Work-related stress: care and compensation

Lodging a workers compensation claim appears to be associated with adverse health outcomes, and many GPs are reluctant to take on workers compensation cases — the system is clearly in need of improvement

STRESS IS A NORMAL PART of everyday life, but it can lead to psychological strain and difficulty coping with life's demands. Although a variety of non-specific symptoms such as headaches, disturbed sleep, depression, anxiety, irritability or substance misuse may result when individuals are stressed, there is generally little evidence that such symptoms are a direct result of particular stressful events. Rather, they are non-specific and can be precipitated by a variety of other causes, including other stressors to which the individual may be exposed. The issue becomes more complex when stress occurs in the occupational arena because of issues of confidentiality and the sometimes competing interests of patients, insurers and employers. In addition, organisational problems related to work stress, such as high absenteeism, high staff turnover, industrial disputes and poor quality control (leading to inferior products and reduced competitiveness for the organisation) may further complicate matters.

In this issue of the Journal, the cross-sectional survey of Western Australian general practitioners by Russell and Roach (*page 367*) attempts to start gathering information on the variety of approaches taken by GPs when faced with symptoms of anxiety which are apparently caused predominantly by occupational stress.[1] Obviously, the article has been written in the context of a political agenda in Western Australia, with a desire by some to consider accreditation for general practitioners in managing work-related stress claims. This was clearly opposed by about 70% of respondents to the survey.

The findings of Russell and Roach suggest that GPs with experience in the practice of occupational medicine are less likely to recommend time off work. Additionally, those who had knowledge of the specific requirements for lodging a work-related stress claim (which is likely to include those with experience in occupational medicine) were more likely to recommend initiating a claim. Many of the GPs surveyed were concerned about practising medicine in a workers compensation environment, and the implications this has for patient confidentiality. Many also reported reluctance to get involved in the workers compensation system. Some of the reasons for this include a lack of confidence in their knowledge of legislative requirements for opening workers compensation claims and concerns that such an approach has the potential to further compromise their patients' health.

In Australia, whether a claim is eligible for compensation is determined by the relevant insuring authority. While some jurisdictions have the option of allowing payment of medical and rehabilitation expenses and reimbursement of salary while claims are being determined, until a claim is accepted no benefits are technically payable, and, if reimbursements have been paid, these may have to be repaid if the claim is subsequently rejected. Thus, incurring treatment expenses while the claim is being determined can have substantial financial complications for an already stressed worker.

Stress claims for which salary reimbursements were received from the South Australian WorkCover Corporation between 1 July 1996 and 30 June 1998*

Time from date of injury to return to work	Number of claims	Claims still receiving reimbursement of all or part of salary: 12–15 months from date of injury	24–27 months from date of injury
Up to 4 weeks	81	16 (20%)	11 (14%)
4 weeks to 3 months	87	23 (26%)	14 (16%)
3–15 months	90	36 (40%)	24 (27%)

* H Woznitza, Program Manager – Education, WorkCover Corporation SA, personal communication.

This is further compounded by the sometimes significant time delays in the determination of some stress claims. For example, in South Australia (which is the only jurisdiction from which I was able to obtain data), 500 claims with stress as the primary cause of injury were lodged in the 1998–99 financial year. It took an average of 77 days to determine whether a claim was compensable or not; 223 claims were initially rejected, but 88 of these were eventually accepted after litigation (H Woznitza, Program Manager – Education, WorkCover Corporation SA, personal communication). There is no reason to expect that this sobering picture is substantially different in other jurisdictions. Obviously, this uncertainty and tardiness cannot assist the mental health of someone who already has a stress-related illness.

As Russell and Roach note, guidelines support a therapeutic benefit from early return to work,[2] although the evidence for this is scanty. There is some support for the benefits of early return to work in the South Australian data. For claims lodged between July 1996 and 30 June 1998 (see Box), in cases of occupational stress where there was an early return to work the likelihood of patients requiring long term ongoing support was reduced. However, these data need to be treated with caution because they are not controlled for severity of illness.

In contrast, there is good evidence to suggest that people who are injured and claim compensation for the injury have poorer health outcomes than those not involved in the compensation process.[3-5] A recent report produced by the Australasian Faculty of Occupational Medicine of the Royal Australasian College of Physicians highlighted the deficien-

cies in knowledge in this area.[5] In particular, research into causes of poor health outcomes for individuals in the compensation system is limited and inconclusive, and not enough is known of the effects of different types of schemes or methods of case management.

Not so long ago in the Journal, Cameron outlined some of the technical and ethical problems doctors face when working within the workers compensation system framework.[6] Issues of role confusion (gatekeeper versus patient advocate), objectivity in the face of coercion, and patient and insurer mistrust all contribute to many practitioners shying away from workers compensation cases. These concerns were reflected in the issues perceived by the GPs in the survey by Russell and Roach as barriers to effective management of patients with work-related stress.[1]

So, what messages can be drawn? Given the recognised adverse health outcomes that commonly occur after lodging a compensation claim, and the obvious stress involved in the process, it is not surprising that many general practitioners elected to temporise rather than immediately commence a compensation claim.

However, patients have rights under workers compensation legislation to receive benefits for work-related illness and injury. These benefits are more generous than those available under the Medicare system (eg, the payment of treatment from a psychologist is able to be reimbursed through workers compensation). Indeed, claiming benefits from Medicare for a workers compensation injury is specifically precluded. There is also a need for systems that enable treatment to occur with certainty of reimbursement of costs while claims are being determined and disputed. Obviously, practitioners would benefit from increased education and skills, and the proposed Western Australian accreditation system may be one way to assist this process.

Increased education and skill sharing of all participants (including consumers and the legal profession) in the compensation system may address some of the concerns about the adversarial system. Another approach may be to change the system itself, particularly by reducing its adversarial nature so that more time and effort is available for patient care. Exploring solutions that recognise "work stress" as a multifactorial problem, often with some of its origins outside the workplace, may be a worthwhile approach. This would necessitate a collaborative approach to managing work-related stress, with all stakeholders contributing their particular skills and perspectives. Finally, confidentiality issues in workers compensation stress claims remain significant barriers in the minds of medical practitioners and their patients. Clearly, there is a need for appropriate research strategies to examine and address these issues systematically to optimise health outcomes in a cost-effective way.

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Manipulation of the neck and stroke: time for more rigorous evidence

To fill this important gap in our knowledge would require collaboration between researchers from the manipulation disciplines and neurologists

MANIPULATION OF THE SPINE is a popular treatment which is used frequently by chiropractors. In the past 25 years, its use has been evaluated by increasingly sophisticated randomised trials. In a recent review of the emergence of the chiropractic profession from "alternative" to more "mainstream",[1] the results of 20 randomised controlled trials of cervical manipulation (for migraine and tension headache, cervicogenic headache or neck pain) were described: 11 were positive, and nine equivocal. Given this supporting evidence, as well as the frequency of use of manipulation[2] and the health and social impact of the conditions treated, it is important to consider any suggestions that manipulation may do more harm than good with some care.

In this issue of the Journal, Ernst (*page* 376)[3] reviews case reports of serious adverse events associated with cervical spine manipulation. Although Ernst acknowledges the considerable doubt about a causal relationship between the manipulation and the adverse event, he is inconsistent in suggesting that the anecdotal and uncontrolled evidence of the case reports favours the adverse events, often strokes, being an effect of manipulation. Elucidating a causal relationship calls for greater clarity, less ambivalence and generally better science in the present evidence-based climate. Thus, the important question to be answered in the light of Ernst's article is whether the association between neck manipulation and stroke is actually causal and, if so, in what direction?