxed by the loss of work and medical bills attendant the injury. This supposition is only valid in an environment where each party pays their own attorney fees. The system of each party paying their own attorneys fees (sometimes modified by workers' compensation statutes[12]) is called the "American system" of attorney compensation. It is contrasted with the "English system"[66], in which the losing party pays the costs for representation assessed for both parties. The American system is defended on the ground that other systems suppress meritorious claims from being brought due to the risk of the economic burden of loss. The same system is subject to the criticism that it allows frivolous lawsuits, "strike suits" (litigation brought with the hopes of a settlement for less than the cost of

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[10] This action, adverse to the long-term best interests of the client, might be considered a conflict of interest. Interestingly, the Rules of Professional Conduct suggest otherwise. Contingent fees in civil cases (except domestic relations) are specifically approved. See, Model Rules of Professional Conduct, Rule 1.5 (C.), American Bar Association, 2004. Conduct adverse to the client's interests is not considered in the general rule on conflict of Interests. Model Rules, supra., 1.7. The issue could be raised under the following language: "Unless otherwise required by these rules, a lawyer shall not represent a client if the representation of that client may be materially limited by….the lawyer's own interests" supra, 1.7 (B.), however the rules also provide an exception to the rule prohibiting acquisition of a proprietary interest in a claim for contracting for a contingent fee. Supra, rule 1.7 (j.) (2).

[11] The evidence for such events is only anecdotal, but many experienced workers' compensation claims adjusters relate such stories. Personally, I have heard more than a dozen workers relay similar tales, in the capacity of investigator of allegations of fraud, and as an investigator of allegations of attorney misconduct.

[12] For example, in many cases the employer and claimant statutorily split liability for the claimant's attorney fees. See e.g. Section 52-5- New Mexico Statutes, Annotated., 1978.

defense) and "professional plaintiffs" litigation (the practice of a small number of very litigious people to make some or all of their living by maintaining multiple lawsuits, against multiple parties, in the hope of sufficient income for economic viability). The majority of the world follows some variant of the "English" system.

Second, the plaintiff's bar asserts that the contingent fee arrangement is necessary to afford access to representation. They argue that, since the plaintiff is always at risk of non-recovery and therefore the attorney representing plaintiffs is always at risk of non-payment, the percentage of fee generating cases has to carry the risk of loss and the burden of economic viability of the entire caseload. Put another way, the winning cases have to finance the losing cases. This argument would be more persuasive if the attorneys representing the injured were required to accept the cases presented to them. The opposite is the case. Attorneys often will not accept cases that they feel have a poor chance of success in the courts, and, as noted above, even routinely refuse to accept meritorious cases when the potential for fee generation is insufficient.

Finally, the contingent fee system is defended on the grounds that it motivates the attorney to do the very best for the injured party. This argument does not survive much scrutiny. Other professions, including some that are involved in the treatment of injured men and women, seem to survive the test of motivation without making their fees contingent on outcome. Physicians, and related health professionals are often paid on according to schedules for the procedures that they perform, regardless of outcome. This is usually justified on the ground that the physician is not entirely in control of the outcome, which is subject to multiple independent intervening variables. Interestingly, the argument that physicians will put forth better efforts if they are paid contingent on the outcome of their treatment is not considered appropriate.[13] Moreover, like doctors, ethical principles concerning the practice of law already require the attorney to use their best efforts on behalf of their clients.

Defense attorneys are not immune from the lure of additional fees in the practice of workers' compensation. Although there is a growing trend for defense attorneys to be compensated on a flat rate per case basis, the majority of defense practice is still done on an hourly fee basis. The creation of additional work results in higher fees, and the practice of an attorney "churning" the case to generate additional billable hours is a well-known hazard with which claims adjusting personnel are quite familiar. The difficulty with such practices, as will be discussed below, is the creation of additional delay in the resolution of the case and additional circumstances in which the injured party must model disabled behavior. As we have seen this additional time and repetition of the associations between the injury and the emotional and intellectual attitude of disability make it more entrenched and harder to overcome.

