Deftly Managing the Dodgy Patient

Navigating Non-organic Obstacles to Recovery in the Injured Worker

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Nonorganic

- *Adjective. non·or·gan·ic ˌnän-ȯr-ˈga-nik*

- A : not relating to, containing, or derived from living things
- B : not involving the use of organic methods of food production
- C : **not relating to or arising in a bodily organ or part : not due to anatomical or physiological dysfunction**

https://www.merriam-webster.com/dictionary/nonorganic

Dodgy

- *Adjective. dŏj'ē, ˈdä-jē:* **So risky as to require very deft handling.**
- Dodgy does not mean "bad person," it means that the person and his/her case needs to be handled "deftly"—with great skill

dodgy. (n.d.). *The American Heritage® Dictionary of the English Language, Fourth Edition*. Retrieved June 16, 2025, from: https://ahdictionary.com/word/search.html?q=dodgy
https://resources.depaul.edu/newsline/multimedia/Pages/monk-mandala-2018.aspx

The monks rapidly rub the chak-purs together to deposit sand onto the mandala surface. They also wear masks to avoid blowing the sand with their breath.

https://en.wikipedia.org/wiki/Sand_mandala#/media/File:Chenrezig_Sand_Mandala.jpg

Introduction

- Some injured workers over-consume resources in the in the Workers' Compensation system
- Sometimes, clearly, this is because people have serious injuries.
- There are also a variety of other factors that do not always correlate with organic pathology. For example:
  - Psychosocial factors
  - Underlying personality traits
  - Psychiatric disorders
  - Workplace conflicts
  - Secondary gain issues

Objectives

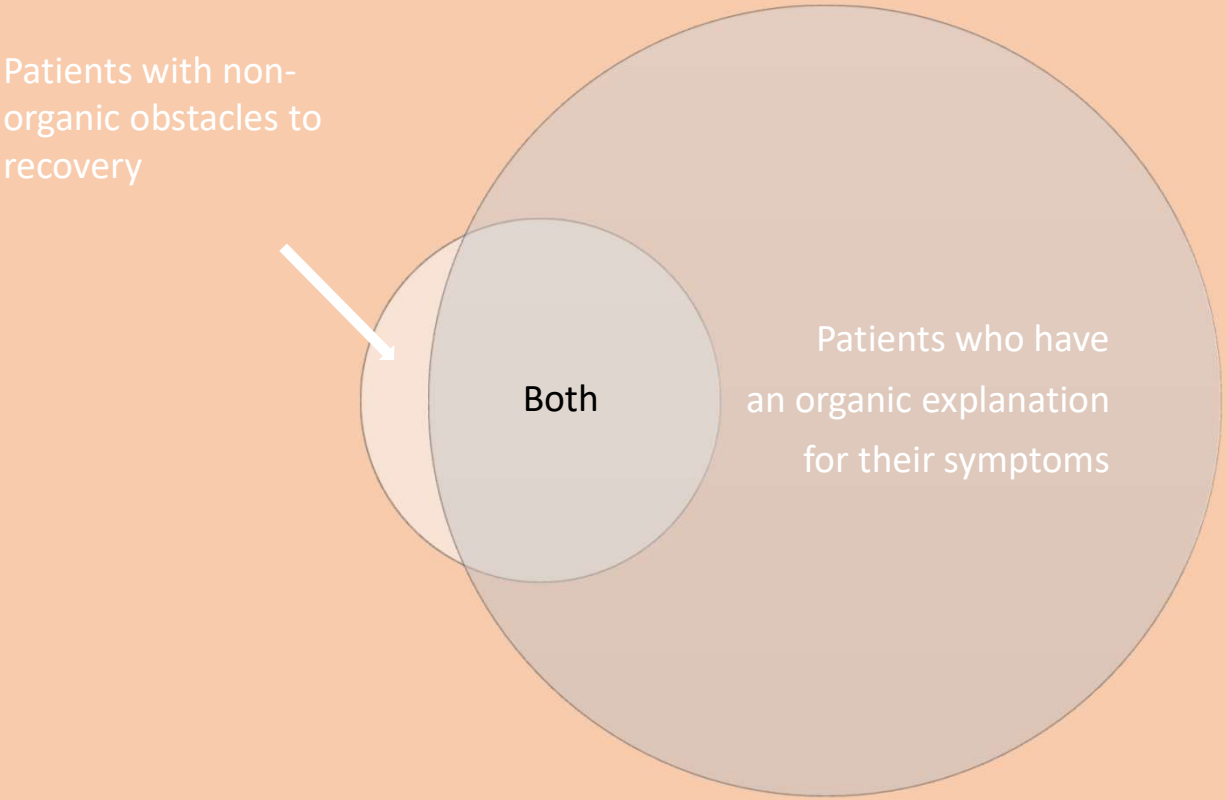
Discuss	Discuss non-organic obstacles to recovery
Learn	Learn how to identify potential obstacles
Discuss	Discuss strategies to address these obstacles • Help injured workers recover in a timely manner • Appropriately utilize limited healthcare resources on challenging patients

Scope of the Problem

- You tell me
- Depending on the practice, dodgy patients are often said to be 15-20% of total WC patients. (The old 80/20 rule)

- These patients over-utilize finite medical resources
- Can drive clinicians (and probably most others in the system) to demoralization….
- Or cynicism….

