RSI Conference 2nd March 2001

The views expressed by Professor Mackay.

LPC comments added in *italics*.

Terminology

Each of the words in the term RSI were criticised as follows:

1) Repetition alone cannot produce DRSI and is not the most important causal factor.
2) Strain is not involved with the pathogenesis
3) Pain and dysfunction are the problem, not injury.

In our view, Professor Mackay was emphasising that the term RSI has little value in forming views of causation, diagnosis, morbidity or duty of care.

He added that in very rare circumstances high repetition rates could cause injury.

Chronic pain

The key problem to be addressed is the development of chronic pain conditions that may begin with otherwise apparently innocuous pain. This is believed to be the case for low back pain and musculoskeletal disorders and RSI.

The development of chronic pain conditions is a multi-factorial problem, with contributions from psychological, psychosocial, ergonomic and organisational factors.

As yet, there is no definitive understanding of the mechanism. However, the role of the central nervous system is believed to be pivotal.

In our review of the state of knowledge of DRSI, we came to the same conclusion: "Significant, but not yet fully accepted, predictors for chronicity are perceived pain severity and catastrophising, both of which are subjective and may have little relationship to the degree of any organic harm." Pain severity and catastrophising are clearly issues for the central nervous system.

Pathogenesis

Interventions to prevent the development of chronic pain conditions should be based on an accurate knowledge of pathogenesis. These are not well enough understood at present. HSE is funding longitudinal studies to determine significant risk factors.

In our view it is essential to monitor and assess such studies very closely. Their expense makes them unusual. They are very persuasive evidence upon which to establish causation and new duties of care.

It is also significant that in his view, it is not possible to be certain that even existing guidance on the prevention of DRSI is accurate.

In designing these longitudinal studies, account will be taken of:

Psychosocial parameters at work:

- Culture and communication
- Work demands (pacing, rest, hours)
- Control
- Role (ambiguity and conflict)
- Support
- Relationships

Psychological parameters:

- Pain thresholds
- Attribution
- Motivation
- Fatigue
- Muscle tension
- Co morbidity
- Illness behaviour

Physical parameters:

- repetition,
- postures

application of force
and combinations

In our view, the relative importance of these factors will be influential in designing what would be regarded as a reasonable duty of care. They will also assist with, clarifying pathogenesis, guiding on proportional causation and guiding on the design of further studies aimed at identification of the best point and methods for intervention (secondary prevention).

It would also be logical to factor in the positive effect work has on mental health.

Risk assessment

As yet there are no objective standards that can be used to predict DRSI.

Measurements of ergonomic factors such as repetition, force and posture do not allow prediction of cases.

The realistic aim is to prevent the conversion of innocuous pain into a chronic pain condition. It is believed that the right approach to this is to identify obstacles to recovery (including psychosocial factors) and eliminate them. Risk assessments should therefore focus on the identification barriers.

In our view, it would be idealistic to aim for the elimination of such barriers to recovery before anyone has reported any problems. However, the more idealistic approach would be consistent with the precautionary principle.

Postures are believed to be very important.

HSE will publish a review of risk assessment methods by early summer (2001).

Interventions

Elimination of barriers to recovery, and measures to counter adverse psychosocial conditions at work. In particular, the support of colleagues and supervisors should be key factors in countering otherwise adverse psychosocial conditions.

Once the key predictors of chronicity have been established by longitudinal studies, it should be possible to design intervention studies to assess their accuracy and the practical value of intervening.

Rehabilitation following work loss.

Job design
HSE are currently developing standards that can be used to help design out psychosocial risk factors for chronicity.

Surveillance

Early signs that are predictive of long term problems have yet to be defined. The right response to the detection of such signs (when they are defined) should be to provide physical and psychosocial interventions.

Surveillance should focus on the identification of inappropriate coping.

A final note
“The Regulatory / legislative climate is likely to alter considerably.”

Summary

In our view, given that risk factors for DRSI have not yet been developed, it would seem logical to focus on identification of people with potential problems and to offer support. We would share the view that the aim must be to prevent unnecessary chronicity and severity of pain and dysfunction.

The tools for accurate identification and intervention have yet to be developed and tested. Such work is now under way.

The Views Expressed by Professor Frank Burke

Hand Surgeon

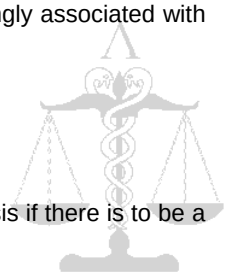
LPC comments added in *italics*.

Ownership

The patient who asks " what are you going to do to make me better" seems to have a poorer prognosis that the one who asks "how can you help me get better".

Relationships at work can be influential. If patients believe they have been the victim of negligence this may often lead to difficulties in restoring ownership of the problem. The pain is strongly associated with the feelings of having a grievance with the perceived assault at work.

Work Causation: assessment of an individual.



Test to apply in establishing work causation:

1) Is there a specific medical diagnosis (not fatigue and not RSI)?
2) What work does the patient actually do, this must be consistent with the diagnosis if there is to be a confirmation of work causation.
3) Is there a cluster of identical diagnoses at the work place?
4) Has there been any change in the work, just prior to the diagnosis? This may be helpful in deciding whether the work caused it or aggravated it.
5) Does the condition improve during absence from work? This is helpful for determination of aggravation.

In our view the first question is more reflection of the requirements of civil law that there is a specific diagnosis.

Differential diagnoses

Professor Burke described several conditions with specific diagnoses that produce pain in the region of the arm as reported in cases labeled DRSI.

Of particular note was his belief that problems with the neck at the C5/C6 joint should be examined more thoroughly in cases labeled DRSI.

Care

In general, the NHS does not respond quickly enough to prevent unnecessary chronicity. Industry would do well to consider providing some sort of fast track mechanism for dealing with cases before chronicity becomes likely.

For cases that have developed to chronicity, re-establishing patient ownership of the problem is a priority – a useful tip would be to ask them to stop going to any more specialists in the hope of finding a cure. Better to ask them if there is anything they enjoy doing and encourage them to do it.

<u>The views expressed by Christine Dodgson</u>

Claimants Lawyer

LPC comments added in *italics*.

Presented a review of the Statutory duty and Official Guidance with relevance to Upper Limb Disorders. Also presented a summary of the civil procedure rules and cases that went for and against claimants.

<u>Alexander & Others v. Midland Bank IRLR</u>
Of particular note was the view expressed by Lord Justice Stuart Smith:

> " even if the Defendants were correct and the Claimants' problems were psychogenic, then it was still possible to have a claim for damages provided that a causal link between the breach of duty and the injury could be established".

If this was a unanimous view it represents a significant deviation from previous case law where injury had to be of organic origin.

Much of the commentary suggested a strong reliance on Official Guidance to establish a breach of the duty of care.

Our view of this is that such guidance could not be applicable specifically to DRSI with any certainty as there is, even now, insufficient knowledge of causation, pathogenesis or the effectiveness of interventions to define an appropriate duty of care.

One of the key questions put to Ms Dodgson was whether or not a Judge would accept a distinction between a condition being revealed by work and, being aggravated by work.

The questioner posed the example of a man with heart disease but who was unaware of it. He then walks up a steep hill, becomes aware of a pain and is consequently diagnosed. It would be unlikely that anyone would suggest that walking the hill had caused or aggravated the heart disease. Ms Dodgson was under the impression that a judge would be able to discern this distinction.

[A review of the case law for RSI has recently been completed for ABI by CMS Cameron mcKenna under the direction of the LPC Centre for Risk Sciences, and will be published in April 2001]