Other factors creating "attorneyogenic" disability

Delay

Delay in the resolution of any disputes in the case causes harm. It creates more time in which to habituate the behaviors that model disability. It creates time where the injured worker may obsess upon

[13] A recent "hot topic" for discussion of in workers' compensation has been the possibility of "pay for performance" for health care professionals. Interestingly, this debate is not based upon an assertion that the doctors will be more motivated to heal the injured worker if their fee structure depends on outcome, but rather on the notion that such a scheme would motivate health care professionals to utilize empirically proven techniques in preference to less effective or more experimental medical procedures.

their condition, the people who have wronged them and the unfairness of the system in failing to compensate them. The obsessive behavior varies among individuals, but where present, it results in repeated association between the injury, the emotional loading of the concern that gave rise to the obsessive behavior, and the worker's status as someone unable to resume their accustomed role in their life. Through the mechanisms discussed above, the worker's neural network adjusts, allowing those associations to become habitually linked, and very difficult to break.

Delay also causes direct hardship, where the worker has medical treatment or benefits necessary for the maintenance of their lifestyle held up by court disputes. These hardships are stressors that increase the tension experienced by the worker and with it the physical symptoms experienced.[67] [68] [69]As the delay stretches on, the delay, the resultant stressor, and the increased perception of physical symptoms may habituate themselves, causing a complex association of thoughts feelings and emotions that has become part of the neural makeup of the worker. They may truly experience the negative results of delay, even though those results were never intended.

Delay may come from a variety of sources. It can be a tactic utilized by the defense to put economic pressure to settle on the injured worker (also known as "starving the worker out"). Delay can occur because the attorneys, in an attempt to maximize their own incomes (or in the case of public plaintiff attorneys, because the resources devoted to the function are outstripped by the demand) simply have too much on their respective plates to give each case attention at the first instance when the case is subject to the next step in resolution. It is common to see attorneys have schedules too full to allow quick scheduling of hearings, and the practice of attorneys seeking continuances of matters set for hearing is a continuing problem in judicial administration.[70] Similarly, the crush of a large caseload often stretches available adjudicatory resources, resulting in delays in resolution caused by the inability to obtain a hearing date from the relevant adjudicatory body. Decisions from the courts can be delayed, after hearing, for the same reason. Delay is also caused by the need to coordinate the care, examinations, and reports from multiple physicians, therapists, rehabilitation specialists and other professionals. Regardless of the source of the delay, it all has deleterious effect upon the party seeking to resume their pre-injury life.

Encouragement of behaviors for the purpose of enhancement of the case

The degree to which attorneys functioning within the dispute resolution system directly or indirectly encourage their clients to model disabled behavior is not well documented. By its nature, the phenomenon is difficult to study quantitatively, because the perceived economic interest in the pending dispute resolution, and eventual award of benefits could be compromised by disclosure of tactics that are perceived as being questionable. There is, however, significant anecdotal evidence to suggest that lawyers on both sides either intentionally or inadvertently encourage the injured worker to act in a disabled manner over a longer period of time than is necessitated by their physical condition. This time in the "disabled" state and repetition of behavior tends to habituate the development of associations between physical sensations, emotional reactions and behavior.

Experienced health care providers and claims management personnel are familiar with the not-infrequent assertion that a worker's attorney told the worker that, "going back to work will damage your case". It is, of course, unknown what percentage of those cases represent actual advise from the workers' attorney and what represent an attempt by the worker to justify their avoidance of return to work, a mis-communication between worker and attorney, or the mis-attribution by the worker of advice obtained from some third party. Nor is it likely to be possible to quantify such behaviors, since an admission by the attorney may be considered a breach of the Rules of Professional Conduct[71] governing the ethical

constraints of attorneys. Nonetheless, the persistence and frequency of such reports suggests that the phenomenon is real. Assuming *arguendo* that such reports are sometimes legitimate and accurate, the holding of a worker out of work for longer than is necessary has clearly been shown to have a detrimental impact on their ability to eventually return to work at all.

Nor are the attorneys representing injured workers the sole source of such deleterious effects. When an attorney engaged in the defense of a claim questions the legitimacy or severity of the disability or its causes, the likely outcome is to force the worker to model the disabled behavior more often and for longer periods of time, with outcomes that are predictable in light of our understanding of neural plasticity and the formation of the "disabled persona"[14]. This effect can be magnified in an atmosphere where there is an expectation that an investigator will be watching the claimant in an attempt to catch them acting in a manner inconsistent with disability.