Scope of the Problem



Unusual Non-organic Obstacles to Recovery

- Malingering
- Factitious disorder imposed on self (Münchausen syndrome)
- Somatoform disorders

- *These disorders are rare.*
- *We'll focus most on more commonly encountered non-organic obstacles to recovery*

Secondary gain

- “Any advantage, as increased attention, disability benefits, or release from unpleasant responsibilities, obtained as a result of having an illness”
- “Secondary gain is defined as the advantage that occurs secondary to stated or real illness.”
- Examples of “gain:” miss work, garner sympathy, monetary rewards, drug-seeking
- Can be a component of any injury or disease
- May or may not be recognized by the patient

https://www.dictionary.com/browse/secondary-gain
https://pubmed.ncbi.nlm.nih.gov/10172109

Faking it? Malingering and factitious disorder

- **Malingering** is intentional fabrication, illness falsification, or exaggeration of symptoms "to obtain obvious external benefits such as money, medications…, time off work," etc.
- The deception observed in **factitious disorder** is not fully accounted for by external rewards.
- Diagnostic and therapeutic procedures (especially those that are painful or invasive) are avoided in **malingering** but readily accepted in **factitious disorder**
- Factitious disorder
  - Characterized by evidence of deception and falsification
  - Can manifest with symptoms involving any organ system.

https://www.uptodate.com/

Somatic Symptom Disorder and Conversion Disorder

- Not the result of conscious malingering
- Terminology and criteria changed in 2013 (DSM-5).
- **Somatic symptom disorder** can occur with or without a general medical illness that "explains" the somatic symptoms.
- Somatization is present when emotional or psychological distress is manifested as physical symptoms with no biological cause found.
- Physical causes must be ruled out, which can be difficult and costly
- **Conversion disorder** — There is no evidence of deceptive behaviors or falsification of symptoms. Conversion disorder always involves symptoms related to the nervous system.

https://pmc.ncbi.nlm.nih.gov/articles/PMC6887443/
https://www.uptodate.com/contents/factitious-disorder-imposed-on-self-munchausen-syndrome

“I was kicked by a cow….”

Non-organic obstacles to recovery are almost always more mundane

The Flag System
Identifying Potential Obstacles to Recovery

Red	Signs of serious pathology	Cauda equina syndrome, fracture, tumor, unremitting night pain, sudden weight loss of 10 pounds over 3 months, bladder & bowel incontinence, previous history of cancer, saddle anesthesia,
Orange	Psychiatric symptoms	Clinical depression, personality disorder, *anxiety disorder*
Yellow	Beliefs, appraisals and judgements	Unhelpful beliefs about pain: indication of injury as uncontrollable or likely to worsen. Expectations of poor treatment outcome, delayed return to work.
	Emotional Responses	Distress not meeting criteria for diagnosis of mental disorder. Worry, fears, anxiety. Catastrophizing. *A propensity to amplify symptoms. Psychosocial stressors.*
	Pain behavior (including pain and coping strategies)	Avoidance of activities due to expectations of pain and possible reinjury. Over-reliance on passive treatments. *Secondary gain issues*
Blue	Perceptions about the relationship between work and health	Low job satisfaction. Poor support at work. Perception that job is very stressful. Poor communication between employer and employee. Belief that work is too onerous and likely to cause further injury. Belief that workplace supervisor and workmates are unsupportive.
Black	System or contextual obstacles	Misunderstandings among those involved. Legislation restricting options for return to work. Conflict with insurance staff over injury claim. Overly solicitous family and health care providers. Heavy work, with little opportunity to modify duties. Social isolation and disconnection from workforce. *Litigation*

See https://www.physio-pedia.com/The_Flag_System (italics mine)
Sall RE. Strategies in Workers' Compensation. 62
LaCaille R, et al. Obesity and litigation predict workers' compensation costs associated with interbody cage lumbar fusion. The Spine Journal, 7:3;266-272

Dodgy Medical History

- Inconsistencies in
  - History
  - Medical record
  - Exam
  - Symptom character / severity / location
- Improbable description
  - Multiple symptoms or locations
  - Unusually sudden onset
  - Extreme severity
  - Symptoms inconsistent with the injury
- Symptoms are medically implausible
  - Anatomically inconsistent
  - Pain worms
  - Strangely evolving symptoms
- Textbook descriptions, unusual grasp of medical terminology
- Vague and inconsistent details
- History of substance abuse
- Drug-seeking behavior

Dodgy Medical Presentation

- Dramatic, theatrical, or histrionic presentation
- Demonstration of substantial impairment inconsistent with the disorder
- Patient doesn't improve as expected medically
- Easy acceptance of discomfort and risk of diagnostic procedures or surgery
- Fluctuating clinical course
- Rapid development of complications if initial findings prove negative
- Distrustful, manipulative, demanding, noncompliant patient

