Series 1: Practical Aspects of Disability Management

ABSTRACT: *In the following Series of articles, you will learn: [1] about the responsibilities of national and community-based advocacy groups in relation to workers with disabilities; [2] the connection between an acquired occupational disability and the strategies necessary to manage and cost-control these disabilities in the workplace; [3] how key disability prevention and management components are essential to quality workplace programming; [4] how Title I of the Americans with Disabilities Act impacts employers, particularly with respect to job analysis and accommodation; and [5] the importance of determining the essential functions of jobs in creating accurate job analyses.*

The Different Responsibilities of National and Community-Based Advocacy Groups

By Jasen M. Walker, Ed.D., C.R.C., C.C.M., and Fred Heffner, Ed.D.

The most common reason cited by employers for not hiring a disabled worker is a lack of qualified workers.[1] Since in fact there are approximately 8.4 million Americans with disabilities who want jobs, the reason cited is not a valid reason. If too many employers still labor under the misapprehension that there is a scarcity of qualified individuals with disabilities available for employment, then advocacy groups have not, and are not, doing enough to dispel the misconception.

To assign responsibility in even more detail, advocacy groups at community-based levels probably have a greater chance to influence the situation than do national groups. National groups need to continue to provide perspective, direction, and resources. National agencies are responsible for the sensitizing of Congress and keeping the pressure on there. National agencies are also more effective with large companies as opposed to small companies. And it is important to have large companies support the cause. Fifty-two percent of companies with 10,000 or more employees hire individuals with disabilities versus only 16 percent of companies with 10 to 49 employees.

As the (only) 52 percent indicate, large companies also need to do more. This is to be the continuing challenge for the national agencies. But the effort to assist small companies to understand the value of employing individuals with disabilities falls almost exclusively to community-based advocacy groups.

What should these community-based agencies be doing to help area employers hire and support qualified individuals with disabilities?[1] Consider the following:

A Commitment to Deal with the Disability Issue

Small companies need to understand that not having a Disability-Management Program (DMP)—or at the very least a strategy—is a cost factor too important to ignore. Small companies are as liable for Workers' Compensation and medical-benefit costs as are their larger counter-part companies, and they are far less able to absorb these (continually rising) costs.

Most smaller companies need to be assisted to make a commitment to disability management. And they also need to be helped to understand the nature of the commitment. At minimum, the commitment is to:

- contain cost through planning for and managing disability programs;
- design and operate safety and wellness programs;
- sponsor return-to-work programs for present employees; and
- reach out to qualified individuals with disabilities for new hires.

Planning Disability-Management Programs

The role of community-based advocacy groups is to reach all employers in the area to make certain they understand the cost of not including individuals with disabilities in the company. The objectives are to

identify the individuals with authority in a company and to get them committed to the process. The commitment is manifested through direct action, and community-based agencies can play an important role in the action by providing planning expertise and development of resources.
The question is, "Who in the company can obligate to the decision? And, if the person who is authorized to do so does not, what responsibility do others have?"

After the commitment, companies need to undertake the following:

- gather relevant data as the basis for decision making;
- assign responsibility for the continuation of the process (a cost containment task force/team);
- create strategies;
- write policies and procedures; and
- train personnel to implement and operate the following initiatives.

Safety and Wellness Programs

Obviously, safety programs are more effective in some businesses than others. In some smaller companies, safety programs may not be needed. But where the business does warrant a safety program, disability professionals in community-based agencies can serve employers as expert consultants. Wellness programs, on the other hand, are applicable to all companies regardless of size. Wellness programs are prevention strategies designed to contain absenteeism and more extended time-loss costs due to illness/injury. Some basic issues here are quitting smoking, maintaining a general fitness level, strengthening muscles (especially back), and controlling obesity. Another serious concern for smaller companies (whether it should be classified as safety or wellness) is assisting employees to avoid situations that could lead to repetitive motion syndrome.

Presumably, community-based advocates are experts on preventive measures, as well as after-the-fact measures and, as such, should be willing to support area employers as they attempt to develop safety and wellness programs.

Return-to-Work Programs

Once an employee has been injured or becomes ill, the single most important thing a company can do is to immediately initiate a return-to-work process. This means that a designated individual, representing the company, goes to visit the employee (in treatment or at home) to assure the individual that the company will do everything it can to effect the quickest possible return to productivity.

The return-to-work commitment includes: professionally managed care using preferred providers, utilization reviews, peer reviews, work hardening/therapy, vocational rehabilitation as appropriate, and transition duty, which is a more useful concept than "light duty".

The heart of any DMP in which cost containment is the goal, must embrace an aggressive return-to-work program. Employers need to understand this critical concept and to create the programming that, in fact, will achieve that goal. A community-based advocacy group, perhaps more so than any other entity, can help to instruct employers on this approach. A company not embracing a return-to-work program will not be doing all it can to contain disability costs.

Finding Individuals with Disabilities as New Hires

In all companies, regardless of size or the nature of the business, people create the margin of success. Well-managed companies learned a long time ago that a diverse, heterogeneous workforce will produce better ideas than one that is not. Well-managed companies seek to attract, to challenge, and to reward the best people and to develop them for the future.

To ascribe to this hypothesis without considering the talents and skills of individuals with disabilities is to limit severely the talent pool available for employment. Community-based agencies need to work with employers to apprise them of the talent/skill pool in an area and to help employers to locate and hire these individuals.

For their part, rehabilitation counselors are responsible for knowing what additional resources, especially community-based resources, are available to benefit their clients. The CRCC *Code of Professional Ethics* for Rehabilitation Counselors speaks to the issue by stating (C.1):

Rehabilitation counselors are aware that disability benefit systems directly affect the quality of life of clients. They provide accurate and timely information or appropriate resources and referrals for these benefits, and

Rehabilitation counselors provide clients with appropriate information to facilitate their self-advocacy actions whenever possible. They work with clients to help them understand their rights and responsibilities, speak for themselves, make decisions, and contribute to society. When appropriate and with the consent of clients, rehabilitation counselors act as advocates on behalf of clients at the local, regional, and/or national levels.

The CDMS *Code of Professional Conduct* speaks to the importance of clients being informed regarding the services being provided (RPC 1.04):

Certificants shall explain services to be provided to the extent necessary to assist the client to make informed decisions, understand the purpose, techniques, rules, procedures, expected outcomes, billing arrangements, and limitations of the services rendered and identify to whom and for what purpose the results of the services will be communicated.

The CCMC *Code of Professional Conduct* also provides case managers with standards of conduct to follow regarding keeping clients informed (S9):

Board-Certified Case Managers (CCMs) will provide the necessary information to educate and empower clients to make informed decisions. At a minimum, Board-Certified Case Managers (CCMs) will provide information to clients about case management services, including a description of services, benefits, risks, alternatives and the right to refuse services. Where applicable, Board-Certified Case Managers (CCMs) will also provide the client with information about the cost of case management services prior to initiation of such services.

The Mission of Community-Based Advocacy Groups?

The professionals who staff community-based advocacy groups certainly have enough to accomplish without additional responsibilities. Still, the important work of making The Americans with Disabilities Act and Amendments Act of 2008/ADAAA effective across the nation requires that such agencies take up the concomitant obligation of partnering with local businesses to achieve the opportunities their client's need in the marketplace.