Change of Locus of Control

The legal process is one where the claimant is almost always subject to a loss of sense of control. Control is lost to the lawyers and judges running the process of dispute resolution, a health system that casts the patient in to the role of passive recipient and claims examiners who may control the means to obtain the basic needs of day to day living. The transfer of control over the necessities of daily living has been shown to be a good predictor for increased disability. In this context it is usually referred to as a change in the perceived locus of control.[72] This is a systemic variant of "medicalization" of a claim, involving the larger actions of the entire medico-legal system in the process The resulting encouragement of an identity as a disabled person, internalization of limitations consistent with that role and change of perceptions so that experience in the world is interpreted to reinforce those limitations has been sometimes called "learned helplessness"[73] [74]The legal system has shown no conscious awareness of the impact of this phenomenon on the plaintiff's long term well being, although there is a tendency for the plaintiff's advocate to assert that the diagnosis, once established, is a permanent condition. Unfortunately, the legal process itself may help fulfill this prophecy.

Abandonment

In general, the legal system stops when the claim is resolved. There is no follow up to see if the litigants have resolved their issues and moved on with their lives. The advocate for the claimant has no systemic motivation to assist him or her after the claim is completed, depriving the claimant of what may have been their only support system during the pendency of the litigation. Planning for functional adaptation and treatment after the dispute is resolved is often lacking. Once the projected future costs of functional recovery are reduced to a monetary figure and an award is made, the claimant is most frequently left to their own devices with regard to actually obtaining services. If the worker felt a sense of betrayal at the abandonment of them by their former employer, when his or her job is not held for the worker's return, then the emotions associated with the employer's actions may be exacerbated by this further abandonment.

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[14] "Disabled persona" is a useful term for the personality organization of a person who, by reason of the habituation of associations between their injury, their experience of physical symptoms, and emotions such as depression, anger, helplessness and hopelessness begins to see themselves as a victim of their circumstances, unable to take control of their situation.

Catastrophic thinking

In the process of presenting the best possible case for a large award of damages, the natural tendency is for attorneys to project the worst possible case into the future, for the purpose of creating motivation on the part of the judge or jury for the award of maximized future damages. When an individual projects the worst case scenario into the future, behavioral health experts are likely to refer to the phenomenon as "catastrophic thinking" and take therapeutic steps to assist the person in recasting their thinking into more useful directions. When the same behavior takes place in the courtroom, it is considered good advocacy, and the lawyers involved seem unconcerned that the claimant may internalize the characterization, engage in his or her own catastrophic thinking about their condition and prospects and habituate the disabled behavior that was being projected.[75] [76] [77]Indeed, conversations with plaintiff attorneys about their clients are usually scattered with reference to lives that have been irretrievably shattered, with no hope of meaningful restoration and only a large award as solace. If the worker's guide to this mysterious process has given up hope for his or her client's recovery, the claimant's opinion is likely to follow.

Professional enabling

Even where the motivation of the attorney representing the injured worker is entirely the pursuit of the workers' enlightened best interests, the role of attorney, by its nature, tends to exacerbate the possibility that an injured person will develop habituated disability behaviors. "Enabling" is a term applied, often in the context of alcoholism, or other issues involving family dysfunction, to describe actions by another, which tend to separate or protect someone from the consequences of their actions. An alcoholic's enabler might work an extra job to keep familial finances under control, make excuses for absence from work, create inaccurate explanations for family and friends for the alcoholic's behavior and even deceive themselves intro thinking that everything is normal, or at least an appropriate response to stressors in the environment. The enabler acts from a desire to maintain the appearance of normalcy and stability rather than from any motivation inimical to the best interests of the alcoholic. Unfortunately, the actions of the enabler often allow the behavior to develop to the extent that the addiction is much harder to address and the chances for a positive resolution are diminished.[78]

Professionals can also take the role of an enabler. A lawyer acts as a professional enabler when seeking to shield the client from the consequences of his or her actions. The most obvious example of this is the role of a criminal defense attorney. Such attorneys conceive their role to be to "get the client off" the charges, or at least to minimize the punishment for the offense, if liability for the criminal act cannot be successfully avoided. Parallel roles often occur in the context of employment law, marital and familial situations, and economic dealings.