Deftly Doing Exams

- Medical provider must know the typical presentation and recovery patterns for diseases/conditions in order to detect when something isn't making sense.
- Responsible to investigate all reasonable, potential organic sources of pathology.
- Cannot equate the presence of non-organic signs as proof of malingering
- Tests for non-organic contributors to pain complaints
- Other non-physiologic findings

Deftly Doing Exams

- **Observation** is most important
  - Let them talk. Ask questions.
  - Notice inconsistencies in history or exam
  - Watch how they get on/off the table and move around the room
  - When possible, watch how the remove a jacket or shirt (e.g. with shoulder pain)
  - Palpation/distraction
  - The Parking Lot Test
- Emotional reactions to symptoms, such as reporting severe pain or distress while appearing comfortable
- Waddell's Signs
  - 3 or more positives strongly correlated with
    - Nonorganic / psychological contribution to symptoms
    - Illness behavior
    - Poor outcomes
    - Depression, anxiety, hypochondriasis
  - Does not necessarily prove malingering, secondary gain, or non-organic pain
  - Does not exclude real/organic medical problems or disorders
- Document everything. Let the facts speak.

Dodgy Workplace Signals

- Workplace conflicts
- Un-witnessed injury
- Angry or dissatisfied worker
- Angry employer
- “Problem” employee
  - Attendance problems
  - Conflict with supervisors
  - Close to losing job
  - Low morale, low job satisfaction

It can suck the life out of you

- Don’t let it bring you down
- Don’t take it personally
- Trust your skills and do your best
- Recognize that everyone else is doing their best to do their jobs, too
- Always have a professional attitude, treat people with respect and dignity
- Focus treatment on the patient assuming responsibility for his/her own health and rehab
- Accept that not everyone is going to get better; not everyone wants to
- Understand the way the system works
- Know when to cease treatment

https://www.harrypotter.com/features/everything-you-need-to-know-about-the-dementors-kiss

Occ Med physicians can use strategies to manage these issues

- Remember: dodgy patients require deft handling.
- Avoid being contentious
- Treat the person with dignity and respect. This does not mean “roll over and be a doormat.” That would not be good for anyone, including the patient.
- Remember dodgy patients can be injured and dodgy.
- Be aware, smart, and savvy. Managing difficult cases requires skills that can be developed.

First, do the basics well

And you’re likely to prevent some of these problems

Managing Injured Worker Care Best Practices

- Occupational Medicine providers
- Case management
- Employers

Physicians and APP's *Managing Injured Worker Care Best Practices*

Provide timely, high quality, evidence-based medical care

- Assess causation
- Identify red flags
- Focus on function (i.e., "sports medicine" model)

Communicate

- Clear communication with all involved
- Document ASR "Activity Status Report" (a standard form) to report status to employee, employer and insurer immediately after the employee visit.
  - Delivers a basic summary of treatment plan
  - Specifies activity status (e.g, if there are restrictions) at every visit
  - Provider/Case Specialist discusses and distributes this

Case Specialists *Managing Injured Worker Care Best Practices*

Serve as communications hub

- Clinician
- Patient
- Employer
- Payor

Contact and educate both employers and patients about

- Activity prescription
- Benefits of stay-at-work/return-to-work
- Suggest basic ways to identify work opportunities.

Get answers for payers to resolve issues about medical care

Ask patients if they have questions; offer to get answers

Monitor cases over time and intervene as issues arise

- Remind physicians to perform and code for best practices
- Request review and input from medical director or specialist consultants

Managing Injured Worker Care Best Practices

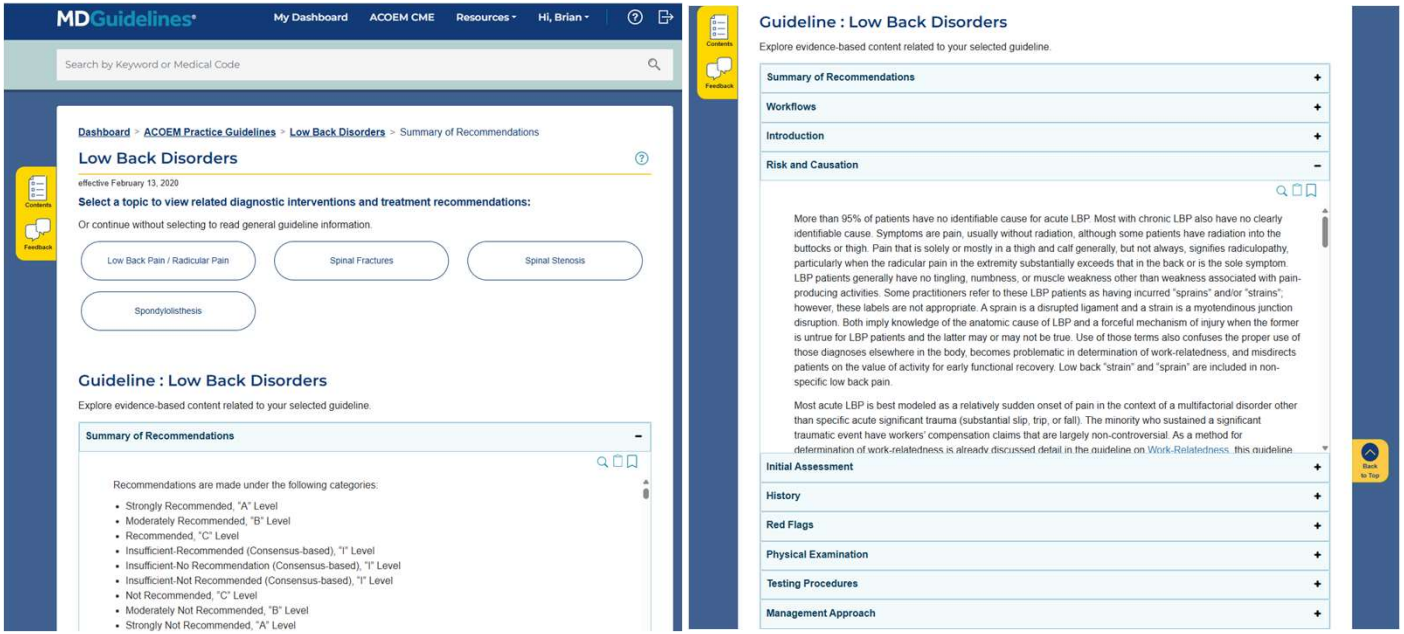
At end of every encounter, address with patient