Explaining Acquired Disability & The Workplace Approach to Managing It

By Jasen M. Walker, Ed.D., C.R.C., C.C.M., and Fred Heffner, Ed.D.

The following articles examine the logical connection between an "acquired occupational disability" and the strategies needed to manage and cost-control these disabilities in the workplace.

(Part I) Explaining Acquired Occupational Disability

ABSTRACT

We have concluded that acquired disability following trauma must be "explained." It is apparent that unless an expert is fully informed of the multitude of pre- and post-injury medical and psychosocial dynamics that surrounds an individual's claim of occupational disability, the expert may not be in a position to make absolute judgments regarding residual employability, pre- and post-work capacity, or the causal attribution of vocational disability. Causal attribution is critical in determining disability chronicity following trauma, as the host of contributing psychosocial dynamics effecting unproductive states are often overlooked when investigating the most obvious reason for work absence, a so-called "explanatory event." We believe thorough and accurate history-taking is necessary when assessing pre-injury work longevity, determining residual employability, and causally ascribing occupational disability to a particular event. Acquiring a complete and reliable history through various sources places the expert in a better position to offer a professionally certain opinion**.**

Background

Central to most personal-injury lawsuits are the issues of vocational disability and lost earning capacity. When injured people begin losing time from work, they inevitably attribute the vocational disability to the most recognizable event preceding the unemployment – the accident. In a purely temporal analysis, most observers would agree with the injured party. That is, a documented event or accident took place and caused subsequent lost time. However, post hoc, ergo propter hoc (after this, therefore on account of it) is frequently a fallacy and too often constitutes a failure in the cause-and-effect analysis of vocational disability. How people explain acquired disability can affect how chronic it might become.

It has become our perception over the past two decades that confusion exists in society generally and in our medical and legal systems specifically, as to who is best qualified to describe vocational capability and disability and delineate the various factors to which occupational disability might be accurately ascribed. Thus, not only does acquired disability have a personal meaning, to be explained by the individual, but of course a larger social context in which professionals attempt to determine who is vocationally disabled and why. In this article, we will reflect on who is best qualified to professionally describe occupational disability and its causes.

Over the 25 years we have examined thousands of injured people for the purposes of providing them with vocational rehabilitation or evaluating them for forensic consultations, we have learned that vocational disability is as much a function of psychosocial dynamics as medical impairment and resultant functional limitations. We believe that when one considers not only a medical impairment, but also the constellation of psychological and social forces that are at play both before and after an accident and work injury in particular, one generally comes closer to defining the true cause-and-effect of lost productivity that may occur following an industrial accident or injury. We also found that thorough and detailed history taking is the key element in the skilled assessment of vocational disability.

Multiple Factors in Disability Analysis

It has been our experience that in the disability equation, one needs to account for the:

1. worker's general health preceding the event in question;
2. work conditions preceding and at the time of the event at issue;
3. employer-employee relationship;

4. employee's self-esteem and psychological strength;
5. psychosocial factors outside of the workplace; and
6. social-economic alternatives to remaining productive.

Let us look at each of these factors and their influences in the lost-time analysis.

Worker Health and Wellness. Minds and bodies are the vehicles that collectively fuel productivity at both the individual and the organizational level. When mental and physical abilities are not maintained with proper health practices, they naturally deteriorate, and under stress these vehicles can actually breakdown. Organizations have more or less recognized the importance of health and wellness among their worker populations. The institutionalization of prevention and early intervention includes such initiatives as smoking cessation plans, employee assistance programs, and exercise facilities available to all workers in particular companies; however, these types of programs are neither universally available nor commonly accepted as means by which employees can remain healthy and productive.

The degenerating musculoskeletal system, an unavoidable aging phenomenon, eventually becomes prone to injury and disability, particularly in industrial settings. Workplace mortality rates for longshoremen, transportation workers, and steelworkers, for example, are generally higher than those for accountants, lawyers, and schoolteachers, although more sedentary employees are by no means immune to mental stressors that can precipitate occupational illness. Absent a focus on worker health and wellness, organizations can serve as the stage on which the aging employee is more or less susceptible to lost time not as a result of a particular event, but because of the degenerative process that makes any body and/or mind vulnerable to occupational stress.

Working Conditions. Workplaces are not always conducive to employee health and wellness regardless of the most enlightened efforts of human resources managers and others in leadership positions. Many industrial plants are more like dungeons than production facilities. Workers can encounter hazardous chemical exposures, run antiquated and dangerous machinery, and function in generally unsafe working conditions, whether in non-unionized or unionized workplaces. Not infrequently, employees who recognize unacceptable conditions surrounding them initiate workers' compensation claims and associated lost time because mere existence, let alone productivity, in such environments becomes intolerable – particularly as the worker ages and eventually perceives no other exit strategy, not even retirement.

Several years ago upon considering the issues of worker health, working conditions, and the employer-employee relationship, we introduced the metaphor of a "toxic tort" as representing some workers' compensation claims. That is, in some instances, the worker filed the claim not because he or she had been injured or become ill, but because the worker considered the occupational environment so potentially harmful or "poisonous," literally and/or figuratively, that filing a compensation claim was a preferred means to economic survival.

Employer-Employee Relationship. Everyone who toils under supervision has perceptions of leadership, sometimes good, frequently bad. Employers (and managers) are seen as authority figures by employees who have been inevitably programmed through early experiences with adults who had power over them. No other relationship than that between the boss and the subordinate has received more attention in books on management, and no relationship has received greater scrutiny in labor-management agreements. The employer-employee relationship is invariably susceptible to conflict. Unresolved conflict is often the precipitator of workplace stress, tension buildups, and resultant lost time.

Employee Self-Esteem and Psychological Strength. When an individual experiences a sense of self-worth, and when the same individual realizes personal power, he or she is able to be assertive and make his or her needs known to others. This is the great striving for most of us, and unfortunately, many of us have not been afforded the building blocks necessary to develop a strong sense of self and self-worth. Criticized and invalidated by significant others in our early lives, we become workers with tenuous egos and defensive self-concepts, more often knowing what we do not want to happen to us rather than helping create the environments and relationships we do want. Personal power in the workplace can be diminished by performance circumstances and/or low productivity. When it does, individuals can become susceptible to workplace injury and/or illness.

With reduced productivity concomitant to lowered self-esteem, the employee may find it easier to leave the workplace with a "face-saving" injury or illness rather than confront the actual problems that led to feeling helpless and depressed in a work environment that seems to lack compassion, understanding, and support. Feeling abandoned in a group of your work peers is far more anxiety provoking than becoming absent from work after the onset of injury or illness. The latter clearly vindicates the "honorably" disabled employee who, in his or her mind, has sacrificed personal health and well-being for the company.

Psychosocial Factors External to Work. All of us experience social demands and psychological pressures outside of work with which we must contend. When those pressures and demands exceed our tolerance for stress, we are susceptible to illness and/or injury. "Disability proneness" is a concept built on the idea that certain individuals are more vulnerable than others to the customary pressures of life outside of work. Personal and financial changes and losses such as relocation, separation/divorce, and other situations to which all of us would have difficulty adjusting can lead to maladaptive behaviors affecting job performance and even work attendance. Experience has shown that individuals with inordinate psychosocial stressors and limited coping skills may very well be disability prone. Moreover, the literature on work dysfunction reveals that certain personality types interacting with social and occupational demands are more likely to succumb to these pressures, learn helplessness, and claim vocational disability.