The role of enabler in workers' compensation involves the promise of outside intervention to spare the worker the consequences of taking responsibility for their recovery and return to normalcy. The television lawyer advertisements proclaim that "you may be entitled to a large cash award", or similar phrasing. The frequently used terms, "award", "settlement" and "compensation" all imply that the status of the worker has changed. The term "entitled" is often used to describe the relationship between the change in status and the "award". The message is that the worker is owed something by the world –they should not focus on their own resources and choices but should rely upon the world providing compensation for the wrong that has been done to them. This focuses the injured party on the outside world as the source of their problems and the lawyer as their salvation. This belief system, while a very good advertising practice, focuses the injured worker on their helplessness and, by repetition of the message, creates dependency. Unfortunately, when the case is over, the attorney will move on to the next case, pulling the support from the worker, who now has to confront abandonment issues as well as

their acquired disabled persona. Unfortunately for the worker, the cash settlement is never sufficient to make them whole as compared to the wage earning potential they have as a working person.[79] [80] [81] [82]

Charges of symptom magnification and malingering

The terms "symptom magnification" and "malingering" are often used, incorrectly, as being synonymous, but both give rise to dynamics that encourage the worker to model disabled behavior longer and more frequently, with predictable, if somewhat ironic, results.

"Symptom magnification" in the legal context is the tendency for a person to focus on physical symptoms that exceeds "normal" expectations. "Normal" however, is in the eye of the beholder. Most people have had the experience of getting a bruise or cut and not remembering how they got it. Many people have experienced themselves, or someone else, overreacting to a relatively minor injury or condition. "Normal" reaction lies somewhere along the continuum between these two responses. The person who focuses on their perception of physical symptoms also tends to focus upon the anticipation of future experiences of the physical symptom and fear associated with those anticipated future events. The complex of physical symptoms, emotional responses, and worries about the future becomes habituated through the mechanism of neural plasticity, and symptom magnification is established.

In this context, the defense attorney, often at the suggestion of a health care provider, investigator or employer, may seek to establish that the worker is magnifying their symptoms in an attempt to gain a larger award. By doing so, the worker may perceive an attack on his or her credibility. The natural tendency of someone under such a perceived attack is to defend himself or herself, often by modeling the disabled behavior that they are accused of magnifying, to demonstrate to the world that the symptom is real. Moreover, the accusation will likely cause delays in the resolution of the case, and an increased probability (whether perceived or real) that an investigator will scrutinize the worker's actions and activities. Thus, the charge of malingering ironically causes the worker to focus more and longer upon the very symptoms he or she is accused of magnifying, causing either an entrenchment of the behavior, if it exists, or in some cases the creation of the magnifying behavior. It becomes a classic case of self-fulfilling prophesy.[83]

Malingering is a much more serious charge and generally a more value- loaded accusation under the law. Malingering is the conscious creation, extension or magnification of symptoms or limitations in the anticipation of "secondary gain". [84] [85] [86] [87] [88] [89] [90]Secondary gain is, in turn a neutral term to which a value loading has become associated, and implies the seeking of an external reward for a particular behavior.[91] Secondary gain can range from increased attention and sympathy from loved ones through permission to avoid disagreeable tasks, to behavior aimed at maximizing the economic payout from a particular incident. Where the worker is consciously seeking secondary economic gain that they are not otherwise entitled to, the malingering becomes a species of fraud.

Like symptom magnification, the ability to demonstrate the requisite mental state is critical to proof of the allegation. Similarly to symptom magnification, the proof of the charge is necessarily indirect, and the allegation itself causes the worker to feel threatened and attempt to defend him self or herself. Often this defensive behavior contributes to the habituation of it, and the resentment of the treatment at the hands of the employer's agent may lead to a sense of justification for intentional creation, maintenance or extension of symptoms for economic recompense. Ironically, in such cases the behavior of defense counsel may actually create the problem it was designed to eliminate or defend against.

The ethical plaintiff's attorney will not encourage malingering or symptom magnification. Aside from ethical considerations, all claimant advocates quickly come to understand that people who are overly focused upon their symptoms tend to be difficult and demanding clients. However, the actions of the plaintiff's advocate are not necessarily benign. The attorney is more highly compensated, the more disabled the worker is shown to be. People who are focused on their symptoms tend to present them as more severe to evaluating physicians and tend to be more credible in defense of those symptoms as witnesses. It is difficult to counsel a client on how to present themselves as a witness without inadvertently communicating the message that the more convincing the worker is about their condition, the better the outcome of the case.