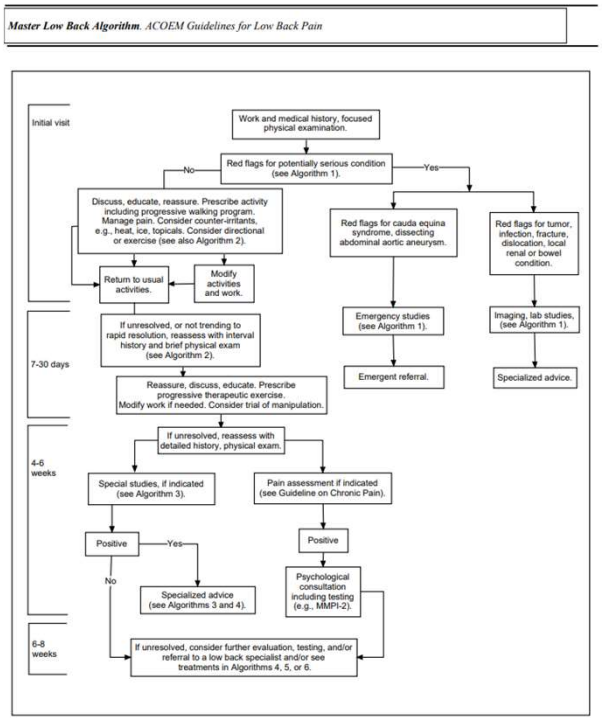
- Questions –the ones the patient asks, and ones they all need answered –if not done already, or any changes
- Treatment plan –what should happen between now and next visit
- Activity at home/work –verbally prescribe and proscribe activity AND write it out
- Self-care/self-management/self-development –what the patient can do to aid recovery
- Connect/communicate –who will make appointments, provide services, give handouts or instructions, etc.

Evidence Based Occupational Medicine

Teamwork

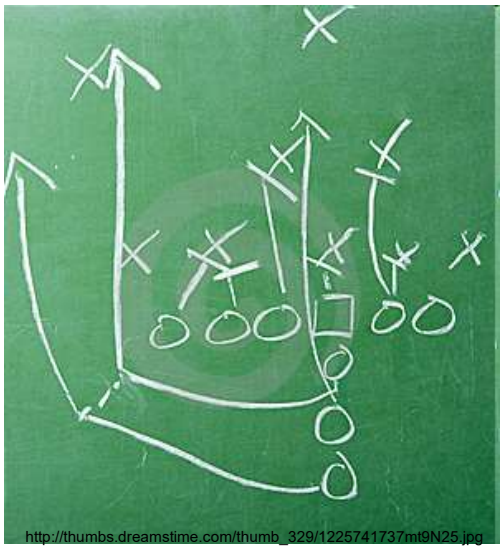
Evidence Based Occupational Medicine





Management Strategies

- Provider-Patient relationship
- Establish and reinforce expectations
- Exclude organic/physical disease
- Excellent communication
- Give the patient an escape ladder
- Play hardball
- Know when and how to close the case



Provider-Patient Relationship

- Very important to have a trusting provider-patient relationship, if possible
- Occ Med Provider develop rapport with patient, if possible
  - This is not the same as being manipulated by a patient
  - Firm but trusting. Requires people skills.
- Establishing rapport, in many cases, can help a great deal in appropriately utilizing resources

- Understand patient's current personal, social and occupational situation
- Regular, frequent follow up
- Recognize this might take a little longer than the average patient
- Recognize patient’s problems are important to them
- Keep them at work

Establish and Reinforce Expectations

- Physician as educator
- Explain typical disease process
- Explain typical recovery, express positive expectations
  - Example: low back pain: (reduce treatment duration)
  - Example: Pain cycle/chronic pain
  - Example: “Half mental”
- When appropriate, give them “permission” to have pain. Reassure that the presence of pain is not indicative of tissue damage. “These exercises are important; it’s OK if they are painful.”
- RTW goals and time-lines incorporated from onset
  - Keep patients at work, if at all possible
  - RTW time can vary up to 1/3 as direct function of education and recovery expectations in the initial treatment session
- Solely a disease-oriented approach will likely fail in such cases, because of a lack of organic pathology