Social-Economic Alternatives to Remaining Productive. For years, we have recognized that a construct parallel to learned helplessness is the phenomenon known as "learned laziness." Once deemed the "welfare pigeon" paradigm, learned laziness is the expectation that certain individuals and personality types will quickly abandon motivational achievement behaviors for non-conditional reward, sometimes in the form of workers' compensation indemnity benefits and/or Social Security Disability Insurance. With most benefits (e.g., workers' compensation and/or long-term disability) being paid at rates of at least 66-⅔% of the employee's pre-accident wages, once-productive workers soon find it difficult to risk losing benefits by returning to the unknown consequences of gainful activity, particularly in an environment that may no longer extend them a welcome. Many times employers perceive injured workers with mistrust, and too often employers treat injured employees as "damaged goods," sometimes worse, as a pariah. With perceived employer disdain following occupational injury and/or disease, the injured worker quickly searches for alternative methods of financial survival.

There is much at stake when an individual claims to be vocationally disabled following accident and/or injury. Among the stakeholders, we find various ways of explaining how an individual's disability occurred and why it might become chronic, but in all cases, regardless of the explanation, the nonproductive consequence of people being displaced from work following accident and/or injury is very expensive to individuals, companies, and our economy in general.

The Mercer Human Resources Consulting and Marsh, Inc., 2002 Survey of Employers' Time-Off and Disability Programs revealed that time-off and disability program costs averaged 15% of payroll in 2001. More specifically, for an employee earning $40,000 annually, companies surveyed paid $6,000 for time away from work associated with sick days, workers' compensation costs, short- and long-term disability programs, salary continuation programs, etc. For years, so-called "acquired occupational disability," an inability to work following injury or illness, has cost our economy billions of dollars each year ($170.9 billion, according to one 2002 estimate), and yet little attention has been given to the concept of how individuals explain vocational disability.

Causal Attributions of Occupational Disability

Attribution theory seeks to understand how individuals interpret events and how explanatory thinking and behavior tends to correlate with human motivation. Attribution theory considers how people make sense of their worlds and what cause-and-effect inferences they make about the behaviors of themselves and others. For years, we have explored the potential role of attribution theory in the cause-and-effect beliefs that people create and maintain when they "acquire" vocational disability. We have postulated that healthcare providers, specifically physicians, trained in assessing impairment are generally ill-equipped to determine the cause of disability in others. We have hypothesized that vocational disability tends to be temporary or become fixed depending on an individual's attributional style. We will again review the difference between medical impairment

and vocational disability, and then discuss the multitude of issues surrounding causal attribution of occupational disability.

Medical Impairment v. Occupational Disability. Medical impairment, an alteration of an individual's health status, is what is wrong with a body part or organ system and its functioning (American Medical Association, 1990). Permanent impairment should be determined only at the end of the normally accepted healing period, or when maximum medical improvement has occurred. Impairment does not determine the impact on the person's capacity to meet social or occupational demands; disability defines the impact of impairment on occupational functioning. Medical impairment is evaluated and treated by healthcare personnel. Disability is assessed by non-medical means, generally by vocational experts and disability evaluators. What causes occupational disability is often more complex than simply a decrease in physical or mental functioning secondary to a particular impairment.

Occupational disability is often caused by pre-existing medical problems, social dynamics, psychological issues, the lack of work skills that might be utilized in alternative or perhaps less demanding work, and/or economic factors such as the availability of appropriate employment given a medically impaired individual's "residual employability." Nonetheless, how people explain acquired disability is very much a function of the attributions they create.

Attribution Theory. Attribution theory, what Weiner (1986) called "naïve psychology" – the cause-and-effect analysis of behavior made by the man-in-the-street – attempts to explain the mechanisms by which people construe the causes of and arrive at their beliefs about success and failure. Attribution theory has been linked with achievement-related behavior, such as learning and working, and mental health concepts (e.g., optimism, pessimism, anxiety, and depression). Attribution theory helps explain not only how individuals perceive their own successes and failures, but also how they causally ascribe the achievement of others.

We postulate that individuals who have medical impairments can attribute occupational disability to an accident or injury for no other reason than a temporal connection – that is, the person became unemployed after a trauma. Because the injury allegedly resulting in impairment came at the time of or after an accident, then it is implied the accident caused the disability. We argue that a "time-based explanation" in the determination of what causes occupational disability is often inadequate in explaining disability given the multitude of other factors, including pre-existing medical conditions, that can cause unemployment subsequent to, but not necessarily as a consequence of, the indexed traumatic event.

For example, a 38-year-old female who sustains a whiplash injury in an automobile accident stops working as an outside sales representative five months after the accident and claims that her chronic regional pain syndrome, diagnosed after the accident, is the cause of her occupational disability. Careful investigation, however, reveals that this individual was previously treating for rheumatoid arthritis and fibromyalgia. Her theory as to why she is unemployed with a loss of economic power is that her occupational disability is directly and causally related to the whiplash injury. A physician treating this person declared that her chronic pain complaints are directly linked to the whiplash injury that has become the basis for the patient's personal injury lawsuit. In reality, her chronic complaints of pain and concomitant allegations that she cannot work are multifactorial at least. Further investigation reveals that this outside sales representative was being disciplined at work for low production. Additionally, the company for which she worked was being purchased by another entity, and company rumors were that layoffs of sales representatives would occur as a result of the acquisition.

Causal attributions of occupational disability are best made by trained observers or evaluators who fully appreciate the psychosocial context in which causal attributions of acquired disability are made. Occupational disability has been studied from numerous social and psychological perspectives. Important constructs have been offered to help us better understand and explain the non-medical antecedents and consequences of vocational disability. The concepts of Disability without Disease and the Disability Process, Learned Helplessness (and Laziness), Co-Malingering, Locus of Control, Loss of Self Esteem, Disability Induction, Disability Proneness, Illness Behavior, and the Meaning of Work help us understand some of the underlying principles of disability causation.

Disability without Disease and the Process of Disability

In the late 1960s, after spending many years treating injured autoworkers, two occupational health physicians, Drs. R.C. Behan and A.H. Hirschfeld, set forth their idea that injured employees can exhibit "disability without disease" or accident (1966). Borrowing on this concept, Weinstein delineated the "process of disability" in 1978.

Rather convincingly, Weinstein graphically portrayed the stages of the disability process. Weinstein reasoned that the troubled worker faced with negative feedback regarding his or her performance would eventually reach a stage where so-called "tension build-up" would become overwhelming and viewed as "unacceptable disability." Weinstein argued that an accident or illness, seen retrospectively as an "explanatory event," would allow the unacceptable disability to become acceptable and stabilize with medical explanations, diagnostic studies, and eventually unnecessary interventions, such as surgery or chronic pain management involving crippling medications. Behan and Hirschfeld concluded, "This remarkable capacity of disability to seize an accident as its apparent cause results in terrible chronicity."