Multiple medical evaluations and treatment protocols

A very significant occasion for development of needless disability comes at the hands of the medical profession, when it is invoked by the legal profession in the process of dispute resolution. In this sense, the drive to maximize awards for disability engenders contact with the medical profession that is sometimes problematic, and the circumstances for the creation of needless disability can be legitimately be said to arise from the legal context.

In the course of a dispute, if one side has a doctor providing an opinion concerning a critical issue, odds are that the other side will want its own medical expert to give a contrary opinion. The potential for this feature of dispute resolution to act as a cost driver is exacerbated by the fact that some U.S. jurisdictions allow, when each side has a contrary medical opinion, the engagement of a "neutral" third medical provider to create a tie breaking opinion.[15] Diagnostic testing is multiplied, additional delay for examinations and opinion generation is encountered and the worker is subjected to repeated deliveries of the message that they are subject to the control of others in the process of dispute resolution. Moreover, the message is often confounded by the variance between professionals. Differing opinions amongst doctors as to the diagnosis, medical causation, and level of permanent impairment lead to the sense that no one knows what they are doing, or that the medical professionals are not objective and interested in the worker's best interests. If the worker has become sufficiently conditioned to think of themselves as being disabled, then efforts originating with a health care provider that believes that the worker can recover his or her life are often misperceived as being driven by the economic agenda of the employer or insurer.

Perhaps more serious is the repeated message that the worker is a diagnosis, rather than a functional human being. It is not uncommon to hear workers refer to themselves by their diagnosis rather than in more personal terms. The negative effects of this phenomenon should be clear, given out understanding of neural plasticity and the "medicalization"[92] of patients. The focus on the connection between injury at work and disability, the worker's personal identification with a diagnosis, and the process of multiple evaluations of impairment repeatedly sends the message of disability, limitation, and inability to resume a normal life to the worker. Like the classic case of the child, told by a teacher that he or she is stupid, conforming to the message in their performance at school[93] it is not surprising when the worker acquires a disabled lifestyle and develops what is for them a genuine inability to return to productivity and normalcy.

[15] See, for instance, http://www.lni.wa.gov/ClaimsIns/Providers/Treatment/IME/About/default.asp, describing the procedure under WAC 296-23-302-392 for an IME to be requested by an insurer. See, also Section 52-1-51, NMSA 1978 for an example of the procedure in effect for the parties to request a "tie-breaker" IME.

This unfortunate cycle is partly perpetuated by the fact that the payment system for medical services is based, for the most part on diagnosis as a condition precedent for payment. Medical practice guidelines and impairment ratings are almost universally diagnosis based, and most payers for medical services in the workers' compensation and personal injury arenas are organized to recognize the provision of services only in the context of a diagnosis. This has led to the description and naming of a number of "diagnoses of exclusion", that are the diagnostic label put on people who exhibit what appear to be genuine complaints, but for which there are no objective signs or symptoms.[94] The placement of these labels on the injured worker creates an opportunity to refer to the various complaints with greater facility, leading to repetition of a consistent message and creation of links between that message and other factors in the life of the worker. Thus, the worker who can refer to the cluster of complaints they are experiencing with an easily uttered phrase, such as "chronic pain syndrome" will be more likely to reinforce their identity with the diagnosis.

Moreover, these "diagnoses of exclusion", by naming the cluster of complaints, tend to give an impression of objective reality to them. Through a process of modern shamanism, the naming of the ailment leads to a faulty syllogism: "If it's got a name, then it's got to be something real. If it's something that medical science regards as real, then it's something that I have to look to an outside professional to treat. If I'm not getting better with treatment, then I must be disabled." Unfortunately, since the original diagnosis was based on the exclusion of all diagnoses for which the etiology and treatment were well understood, the probability of a poor outcome at the end of that process is significant.

Employers

The attitude of employers to their work force and to return to work has profound impact on disability. It is recognized that two significant risk factors for delayed recover are poor job satisfaction and poor relationship with the supervisor.[95] Disability prevention programs that focus on activities of staying at work, despite an impairment, and return to work result in decreased disability. These programs focus on avoiding work avoidance and rather look for ways to prevent or reduce absence from work. Such programs are most successful when employers, employees, unions and insurance carriers are committed to the same vision. An innovative approach to the new work disability prevention paradigm has been organized by Jennifer Christian, MD, MPH and The 60 Summits Project.[96]

The American College of Occupational and Environmental Medicine developed a Guideline entitled "Preventing Needless Work Disability by Helping People Stay Employed."[97] This report focuses on the large number of people who due to a medical condition that should normally result in only a few days of work absence, end up withdrawing from work either permanently or for prolonged periods., with particularly reference to the role of employers and occupational medicine physicians.