Exclude Organic/Physical Disease

- Exclude physical disease/hasten workup
  - Judicious use of testing ("prove" a negative)
    - Thorough workup will help give power to close a difficult case
    - Explain typical degenerative changes
  - Judicious use of specialist consults
    - Often (but not always) confirms a lack of serious pathology
    - Can give case more power to close
  - Judicious use of psych testing can sometimes help.
- Assess the likelihood of a serious problem, weigh risks and benefits, etc.
- This is not withholding appropriate care.
- Differentiating between physical/organic and behavioral or non-organic causes is especially challenging

Communication

- Document well.
  - How to describe your findings (including non-organic findings)
- Aggressively address causation early-on; reassess as needed as you get more info
- Promptly discuss inconsistencies in history with patient
- Communicate with all parties involved
  - Expect communication to occur with: physician/provider, therapists, specialists, employer, insurance, nurse case manager, etc.
  - Regarding: treatment, testing, functional impact of the condition, activity status, alternate duty options, etc.
- Don’t try to solve management and industrial issues through clinical management.
- Workers may very selectively describe workplace issues and over report negative experiences

Communication Keys

Mannerisms

- Look them in the eye.
- Offering reassurance “good news”
- Be surprised
- Firm confidence

Be straightforward and truthful with everyone involved

Work together! Do not foster adversarial approach toward employer or case manager.

Between patient and employer

- Poor communication increases likelihood of poorer outcomes
- Supervisory support—you can be firm but still kind and respectful

Give the Patient a Ladder

- Good news!
- Can be especially useful after testing has ruled out serious pathology
- Explain ways to improve daily activities and replace illness behavior
- Gives the patient a “ladder” to climb out of the situation
- Gives the patient an opportunity to recovery gracefully. Remember, most people aren’t “faking it.”
- Almost always more effective to use this strategy before abruptly confronting

https://www.forbes.com/sites/chrissmith1/2024/03/22/fundraising-how-to-recognize-and-manage-the-pit-of-despair/

https://www.sfchronicle.com/athletics/article/A-s-batters-playing-a-leading-role-in-MLB-s-15531255.php
http://fakehustle.files.wordpress.com/2008/12/magnum-pi.jpg

Play Hardball

- Sometimes the treating physician
- Sometimes someone else in the system
  - Deny claims
  - Sometimes an IME
  - Others, such as surveillance

Know When and How to Close the Case

- At some point, cases need to be brought to some sort of closure.
- How to handle the conversation when there is a disagreement or difference of opinion
  - Focus on the medical facts
  - Encourage them with things to do—like exercises.
  - Document the details
- Patients usually already will know that they are entitled to pursue redress (legal counsel) for perceived injustice.
  - This should not postpone efforts to resume normal functioning and vocational involvement.
  - Typically, once a case gets to this point, closure of the case is in everyone's best interest. Allow the system to proceed.

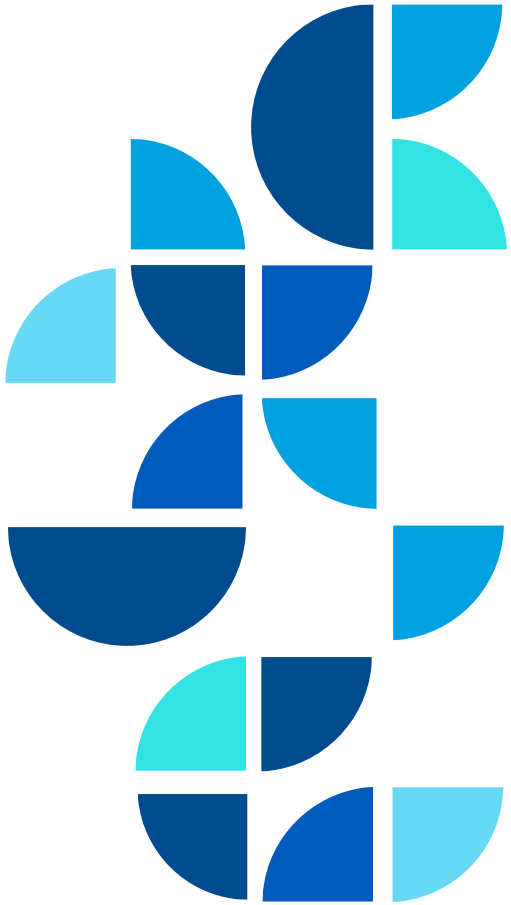
•Flashback

- To 2024....