Learned Helplessness (and Laziness)

Walker (1992) offered the concept of "Learned Helplessness" (Seligman, 1975) as a useful framework in understanding how injured workers perceive loss of control in the workers' compensation system – a system that simultaneously rewards and punishes injured workers. Learned helplessness is caused by repeated experiences of aversive, uncontrollable situations. The person caught in a learned helplessness syndrome exhibits passive, resigned, inflexible behavior associated with dysphoric feelings of depression. Walker described how the workers' compensation system breeds conditions ripe for injured worker helplessness. However, he also pointed out that the very same system often financially rewards people non-contingently, thereby also inducing "learned laziness" by making a return to work financially impractical or disadvantageous for the workers' compensation claimant. Walker argued that injured workers, trapped in the quagmire of workers' compensation systems as they are designed (i.e., to make a person whole), generally manifest amotivational behaviors and surrender their will to work.

After proposing learned helplessness as a model for depression and motivational disturbances, Seligman reformulated the learned helplessness model to include the concept of "attributional style." That is, individuals with particular attributional styles are more susceptible to learning helplessness.

Co-Malingering

Lost time from work may be a function of either medical restrictions that are related to impairment as determined by physicians or dysfunction associated with behavior and social relationships that develop both before and after the accident/injury. At times, injured workers are accused of malingering, the falsification of symptoms to avoid responsibility, including work. Previous research conducted by members of the National Rehabilitation Planners, Inc., has found that only 10% of compensable lost time is due solely to medically imposed restrictions. "All other reasons for lost time are due to employer- and employee-controlled impediments for return-to-work, such as:

- inflexible supervisory decisions,
- poor injury management practices,
- breakdowns in communications, and/or
- employer failures to make reasonable work accommodations."

These employment situations may represent a form of "co-malingering," which Kenneth Mitchell, who coined the term, described as "the mutual actions of employers and employees that extend [the] disability duration and impede early return to productive employment." Co-malingering is also sometimes referred to as negotiated disability. "Employees incur 100% of lost time; employers control 90% of it." However, for many years now, we have recognized that other members of the lost-time community can function in relation to the injured employee as co-malingerers, and those other parties include physicians, lawyers, and family members. Co-malingering appears to be much more common than malingering in lost-time cases.

Locus of Control

Locus of Control is a useful construct in terms of vocational rehabilitation. At its simplest, Locus of Control is an individual's perception of the cause of events in one's life: either one believes he/she controls his/her own destiny ("internal") or one believes that others, luck, or fate control one's outcomes ("external").

Locus of Control is closely related to the concept of "attribution." An attribution is an explanation of what happens to one's self and/or others. For those not comfortable with the terminology of psychology, it may be more meaningful to use "explanation" as a synonym for attribution.

In general, an internal Locus of Control is seen as being more desirable. Consider the following descriptions of internality and externality:

- It is an internal attribution about oneself when one succeeds (I did it myself).
- It is an internal attribution about others when they fail (It was their fault).
- It is an external attribution about oneself when one fails (Something/Someone else made me fail).
- It is an external attribution about others when they succeed (They got lucky).

Research (Mamlin, Harris, & Case, 2001) has shown the following trends:

- Males tend to be more internal than females.
- As people get older, they tend to become more internal.
- People higher up in the organizational structure tend to be more internal.

Although these trends are not absolute, they may serve as a starting point for vocational counselors working with clients. It is generally agreed that Locus of Control is largely a learned condition. For a client who is resisting vocational counseling and incidentally exhibiting an external Locus of Control, it may be a useful strategy to work toward reversing that bias. There are a number of questionnaires that are designed to determine internal and/or external Locus of Control. Rotter's original "29-item Locus of Control Questionnaire" is still used, and there are newer questionnaires that are also available.

The value of starting with knowledge of the client's Locus of Control bias is that an external Locus of Control can lead directly to the loss of control. The important research in respect to loss of control is Seligman's learned helplessness. Since Locus of Control is learned as opposed to innate, clients drift toward learned helplessness as an outcome of having no control over of what is happening to them. Moving from what may have been an internal Locus of Control to an external Locus of Control is an adaptive response that may be reversed by sharing knowledge of the condition with the client and devising reversal strategies. Counselors need to be cautioned against simplistic judgments derived from an over reliance on the Locus of Control concept, but sharing knowledge about a reality can seldom be injurious. Acknowledging personal responsibility is an important first step for clients resisting return-to-work actions.

Loss of Self-Esteem

Another significant factor in resisting a return to work after an illness or accident is rooted in psychological issues such as depression, anxiety, and low self-esteem. Frese and Mohr (1987) stated, "Depressed persons who are inactive and pessimistic in their outlook will be unemployed much longer or will become unemployed more readily."

Weinstein (1978) pointed out that a worker's loss of self-esteem taking place simultaneously with decreased productivity are two key factors in "unacceptable disability" that requires an "explanatory event," such as a future accident or injury in order to justify continuing dysfunction and ultimately a prolonged period of lost time from work. In other words, Weinstein believed that a worker's loss of self-esteem is a key predictor to future vocational disability even before the accident that will be labeled the cause of lost time! Furthermore, Weinstein pointed out that following the "explanatory event," medical, psychological, and social factors may actually work to restore the individual's self-esteem and allow for one to be declared "honorably disabled," thereby signaling a stabilization and chronicity to the disability.

In the final analysis, intractable cases of depression and/or personality dysfunction will need to be referred to competent mental health professionals who understand behavioral medicine and the importance of vocational rehabilitation. Of course, most rehabilitation counselors are not trained as clinical psychologists, but there are interventions that vocational counselors can and should utilize.

Basic interventions that can be applied in counseling clients who are resisting return-to-work would include:

- discussing the importance and the value of work with the client;
- identifying and discussing psychological issues, especially depression and the loss of self-esteem, and the need to find ways to overcome them;
- discussing Locus of Control and Causal Attributions and their significance to motivation and productive return-to-work efforts;
- recognizing learned helplessness and planning a way to achieve countervailing strategies to prevent helplessness from establishing itself;
- setting realistic goals with clients and helping them work to achieve goals; and
- supporting the client throughout the counseling and behavioral change processes.

Kelly (1955) said of vocational development, "It is one of the principal means by which one's life role is given clarity and meaning." Vocational rehabilitation counselors hold a significant responsibility to assist clients to understand the obstacles to personal fulfillment through work and to provide the professional guidance to help to achieve "clarity and meaning."

Disability Induction

Occupational disability and lost productivity can often be explained by understanding that acquired disability can be encouraged, prompted, influenced, and solicited. That is, vocational disability can be induced. We have identified at least four separate methods of disability induction, namely, iatrogensis, beaurogenesis, litogenesis, and psychogenesis. We again would like to thank Ken Mitchell for his creativity and astuteness in helping us formulate these ideas presented previously and elsewhere (Walker, 1998).

Iatrogenic: Iatrogenic disability occurs more frequently than the casual observer might suppose. Low-back surgery, for example, is well known to resolve less often in the injured-worker population. Indeed, for many years, the most renowned neurosurgeon in Philadelphia would not treat compensable back injuries surgically because of the dramatically different "success" rates in the occupationally injured v. non-occupationally impaired populations.

Iatrogenic disability need not be the result only of surgical intervention. Physician induction of disability can often result from mere suggestion. The susceptible, or all-too-vulnerable patient can hear, or think he heard, the physician say that he was "unable to work." Physicians unknowingly underestimate, or consciously abuse, the power invested in them by the generally naïve health care recipient.

