Pain in the workplace.

Report of the employers forum: a one day meeting on the 7th September 2001, Edinburgh.

The workshop was organized by the Scottish Network for Chronic Pain Research (Director Dr Anne White 01786 466 343) and paid for by the Scottish Higher Education Funding Council.

The meeting was attended by academics, physical therapists, employers, insurers and occupational health service providers.

As always with meetings of this sort it is not anticipated that a high degree of academic rigour will be in evidence, the significance is the development of beliefs about chronic pain and the services that accompany them. Beliefs held by academics medics and employers will probably be regarded as the state of knowledge unless systematically addressed.

The scope of the workshop included Diffuse RSI and low back pain (LBP). It is our view that Diffuse RSI should be regarded as a chronic pain state.

The workshop addressed two key issues:

- The prevention of the conversion from acute pain to chronic pain.

- The rehabilitation of people off work with chronic pain.

Opinion as to the prevalence of pain among the workforce ranged from 10% to 25%.

Ergonomics?

The opinion of the specialists was that ergonomic interventions, such as manual handling Regulations, DSE Regulations, were at best of equivocal value in preventing the onset of pain and that the effect of poor ergonomics was not well understood when considering conversion to chronic pain states.

Research problems

Pain is of course subjective. As such its reporting and its effects on daily life vary with individual beliefs, expectations and general health, among many other factors. Research is considerably hampered by the lack of any objective measures of pain. However, the effects of pain on usage of health care and impact on daily life and work can be measured. Functional capacity can be measured but assumptions about individual volition and beliefs about pain usually cast doubt on the validity of these results.

The most successful research has therefore been into the effects of pain and factors which influence an individual to develop/maintain a chronic pain state.

Prediction of long term pain problems

Red flags

A small proportion of pain cases among the working age population will have serious underlying pathologies, known as red flags. Examples include cancer, arthritis, degenerative conditions, connective tissue disorders and so on. Their role in the development of chronic pain states is (largely) self-evident. However, the ways people cope with them and their effects on daily life are highly individual and may not be predicted by their effect on functional capacity alone.

Yellow flags

Psychosocial factors which can affect conversion from acute pain states (self resolving) include:

- Attitudes and beliefs about the meaning of pain. A conviction that all pain must be a sign of serious pathology is not founded on fact, but can have a strong influence on coping and on progression to chronicity. An expectation that a cure is just around the corner, or that there must be an underlying pathology often indicate a passive role in injury management.

- Pain behaviour. Maintaining the role of an injured person can fulfil psychological needs and is therefore difficult to break. This applies to the individual and close family (who may come to expect the presence of the pain victim and adopt to their new role)

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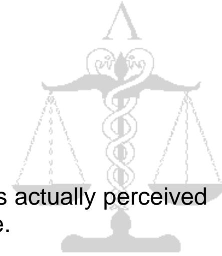
- Uncertain medical advice/care. Uncertainty has a strong effect on action. This will affect attempts to regain a normal life and may lead some people to believe that they must be continually referred to specialists until a real physical problem has been identified and therefore a cure will be found.

- Problems at work. A history of conflicts or under performance at work may suggest barriers to a return to normal activity.

- Emotional instability and depression.

- Compensation disputes.



Blue Flags

Return to or retention at work can be affected by the way work and its environment is actually perceived by the pain victim. Whether or not these perceptions are accurate is not the key issue.

- Un-supportive management.

- Monotony.

- Job satisfaction (or lack of it).

- Hazardous work.

Black Flags

Return to work can be affected by objective factors such as:

- *Company policy* e.g. policy on pain may require a medical certificate stating that the worker is free of pain before return to work. Life and Liability insurers may be thought by many to be the origin of such policies.

- *Work hours* may be inflexible, requiring the returnee to commit to full work with no period of re-habituation.

- *Ergonomics/physical work demands.* May interfere with gradual habituation.

Prevention of conversion from acute to chronic pain and disability

Clearly there are a large number of individual and circumstantial factors that can influence the development of chronic pain and chronic disability. The workshop highlighted:

Pre-injury performance

Under performance, boredom and conflicts at work can all be managed, even if the motivation for this is not usually the hope of avoiding chronic pain states! The workshop did not provide objective measures of these factors which might be predictive. Perhaps the intent was to indicate management qualities which would be perceived as supportive?

Retention

It was generally agreed that physical work factors are rarely the cause of the development of chronicity, though some reduction of workload or variation of tasks would be appropriate in many cases until the problem had sufficiently resolved. The key factor was the retention of the worker at the workplace while resolution occurred. This would avoid losing the working habit and losing social contacts at work as well as encouraging normal levels of physical activity. On the other hand, poor work habits should not be maintained.

Support

Acceptance of the pain state is important. Open or inferential criticism of the pain state or even suspicion of the honesty of the pain victim can lead to unnecessary complications. Family influences can be important if they support the expectation of loss of ability or the (ill-conceived) need to be pain free before resumption of work.

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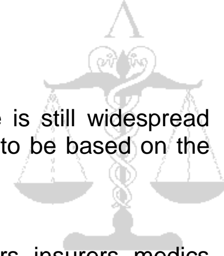
Passive physical therapies

There was strong physiotherapy/occupational therapy contingent at the workshop. They were at pains to point out that passive treatments, where the pain victim is treated but does not engage with the treatment are no longer widely practiced in the UK. Instead patients are encouraged to learn ways of coping and to extend their physical range (fitness, mobility, range of motion). Passive physical therapies are at best palliative (which may encourage self activation) but at worst encourage the perception that there must be an underlying pathology which can be cured without any intervention on the part of the pain victim.



Comment

Not all practitioners of physiotherapy would agree, passive manipulation/massage is still widespread and presumed to be appropriate for care of chronic pain states. This would seem to be based on the observation of pain relief which comes with such care.

Beliefs

There is a systemic problem in the way pain is perceived and managed by employers, insurers, medics and of course the pain victim. There is a belief that pain is always an indication of an underlying pathology.

Equally unhelpful is the belief that injury necessarily implies disability.

Attempts to address both these misperceptions are now manifold for back pain and there are reports of some success. All those involved with a pain victim management need to understand and believe that life can go on and that most often, normal life encourages faster resolution of pain problems than any other intervention.

A leading example of the campaign is available from www.workingbacksscotland.com.

Advocacy

The number of barriers to recovery and ability are many. So long as health and other services have limited scope to act, there appears to be a need for patient advocates to help deal with all the relevant issues on a case by case basis. Such advocacy/case management would require accurate assessment of the barriers. General opinion of the optimum timing of assessment ranged from 6 weeks to 12 weeks.

Comment

A number of physiotherapy and occupational therapy groups are beginning to promote themselves as interested in and able to make full biopsychosocial assessments and to act as patient advocates at work, health care provision and financial support.

Their success rates will only become apparent if their services are engaged.

Assessment tools have begun to emerge.

The underlying principles of their approach seem to be supported by a wealth of research evidence. Implementation should be fine-tuned to local cultural and social/financial support environments.

Rehabilitation of pain victims with several years absence was not fully discussed, but seemed to revolve around the same concepts.

The approach to pain advocated at this workshop is that adopted by the Pain Association Scotland (0131 312 7955) a charitable organisation. Is there an English or Welsh equivalent? Apparently not.

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