The Canadian Medical Association issued a policy entitled "The Physician' Role in Helping Patients Return to Work After Illness or Injury" stating "prolonged absence from the workplace is detrimental to a person' mental, physical, and social well being. Physician should therefore encourage a patient's return to function and work as soon as possible."[98].

Insurance Benefits and Disability Systems

Disability systems themselves may contribute to disability, particularly if they do not focus on the prevention of disability. In 1870, Bismarck established the Prussian "welfare monarchy," whereby injured workers were cared for financially until they returned to full health. In the United States, this tradition continues via workers' compensation systems, private disability insurance programs, and government-funded programs through the Social Security Administration (SSA). [99] Most of these systems focus on the reported deficits of what someone can do, rather than their capabilities.[100] The judgment of whether someone is "disabled" is often based more of the tenacity of the complaints, than a consistent objective basis.

As noted above, studies have clearly documented that delays in returning to work are common for individuals who lacked job satisfaction and had a poor relationship with the employer before their injury; for those who sustained work-related injuries late in their careers and for whom limited education decreases their retraining potential; and for those who are out of work for more than one year.

Media and Internet

Individuals who have a health issue that is seemingly irresolvable by conventional medicine often must turn to self-diagnosis or using questionable sources on the Internet to find a label that seems to fit with their set of symptoms. There is a proliferation of unscientifically supported medical information that is available online. The media, including television, radio, newspapers, and magazines contribute to beliefs in illnesses by hyping inconclusive findings and preying on people's fears. For instance, some news stories have played up the spurious link between connective tissue disease and silicone breast implants; years later this link was not found to exist – the cost in the interim – human and financial – was severe.[101] Others that warn readers to "beware of toxic mold" feed people's fear of environmental exposure. The legitimate status of these conditions in the public's mind and popular discourse contrasts greatly with their unproven scientific and biomedical status

Sometimes, when no medical cause can be determined and no diagnosis or treatment provided, patients turn to self-diagnosis by searching the Internet and matching their complaints with those others and then adopting their illnesses as their own, "cyberchondria". Suggestible individuals may fall prey to the media's sensational portrayal of the syndrome du jour. Magazines and talk shows hype diagnoses that are based on incomplete, anecdotal findings or solely on personal accounts of patients. Widespread publicity may tend to create "outbreaks" of somatic syndromes in certain populations. Individuals who embrace these explanations for their discomfort may eventually find health care providers and clinics that will confirm their belief in chronic and often incurable condition; such medical groups usually have professional and financial stakes in the promotion of these syndromes. Patients may find their way to advocacy groups of other individuals who share their symptoms and validate their self-diagnosis. Such groups have a considerable influence on public opinion and can gain legitimacy for syndromes that are not medically proven solely) by organizing great numbers of individuals with the same belief system.

Symptomatic patients may also understandably seek validation of a diagnosis and may seek the support of others. Such individuals are prime candidates for participation in advocacy and "self-help" groups, which are very effective at swaying public opinion and shaping scientific debate, often reinforcing the concept of being victim to an injury or diagnosis.[102]

The Solutions

The disabling process is complex, since there are many interrelating issues and multiple players. Solutions start by recognition of the underlying problems that drive disability, including core concepts of self-responsibility. Individuals need to experience "hurdles" as barriers rather than opportunities. Strengths and weaknesses in expectations take root in childhood. It is critically important to move from habits of helplessness to traditions of strength.