Disability induction through iatrogenic means is sometimes a function of the employer not insisting that its health care providers stay within their disciplines and avoid making vocational decisions. Employers and employees make vocational decisions; physicians diagnose and treat disease.

Beaurogenic: Work disability is often caused by the bureaucracy that surrounds occupational injury and non-occupational disease. Organizational policies and personnel decisions often ignore the consequences of shortsighted and antiquated return-to-work practices. From "you cannot return to work until you are 100%" to "light duty for workers' compensation recipients only," return-to-work programs seldom serve both employee and employer. Although the rising costs of workplace disability and the Americans with Disabilities Act led to some reevaluation of these return-to-work standards in the 1990s, the beaurogenic induction of disability remains a significant problem for most work organizations and our country at large.

Some self-insurers of both workers' compensation and long-term disability have failed to realize that, as work organizations, they create disincentives for employees to return to work following the onset of injury or illness. With employees able to receive nearly 70% of their income in wage-replacement benefits, the employer

has introduced secondary gain (defined below) as a factor that the injured or ill worker would find difficult to overcome despite a strong work ethic. The Social Security Administration has recognized that most recipients of Social Security Disability Insurance are of working age, yet few take advantage of the trial work period available to them. The widespread use of managed care organizations in the treatment and rehabilitation of injured workers raises a legitimate question regarding the possibility that managed care adds a layer of bureaucracy to the already complex social and political systems that induce disability in the workplace. Bureaucracies can foster disincentives to get well and return to work.

Litogenic: Representing injured or ill employees (or people pursuing economic damages through personal injury litigation), legal advocates hope to demonstrate that their clients have lost potentials to work and earn "a living." Such an argument ensures representation that the plaintiff is disabled. To argue otherwise is a contradiction. Thus, lawyers, in their advocacy of injured employees, pursue economic recovery in claims such as personal injury, workers' compensation, Social Security disability, and long-term disability. These litigations almost always induce or encourage an argument of disability. Even the most ethical lawyers believe that their clients have more to gain if they can prove economic damage secondary to vocational disability.

Psychogenic: Psychogenic disability suggests the inability to work because of symptoms caused or produced by mental or psychological factors rather than organic problems. Depression, substance abuse, personality disorders, and psychosis can lead to psychogenic disability. Such "disability" is, unfortunately, often assessed by health care professionals who legitimize symptoms manifested following the diagnosis of a disease or disorder that is not necessarily disabling.

Psychogenic disability can arise when workers report symptoms secondary to stress that they attach to a particular cause external to them, rather than taking responsibility for reducing the stress. Psychogenic disability is often precipitated by work dysfunction. For an excellent text on psychogenic disability and its causes, we reference Psychiatric Disability: Clinical, Legal and Administrative Dimensions, published by the American Psychiatric Press, Inc.

It is the rehabilitation counselor's task to encourage autonomy in clients. The CRCC *Code of Professional Ethics* for Rehabilitation Counselors states (A.1.d),

Rehabilitation counselors respect the rights of clients to make decisions on their own behalf. On decisions that may limit or diminish the autonomy of clients, decision-making on behalf of clients is taken only after careful deliberation. Rehabilitation counselors advocate for the resumption of responsibility by clients as quickly as possible.

Disability Proneness

Our experience tells us that some employees have a predisposition toward disabling disease or illness. We believe that "disability proneness," is a real and significant phenomenon antecedent to and at times a cause of many cases of chronic vocational disability. We have found that individuals with particular work dysfunctions are more prone to occupational disability and claims of incapacity. We think that the workers' compensation system in particular breeds the requisite conditions for learned helplessness and laziness, and we also believe that particular attributional styles make individuals more prone to developing chronic disability than others with different styles of causal attribution.

Illness Behavior

Illness behavior is frequently exhibited by individuals who are indeed sick. However, some individuals exhibit illness behavior that is abnormal or inappropriate to the situation. According to Pilowski (1978), abnormal or inappropriate illness behavior is "the persistence of an inappropriate or maladaptive mode of perceiving, evaluating and acting in relation to one's own state of health," even though available evidence suggests that this illness behavior is unexpected or inappropriate. In other words, inappropriate illness behavior is thought to be exhibited if individuals are of the conviction that their pain or other symptoms are due to organic disease, but no evidence of organic disease exists or the illness behavior is inappropriate to the organic disease that does exist.

Illness behavior as a concept provides a framework for understanding the observed differences among pain patients. According to the Institute of Medicine (1987), "Illness behavior is a process that includes a perception of one's own symptoms, and attribution of meaning to them (from something trivial to an ominous indicator of serious illness), and the way in which one seeks help in dealing with the symptoms. Such behavior is influenced by the person's personality and coping style and by the surrounding culture and society. The fact that such factors can be strong influences on the pain or other symptoms that people experience does not, however, make pain any less real."

The meanings given by a patient to an accident, sickness, personal suffering, or the relentless presence of pain effect subsequent illness behavior and help order experience in several ways. Patients form causal attributions to account for their perceived circumstances. Limitations imposed on a patient's lifestyle by chronic pain may be significantly attenuated if the patient believes that he or she can control the pain or can, despite the pain, undertake activities without harm. In contrast, it has been observed that patients who believe they have little or no control over their health and well-being (learned helplessness) endeavor less effectively to achieve rehabilitation (Pilowski, 1984). Finally, personal meaning of an illness or symptom may affect self-esteem either positively or negatively. Becoming an invalid, even briefly, can be a blow to a person's self-esteem. Similarly, being unemployed or forced to accept employment at a lower wage or job status because of pain can be demeaning. However, for some patients embracing the sick role is seen as an elevation in status (i.e. "honorably disabled"). These people value the nurturance and special consideration of friends, family, and neighbors that follow injury and the development of chronic pain. Personal meanings are likely to be influenced by the shared meanings of the group to which the individual belongs (Institute of Medicine, 1987).

At the same time, the meaning of work held by the individual and/or the group to which this individual belongs can be a powerful influence on the individual's capacity or willingness to overcome illness behavior. When work is a central theme in the injured person's life, chances are illness behavior and associated dysfunction will not lead to total vocational disability.

The Meaning of Work

In her research at New York University, Dr. Amy Wrzesniewski has determined that individuals experience work in one of three distinct ways:

1. Job: the individual is primarily concerned with the financial rewards of work;
2. Career: the individual is focused on advancing within the occupational structure; or
3. Calling: the individual works not for financial gain or career advancement, but for the sense of fulfillment that work brings.

In our work, we have found that individuals who viewed their work as just a job prior to the onset of injury or illness were less likely to return to work than individuals who considered work a career. In contrast, individuals who perceived work more or less as a calling were eager to return to work following illness or injury.

Employees who believe that work is a calling are not representatives of typically esteemed professions only. We have found just as many longshoremen, waitresses, custodians, and landscapers fully invested in their vocations as "callings" as are teachers, lawyers, and physicians. The meaning of work is an experience unique to the individual and not necessarily a function of how society in general might perceive the job title and the employee's day-to-day responsibilities.

