Does Knowledge of a Patient's Workers' Compensation Status Influence Clinical Judgments?

Maureen Simmonds\(^1,3\) and Shrawan Kumar\(^2\)

It is generally acknowledged that compensation payments (WCB) influence rehabilitation outcome in a negative manner. Patients receiving WCB have more treatment over a longer time period than their non compensated (NWCB) cohorts. It is not clear whether therapists (PT) perceive WCB clients as being more impaired and expect them to have a worse outcome than clients without WCB. The purpose of this study was to determine whether PTs' clinical judgments are influenced by the knowledge of a patient's WCB status and whether this knowledge influences their assessment findings or prognostic judgments. A convenience sample of 69 physical therapists (PTs) participated. Each PT viewed three videotaped assessments, of patients with low back pain (LBP) that differed in severity. The PT was provided with a brief history of the patient. Included in the history was a statement that the patient was (WCB group), or was not (NWCB group) in receipt of workers compensation benefits (WCB). The third group of PTs was given no information (control group) about the patient. PTs recorded physical assessment findings and made prognostic judgments about the patients. Data for the physical assessment findings and prognoses recorded by the PTs was analyzed across information groups using ANOVA. Knowledge of compensation status did not influence the PTs' physical assessment findings but did influence prognostic judgments. WCB status was deemed to have a negative effect on outcome in patients with mild LBP. Additionally, NWCB status was deemed to have a positive influence on outcome in patients with severe LBP. The differences were most marked in the short term (1 month). It was concluded that PTs expectations of outcome are influenced by prior knowledge of compensation status.

KEY WORDS: low back pain; spine; assessment; impairment; prognosis; bias.

INTRODUCTION

Low back pain (LBP) has been a human affliction since ancient times, but the high rate of disability due to LBP, is a relatively recent phenomenon. In industri-
alized countries, disability due to LBP has increased at a rate 14 times greater than the population growth (1). This phenomenon is frequently attributed to the system of compensation for LBP but the influence of compensation on LBP related disability is not as clear as anecdotal evidence suggests (2).

It is clear that LBP causes disruption of work and social activity and leads to tremendous utilization of healthcare services. Medical costs such as physicians’ fees and drugs are high in back injuries compared to other musculoskeletal conditions (3). Rehabilitation costs are also much higher in compensated patients as the recovery period is longer and treatments are continued (4). The reason for the discrepancy in treatment regimens is not clear. The contention that payment of compensation is the only reason for a poor outcome from rehabilitation oversimplifies a much more complex problem. Patients in receipt of compensation are not homogenous, and factors such as employment status have been shown to exert a far stronger influence on outcome (5). Presumably, the quality of medical practice will also play a role in the outcome of LBP.

The traditional medical model has tended to focus on the physical factors in LBP and this has contributed to its failure to halt the disability epidemic (1). The multiplicity of empirical treatments, documentation of inappropriate treatments and investigations (6), and the persistence and recurrence of the problem are further testimony to this failure (7). No treatment is better than inadequate treatment (8). The fact that most cases of benign LBP settle with no treatment (9), supports the suggestion that the medicalization of LBP has added to the problem rather than the solution of the LBP problem (10).

Psychosocial factors play an important role in determining the effects of LBP (11-13) and the response to treatment (14). The health beliefs and expectancies of the patient as well as those of the practitioner will influence the outcome. The relationship formed between professionals and their patients also has the potential to influence rehabilitation outcome (15). The quality of the relationship, the enthusiasm of the clinician, and their beliefs or expectancies regarding treatment efficacy will influence the actual treatment outcome (16). These nonspecific effects of physical therapy techniques have been demonstrated in numerous studies (for review, see Ref. 17). While this nonspecific or placebo effect of a treatment is not well understood theoretically (18), both conditioning and expectancies are thought to contribute to the effect (18). Thus, the past experiences and current beliefs and biases, both positive and negative, of the clinician and of the patient, will influence the effectiveness of the treatment.

The presence of negative bias and suspicion toward patients receiving compensation has been reported (19-21). Patients with LBP may be viewed with suspicion if they are known to be in receipt of compensation and this may color clinical judgments (21). Clinical judgments concerning malingering may have some veracity but they are prone to error. When symptoms are viewed with suspicion, the clinical response can be selective and judgmental (22). Thus, the patients’ complaints do not get the attention that they deserve, and this may cause the patient to exaggerate their symptoms and behaviors in order to obtain appropriate clinical attention. The negative implications of this scenario are obvious.