Their needs to be change from disability management to disability prevention, with focus on staying at work and early return to work. The American College of Occupational and Environmental Medicine guidance statement on "Preventing Needless Work Disability by Helping People Stay Employed" made recommendations in four areas to stay at work and return to work, as illustrated in Figure 1.[103]

Figure 1. Recommendations of ACOEM Preventing Needless Work Disability by Helping People Stay Employed

I. ADOPT A DISABILITY PREVENTION MODEL

1. Increase Awareness of How Rarely Disability is Medically Required
2. Urgency is Required Because Prolonged Time Away from Work is Harmful

II. ADDRESS BEHAVIORAL AND CIRCUMSTANTIAL REALITIES THAT CREATE AND PROLONG WORK DISABILITY

3. Acknowledging and Dealing with Normal Human Reactions
4. Investigate and Address Social and Workplace Realities
5. Find a Way to Effectively Address Psychiatric Conditions
6. Reduce Distortion of the Medical Treatment Process by Hidden Financial Agendas

III. ACKNOWLEDGE THE CONTRIBUTION OF MOTIVATION ON OUTCOMES AND MAKE CHANGES TO IMPROVE INCENTIVE ALIGNMENT

7. Pay Physicians for Disability Prevention Work to Increase Their Professional Commitment
8. Support Appropriate Patient Advocacy by Getting Treating Physicians Out of a Loyalties Bind
9. Increase "Real-Time" Availability of On-the-job Recovery, Transitional Work Programs, and Permanent Job Modifications
10. Be Rigorous, Yet Fair in Order to Reduce Minor Abuses and Cynicism
11. Devise Better Strategies to Deal with Bad-Faith Behavior

IV. INVEST IN SYSTEM AND INFRASTRUCTURE IMPROVEMENTS

12. Educate Physicians on "Why" and "How" to Play a Role in Preventing Disability
13. Disseminate Medical Evidence Regarding Recovery Benefits of Staying at Work and Being Active
14. Simplify/Standardize Information Exchange Methods between Employers/Payers and Medical Offices
15. Improve/Standardize Methods and Tools that Provide Data for SAW-RTW Decision-Making
16. Increase the Study of and Knowledge about SAW/RTW

Change is required for all participants. For example, physicians are called on to respect patients and demonstrate compassion about their symptoms with heightened interest in helping to evaluate and

manage their problems. Whenever possible, evidence-based, functionally oriented, treatment should be provided for identified physical and psychiatric disorders, with the first objective being to empower the patient to assume an active role in health management. Such an approach to the treatment of problems can reduce patients' total burden of suffering and may improve their ability to cope with symptoms and achieve maximal function. Often a complete cure is not possible so the overall goal of treatment is to maximize potential and to control, if not cure, the patient's symptoms. Physicians should also know when to stop testing and using ineffective treatments; keeping it simple is typically for the better.[104] Ordering more tests and making referrals to several specialists for unexplained problems only increases patients' anxiety that they have a mysterious ailment. They should also be assured that hasty judgments were avoided in order to prevent inaccurate labeling of patients with diagnoses of that lead to unnecessary chronic disability. Physicians should also be on the lookout for potential psychiatric disorders (especially depression and personality disorders) and for angry, unmotivated, and manipulative patients who are trying to exploit health care and disability systems. Furthermore, the structure of health insurance systems should permit physicians to spend needed time with their patients and not to have to inappropriately assign diagnostic labels to obtain reimbursement.

Different system of rewards for each of the participants is recommended to encourage function rather than disability. A stay-at-work approach is encouraged, based on a defined plan and including an effective flow of accurate information among the employee, employer, health care provider, and insurer. Gainful employment provides a purpose in life; it also provides time-structuring and a normalizing rhythm. It provides a reason to get up in the morning and is one of the major therapeutic ingredients for pain relief (i.e., distraction). As such, it directly combats the primary psychological foe of all persons who experience chronic pain—rumination. Given the proper placement and working conditions, work provides a platform for one's ability, identity, status, responsibility, achievement, compensation, and financial security. It combats the tendency for social isolation and feelings of helplessness and hopelessness.

The adversarial legal system in the United States needs to be restructured, providing incentives for individuals to return to maximum function and rather than for being impaired and/or disabled.

The epidemic of disabling conditions in America can be reversed. This reversal depends on an understanding of the complexities of systems that are often dysfunctional and that reinforce disability rather encourage individuals to achieve their full potential through empowering solutions.

Solutions that empower not disable include creating positive realities, gratitude, traditions of strength, new paradigms rewarding recovery, disarming diagnoses, creating new expectations concerning the legal system and redirecting individuals toward healthy self-identify. People are able to live beyond assigned labels and be exceptional and productive. The ultimate responsibility for our actions, choices, and realities remains with each of us. Changing our state of mind changes our reality, both for ourselves and those around us.

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