We suggest that when organizational leaders can imbue every member of a work team, from the least skilled to the most highly trained, with the belief that he or she is highly valuable and important to the organization's success, the organization will probably have fewer problems with lost time. We recall specifically the camaraderie of a hospital maintenance staff, the members of which were encouraged to wear surgical garments in their work. The maintenance manager felt that without his crew's involvement, the hospital could not operate and effective health care could not take place, no matter how skilled the staff physicians. This simple but clever gesture was, of course, designed to remind the maintenance staff members of their critical contribution to the hospital's daily functioning. That particular hospital maintenance staff had few instances of occupational injury/illness/lost time.

The development of occupational disability or the "onset" of acquired vocational disability may result traumatically from a single event (i.e., the above the knee amputation in a professional football player), but as we have shown above acquired total disability is often a process that involves numerous contributions that are not only medical in nature but in fact psychosocial. Because acquired disability is heavily weighted by psychosocial dynamics, we believe that professionals trained in determining impairment (medical authorities) should defer to vocational counselors for a total picture – or explanation – of acquired disability.

Causal Attributions of Acquired Disability: Who is "Qualified" to Make the Call?

For several years, we have declared that the difference between medical impairment and occupational disability is not only a significant distinction, but one that must be recognized in the proper adjudication of damages in personal injury claims. As noted above, the American Medical Association recognizes that "impairment" refers to an alteration of an individual's health status and is assessed by medical means. "Disability" is an alteration in an individual's capacity to meet personal, social, or occupational demands and is assessed by non-medical means.

In personal injury cases involving multiple impairments, for example, the vocational expert may be the most qualified professional to speak to both the occupational disability and the actual cause of that disability. The CRCC *Code of Professional Ethics* for Rehabilitation Counselors describes that process (F.1.a):

Rehabilitation counselors produce unbiased, objective opinions and findings that can be substantiated by information and methodologies appropriate to the evaluation, which may include examination of individuals, research, and/or review of records. Rehabilitation counselors define the limits of they opinions or testimony, especially when an examination of individuals has not been conducted. Rehabilitation counselors acting as expert witnesses generate written documentation, either in the form of case notes or a report, as to their involvement and/or conclusions.

Disability management specialists are also available to perform forensic evaluation of injured workers. According to The CDMS *Code of Professional Conduct* (RPC 3.01),

When providing forensic evaluation for an individual or organization, the primary obligation of certificants shall be to produce objective findings and opinions that can be substantiated based on information and techniques appropriate to the evaluation, and as required by applicable case law within the appropriate jurisdiction, which may include assessment of the individual and/or review of records. Certificants shall define the limits of their reports or testimony, especially when an assessment of the individual has not been conducted.

Case managers are involved as advocates for clients when dealing with personal injury cases. In such roles, the case manager must abide by their *Code of Professional Conduct* by providing care coordination, which is defined as:

The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care. (CMSA Standards of Practice, 2010 p 24)

Heretofore, the misconception has been that physicians are trained and qualified to offer opinions with medical certainty as to why an individual can or cannot work. We suggest that this is an error in professional judgment on several levels, and if the legal community wishes to pursue accurate disability determinations, it must continue to educate its members as to which professionals are best qualified to testify as to the cause of occupational disability in an individual who has multiple impairments.

In order to arrive at a point in vocational/disability analysis where informed and detailed assessment of future employability can take place, one must know the subject's past. Not only is educational and occupational history relevant, but the subject's past medical history can be critical in accurately determining potential for future work, particularly occupational longevity or "worklife expectancy."

Worklife expectancy. This term is commonly used in determining how long an individual is likely to participate in the workforce given factors such as age, race, gender, and disability. Although they are hardly a data set without controversy, the Bureau of Census information on individuals absent from the workforce because of health-related problems is frequently cited by various vocational experts to argue disability. In a report called The New Work-life Expectancy Tables (1998), A.M. Gamboa, Jr., Ph.D., introduced the concept of work-life expectancies for persons defined as severely disabled, disabled, not severely disabled, and non-disabled.

Gamboa's hypothesis is that people with various (pre-incident/accident) medical problems are already disabled with some level of severity. The issue then becomes one of determining the level of severity. If the Gamboa hypothesis is correct, then how does a 54-year-old Certified Nursing Assistant (CNA), who is 5'4" tall and weighs 350 pounds (morbid obesity) claim that absent her lower back trauma (incurred from falling on a slippery floor, for which she is suing the floor cleaning contractor and the floor wax manufacturer), she would have worked until age 65 all the while lifting, bathing, and otherwise caring for geriatric patients, most of whom were non-ambulatory? Moreover, post-injury x-rays of the CNA's hips and knees show significant degenerative changes. Nonetheless, with the support of a vocational expert, she is claiming that she cannot work and had she not slipped on the floor, she would have continued working full-time in direct patient care until normal retirement age.

Obviously, there is a need for reasonableness in these arguments of disability causation. However, even competent vocational experts can find themselves perplexed when faced with evaluating an individual who has multiple, and often compounding, medical problems pre-existing those specific injuries for which the individual is claiming vocational disability.

What has become abundantly clear from our experiences in evaluating thousands of people who claim they cannot work is that thorough history taking is a crucial step in gathering sufficient information in order to determine the cause(s) of lost time following an observable change in a worker's health status. Only a detailed and complete history can assist trained observers in identifying the causes of unproductive occupational states.

What is also clear is that in most cases the vocational expert who is trained and experienced in disability analysis, is generally better prepared than a medical expert who may not fully appreciate the exertional and non-exertional demands of specific jobs, or more importantly, how those demands might be reasonably reduced by job accommodation. Although it is true that medical experts have greater training than vocational professionals in understanding physical and/or mental diseases, the critical factor in disability assessment is whether an individual with physical and/or mental impairment can function in relation to a particular set of job demands.

A Case in Point. A 56-year-old Industrial Electrician fractures his back while operating his son's trail bike (motorcycle). The Electrician attempts to return to his customary work after spinal surgery and rehabilitation, but perseveres no longer than eight weeks after medical rehabilitation, and subsequently claims total vocational disability and absolute loss of earning power in his personal injury lawsuit against the motorcycle manufacturer.

The Electrician's lawyer hires a vocational expert who interviews the Electrician, performs no vocational testing, and opines that the Electrician cannot work in any capacity and has lost all power to earn money based on the interview information and medical records, including statements from the treating physician that his patient, the Electrician, is "totally disabled." Meanwhile, the industrial plant in which the Electrician had worked for 25 years closes down. Nonetheless, plaintiff's vocational expert opines that through the union, the Electrician could have continued to work as a journeyman, work involving medium and heavy physical demands, had he not been injured in the motorcycle accident.

The defendant hires an orthopedic surgeon to examine the plaintiff's back complaints. The consulting physician finds and states with certainty that the Electrician does have exertional limitations and that his spinal impairment prevents him from lifting greater than 10 pounds and performing more than sedentary work. The defendant also retains a vocational expert.

The vocational expert reviews the plaintiff's complete medical records, studies the Electrician's employment/personnel file, interviews the Electrician, and performs a battery of standardized tests measuring abilities, aptitudes, temperament and interests. The testing shows that the Electrician possesses the linguistic capabilities and vocational aptitudes sufficient to perform sedentary desktop positions, such as Maintenance

Scheduler, Production Scheduler, and Motor Vehicle Dispatcher. The ex-Electrician expresses greater interest in Communication Work than in his prior employment of Craft Technology. Defendant's vocational expert also finds that medical documentation shows the Electrician had chronic left, dominant upper extremity impairments, including a rotator cuff tear and chronic shoulder bursitis secondary to a work-related accident when he tried to lift a 65-pound fiberglass ladder five years before the motorcycle accident.