MMI and Impairment

- *Guides*, 6th ed, 2024

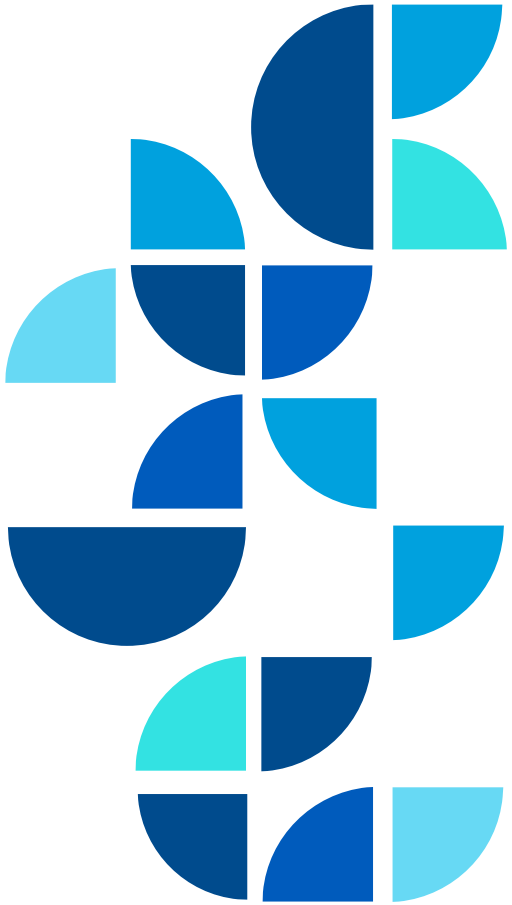
- "Maximum medical improvement (MMI) refers to a status where patients are as good as they are going to be from the medical and surgical treatment available to them." 1.3d
- Impairment can only be assigned once the condition has reached maximum medical improvement.
- Impairment is "a significant deviation, loss, or loss of use of any body structure or body function in an individual with a health condition, disorder, or disease." 2.5e