Defendant's vocational expert also reviews the Electrician's personnel and occupational health records, which reveal that the plant physician had consistently restricted the Electrician to lifting no more than 30 pounds with his left upper extremity occasionally and 10 pounds frequently. For the last four years of the Electrician's employment, the company had maintained him on restricted duty, working exclusively in the maintenance shop. Finally, company records reveal that the plant closed down, as noted, one year after the Electrician stopped working. The defendant's vocational expert opines that the Electrician was disabled from the full range of physical activities associated with his craft by his pre-existing upper extremity impairments that had obviously limited the Electrician for several years prior to the personal injury event. Moreover, the defendant's vocational expert declared that the Electrician could not have functioned as a journeyman electrician in the open labor market (as alleged by the plaintiff's vocational expert) absent the spinal injury because of pre-existing upper extremity limitations and medically established lifting restrictions.

The Outcome. Who is right? What should a judge decide about these opinions and arguments? Does the determination of what constitutes occupational disability remain with the medical expert? Does the vocational expert possess the knowledge and skill to make a causal attribution of occupational disability when the vocational expert knows that certain pre-existing or unrelated medical conditions would in all probability make certain physical demands as an Electrician impossible to execute? Is not the vocational expert compelled to take a thorough medical history and consider all health-related issues that might otherwise affect an individual's employability?

Plaintiff's medical expert stepped outside the confines of her expertise and offered a vocational opinion of "total disability." The medical opinion of disability, for all intents and purposes, nullified the purview of the vocational expert, and perhaps the plaintiff's vocational expert perceived little "choice" but to follow suit and also opine that the plaintiff was "totally vocationally disabled." Incidentally, in his opinion, plaintiff's vocational expert declared that the Social Security Administration had found the plaintiff totally disabled, and therefore, he agreed. What the plaintiff's vocational expert failed to recognize is that Social Security disability determinations are not accident or injury specific; disability is determined on numerous factors, including the individual's residual functional capacities without taking into account the cause of the impairment(s) or other dysfunctions (limitations) at issue. Neither of the plaintiff's experts considered the totality of the Electrician's medical history, especially his pre-existing upper extremity limitations and their occupational relevance in terms of the plaintiff performing the medium and heavy work of the journeyman electrician's trade notwithstanding the effects of the spinal impairment.

The defense medical expert was told to examine the plaintiff's injury-related complaints, including his spinal impairment and associated lower extremity symptoms, but did little investigation into this gentleman's prior upper extremity medical history. The defense vocational expert, supplied with sufficient information to understand the plaintiff's employability both before and after the accident in question, could attribute the plaintiff's vocational disability from journeyman electrical work to a pre-existing upper extremity disorder, notwithstanding the effects of the musculoskeletal injuries sustained in the motorcycle accident.

Another example might prove useful. A lawyer suffers a stroke, and on the way to the hospital, the ambulance is involved in a vehicular accident. The lawyer is trapped under the wreckage and miraculously survives. However, when he does arrive at triage, he presents with a significant compound fracture, and although the fracture is repaired, infection sets in. As a consequence, the lawyer loses his leg above the knee. The stroke, for its part, results in cognitive and language deficits. Through rehabilitation, the recovering amputee struggles with using his prosthesis and ultimately decides that life is easier in a wheelchair. He tries to return to his profession, but he struggles with neuropsychological impairment. A lawyer representing the amputee in court argues that the motor vehicle accident resulting in the compound fracture and resultant amputation has caused the lawyer occupational disability and lost earning power. Which of the medical impairments, the neuropsychological deficits or the post-amputation ambulation problems, causes disability in the practice of law?

Although causal attribution of occupational disability in the case of the lawyer may be more evident than in the case of the Electrician, both scenarios represent a potential problem for those who do not fully appreciate the difference between medical impairment and occupational disability in the adjudication of monetary damages associated with lost work capacity. When the injured lawyer was neuropsychologically evaluated by a consultant retained on his behalf, the neuropsychological examiner explained that the lawyer's cognitive deficits were not secondary to the stroke, but rather a result of reactive depression linked to the loss of the limb. However, the defendant retained both a neuropsychological expert and a vocational expert. Both tested the lawyer with objective personality measures and found that the lawyer was indeed anxious, but not depressed. Moreover, the defendant's neuropsychologist found a pattern of neuropsychological deficits that were directly associated with brain injury in an area of the cerebrum shown by MRI to be damaged by the stroke. The vocational expert opined that based on all of the information gathered and reviewed, the lawyer's vocational disability was a result of the stroke and not the post-MVA amputation. Had he not had a stroke, the attorney could still be practicing law.

The vocational expert or occupational disability analyst is frequently confronted with the problem of assessing the employability of individuals with a history of multiple medical impairments. More often than not, the expert is asked to opine as to the effect of trauma/ injury on the occupational capabilities of an individual who has a pre-existing impairment or co-morbidity. The disability analyst's challenge is to determine the effect of pre-existing impairments, and with thorough medical information, perhaps the differential functional effect of co-morbidities and how those affect an individual's capacities to work.

Still in another example, we hypothesize the case of a teacher who has had a long history of mental disorder, specifically a so-called manic depression that has not been well controlled. The teacher claims that because of a motor vehicle accident (MVA) and an associated whiplash injury, he suffers from chronic neck pain, dominant upper extremity radiculopathy, and headaches. It could be argued that the MVA injuries alone could constitute disability in classroom instruction. However, what effect would the uncontrolled bipolar disorder have upon the teacher's capacities to work? It would be difficult to resolve this issue on a logical basis. Moreover, the history of this specific claimant's pre-existing mental disorder may be legally eliminated as a factor because it might produce prejudice for a fact finder or a jury.

Our bias that the vocational expert is better able to attribute occupational disability to a particular cause and to determine residual employability in individuals who are impaired remains unaltered because the vocational expert is more knowledgeable in the actual demands of particular jobs throughout the world of work and should be in a position to thoroughly analyze the injured person's vocational options in light of medical impairment, whether singular or multiple. Certainly, the medical professional is better qualified to identify and describe medical impairment (physical and/or mental) and, in some cases, the injured person's residual functional capacities. But it is the vocational expert (knowledgeable of medical impairments, their general effects on functioning, and how dysfunction might interact with job demands) who remains far better suited than medical professionals to state with certainty whether a particular individual possesses the ability to work (residual employability) or the capacities to perform gainful activity. More to the point, both medical experts and vocational experts possess unique training and skills that require the assistance of the other in fully determining whether an individual can work gainfully and in clearly attributing what particular health problem may be occupationally disabling.

Obviously, whatever the training and experience of the individual evaluator, thorough histories are critical in understanding the entire picture of the injured worker and how that history relates to acquired disability. It is important to recognize that a lack of adequate history-taking can lead to unnecessary or inadequate medical treatment, which is sometimes a contributing factor or indeed a cause of acquired disability.