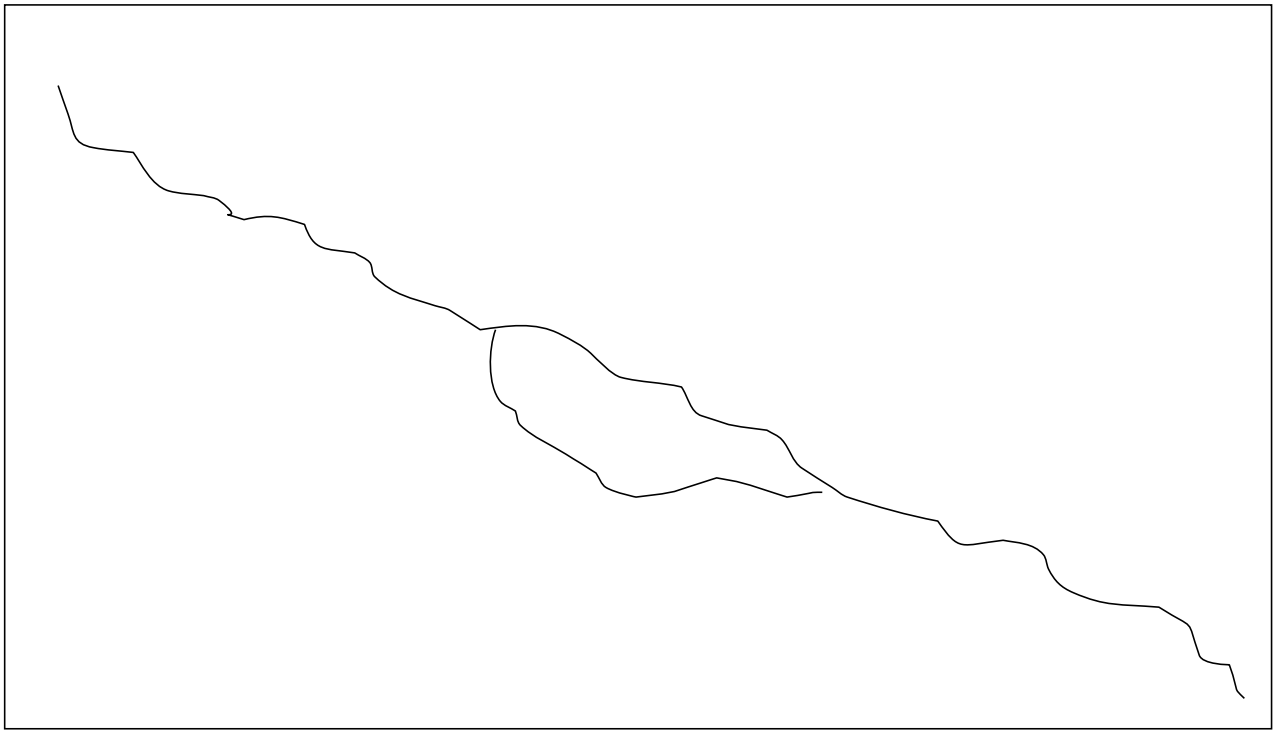
• Impairment

- The *Guides* is now online

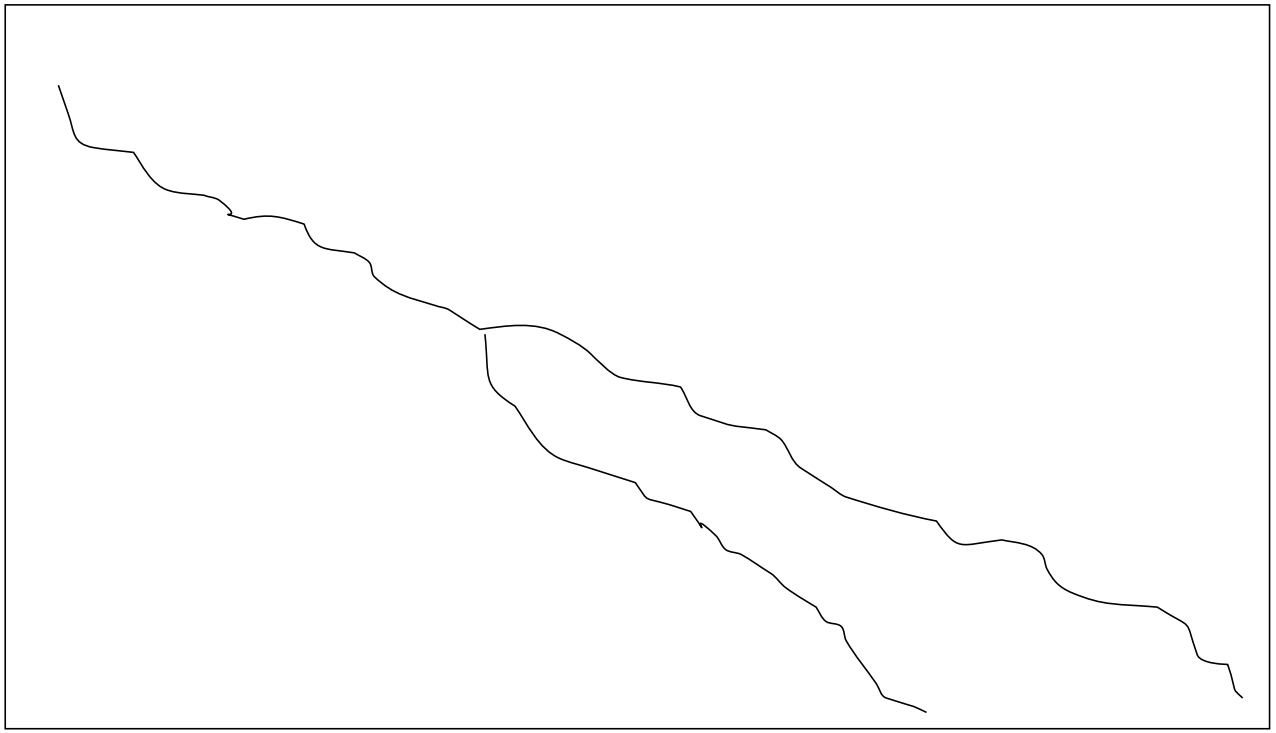
- AMA Guides® to the Evaluation of Permanent Impairment, Sixth Edition, 2024
- Publisher: American Medical Association
- Publication Date: 12 Sep 2024
- https://ama-guides.ama-assn.org/



- **Exacerbation**

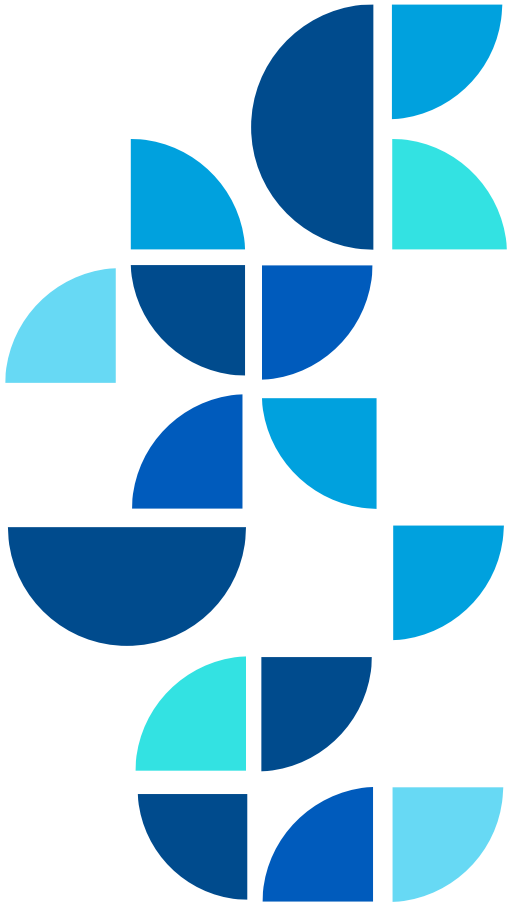


- **Aggravation**



• Bringing a Case to Closure

- In general, once a case is “compensable” (i.e., considered work related), it must be brought to MMI.
  - ✓ *For example: Someone strains their low back at work and it’s determined to be compensable. Six weeks later you get an MRI, and it only shows degenerative changes.*
  - ✓ *You can’t just say “oh, it’s not work related after all. Go see your own doctor.”*
- In difficult cases:
  - ✓ *I typically recommend getting definitive workup and specialty consultation.*
  - ✓ *Then plan for the OH physician to see the patient back. OH providers should be (or become) better at closing cases than most specialists.*
  - ✓ *At that point, even if still symptomatic, it may be time to declare MMI and get a rating and/or IME.*



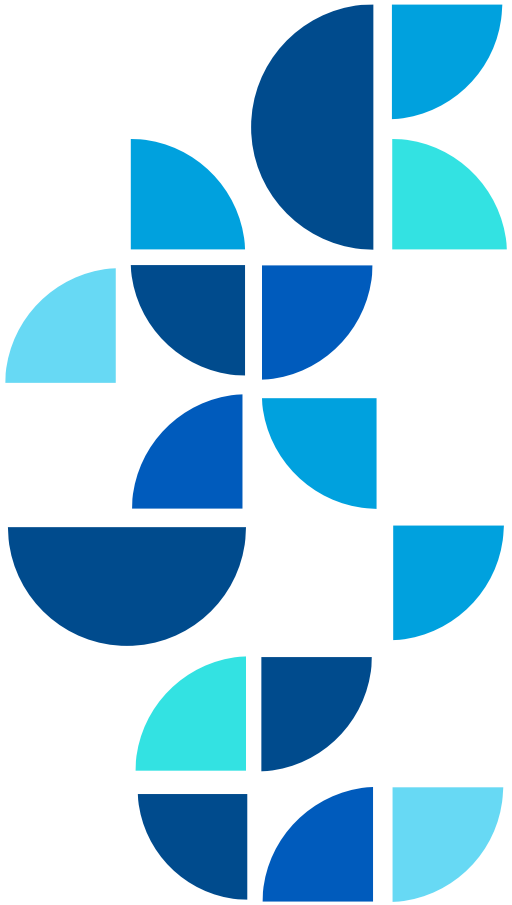
• Impairment vs. Disability

- Guides, 6th ed, p. 5-6

- "The relationship between impairment and disability remains both complex and difficult, if not impossible, to predict."
- "The Guides is not intended to be used for direct estimates of work participation restrictions [or 'disability']."
- …a given physical impairment can be highly disabling in one occupational context and virtually non-disabling in another.

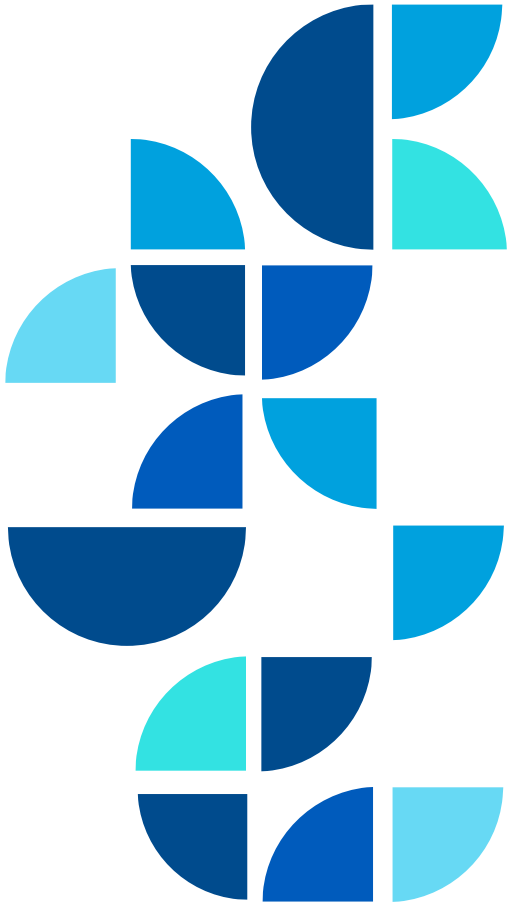
  ✓*Christopher Reeve*

  ✓*Toe amputation in a ballerina vs construction worker*



• Who Brings the Case to Closure?

- It depends.
- Options:
  - ✓ *Treating provider*
  - ✓ *Another OH provider for a simple impairment rating*
  - ✓ *Independent Medical Evaluations (IMEs)*
    - An IME is a special medicolegal evaluation by a physician who has never seen or treated the patient before. They are typically most useful when you have already completed exhaustive workup and already sought specialty consultation.
    - They can be requested by the surety, or by an attorney, and can be suggested by the treating provider.
    - They are expensive. Not all IMEs are created equal.
    - When appropriately requested, an IME can be very helpful to close difficult cases, especially when there are multiple and/or consequential questions to answer.



Summary

- Dodgy does not mean “bad person”, it means that the person and his/her case needs to be handled “deftly”—with great skill
- Remember the most common non-organic obstacles to recovery
- “Non-organic” does not usually mean “faking it”
- Colored flags & the clues to watch for
- Management Strategies
  - Provider-Patient relationship
  - Establish and reinforce expectations
  - Exclude organic/physical disease
  - Excellent communication
  - Give the patient an escape ladder
  - Play hardball
  - Know when and how to close the case

Conclusions

If “**dodgy**” patients (those who have non-organic contributors to their injury complaints) are managed **deftly**, they are more likely to appropriately utilize healthcare resources and recover in a timely manner. Patients will avoid risk of unnecessary/unhelpful treatments and unnecessary disability. Their cases will be less costly and less painful to manage.

https://new.artsmia.org/stories/into-the-mystic/

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