Conclusion

Our observations over the past 25 years have led us to the conclusion that acquired disability following accident or injury begs to be explained. Disability is explained by the person who experiences lost time and by a host of others in the injured person's social and professional networks. Based on our experiences and the contributions of informed others, disability can be explained by numerous psychosocial dynamics independent of the actual injury or impairment, forces that can precipitate, cause, and stabilize unproductive states following trauma or any change in one's health status. Too frequently, these dynamics are overlooked in consideration of what

appears to be the most obvious reason for the absence from work, a so-called "explanatory event." We have also concluded with certainty that a thorough and accurate history is necessary to assess pre-accident work longevity, determine residual employability, and causally ascribe occupational disability to a particular event. Possessing a complete and reliable history (preferably from documentation of various sources) places the expert charged with disability analysis in a better position to offer a professionally certain opinion.

We have confirmed, over and over again, what Behan and Hirschfeld call "disability without disease" or accident does exist. We recognize the importance of attributional style in an individual's effort to explain disability. Causal attribution of occupational disability remains a major issue that often challenges all rehabilitation personnel in forensic vocational/disability assessment matters and occupational rehabilitation of those who have become injured or ill. The more detailed and reliable a picture one can construct, and more information we have about the injured worker's personal constructs and tendencies to explain cause-and-effect, the more accurate the examiner can be in not only assessing vocational disability but its actual cause(s). Through explanations, we anticipate finding causes, and from causes, we hope to find solutions.

As we bring this article to a close, we must confess that the question, "Who is qualified to make the call on occupational disability?" is not answered to our complete satisfaction. What has become apparent in our discussion of how disability is explained is that neither expert, medical nor vocational, may be in an absolute position to make judgments regarding residual employability, pre- and post-capacity to work, or the causal attribution of vocational disability unless the expert is fully informed of the multitude of medical and psychosocial dynamics that surround an individual's claim of occupational disability.

We believe that causal attribution and attribution theory are critical determinants in disability chronicity following accident and injury. We are aware that the literature on pain in disability offers substantial insight into the multiple factors that can cause one to claim total vocational disability. We most certainly encourage medical, rehabilitation, and legal professionals to recognize the complexity of occupational disability claims. We ask for more frequent and thoughtful research in the areas of psychosocial antecedents to vocational disability, illness behavior in situations of claimed disability, and attribution theory as determinants of vocational disability.

(Part II) Toward Organizational Health

The Basic Analogy:

Work organizations are similar to human organisms in many ways. Like human beings, for-profit organizations are conceived and born generally as an extension of ego. Usually the work organization is sired by someone emotionally invested in the notions of perpetuity and legacy, forces comparable to those in the decision or desire to have children. As with human beings, work organizations are not only born, when healthy, they grow and develop. Moreover, one would trust that work organizations survive, in part, because they attempt to contribute to the collective good, again, not unlike human organisms.

In addition, like human organisms, work organizations can be dysfunctional and so troubled by neurotic tendencies that they can fail to reach their potentials. When troubled and yet motivated toward wellness, humans must learn to manage or change their states by controlling their minds and emotions. Likewise, when faltering, organizations must strive to manage or change internal processes and procedures to become more effective and productive. In either case, human organism or for-profit organization, fear of creating change can be a roadblock to health and prosperity.

The Organizational Problem:

One common organizational failure seems to result from unrecognized fear of proactively and comprehensively managing lost time associated with employee illness or injury. Most work organizations manifest an incomprehensible avoidance of proactively managing absenteeism and disability. Although many companies have intense and system-wide safety programs, most organizations lack a comprehensive, proactive program to prevent **and** manage lost time following injury or illness. Instead, like the neurotic who fails to act definitively, even in his/her best interest, the dysfunctional organization abdicates responsibility for preventing absenteeism

or managing disability and, thereby, fails to control human and financial costs, a consequence certainly antithetical to a company's effort to achieve its potentials.

Proactive disability management is a critical aspect of any organization's overall well being. Unlike the neurotic individual who tends to deny, procrastinate, disassemble, and ultimately resign in the face of life's challenges, the healthy work organization sets out to both prevent and manage problems, including disability.

Disability management involves the coordination of the organization's various human capital strategies to assure that all employees are afforded the opportunities to remain productive. More than a system-wide safety program is needed to achieve an effective Disability Management Program (DMP). A quality DMP requires:

- top level management commitment to the process and outcome,
- the activation and integration of benefit programs,
- health and wellness initiatives,
- lost-time management teams,
- job accommodations,
- transition-to-work programs, and if necessary,
- employer-sponsored vocational rehabilitation programs designed to assist displaced employees with career change and job placement services.

Proactive disability management realizes the value of human capital in the success of any for-profit organization. Some organizations, however, tend to deny that their most valuable resource is their employee population with their requirements for health and health maintenance support. Organizational leaders may procrastinate on taking proactive measures and choose to deal with problems as they arise. These leaders often deceive themselves and others by delegating the company's human resource programs to outside contractors. In fact, many companies have abdicated responsibility for human resources management to vendors! Ultimately, these companies and others also resign themselves to paying disability costs and writing those expenses off simply as a consequence of doing business. Too often, the neurotic company does not realize the cost of being dysfunctional. Frequently, it requires outside auditors or financial consultants to bring the real cost of disability to their attention, and the cost of workplace disability and associated absenteeism can be daunting.

Consider the following:

- The Mercer Human Resource Consulting Group reports that absenteeism costs were 14.3 percent of payroll in 2000. Those costs have been rising steadily and will continue to climb.
- The U.S. Department of Labor reveals that companies lose 2.8 million workdays each year because of employee injuries and illnesses.

Research has shown that if organizations do not actively assist workers in early return or transitional employment, the consequences can be disastrous. Disability management consultants cite studies that indicate of the 500,000 newly disabled workers each year who remain out on disability five months or more, only 1 in 2 will ever return to work. Most organizational leaders do not recognize what their individual organizations are paying in both financial and human capital as a result of not proactively preventing and managing disability.

However, analogous to good cognitive therapy and effective re-education for the neurotic, skilled interventions in the workplace are available to the less than fully functional organization. Such an organization can be defined as one that has failed to recognize the problem of occupational disability and integrate its various human resource programs to proactively manage disability and resultant lost time. Again, similar to the neurotic who fails to recognize a significant problem and assume responsibility for overcoming the dysfunction, an organization may continue to deny, procrastinate, dissemble, justify, and rationalize its status quo. Consequentially, as does the individual, the organization fails to reach its potentials.

What is Required?

Conscious and purposeful change is not easy. The neurotic individual eventually experiences enough personal pain that the brain and body ultimately insist on change. Organizations can have the same experience, but generally the "head" of the organization must search for the source of pain because it is not always palpable, however disturbing. Organizational pain can be hidden by layers of bureaucracy and the forces of inertia. Nevertheless, the competent business leader remains open to change, and when given proper information, recognizes the value of proactive methods for maintaining and enriching the company's human capital.

In order for leaders of organizations to better appreciate the need for comprehensive disability management, they are encouraged to ask themselves questions. One of the most useful and universal concepts in exemplary disability management is "co-malingering." This term refers to the role of all the individuals including, but not limited to, employers and co-workers, in causing and perpetuating disability.

Questions to Guide Disability Management Programming Evaluation:

In assessing the company's present policy in respect to employee absenteeism, company management will need to consider (and document) the reason for having a DMP. Reasons why having a DMP is crucial include:

1. The competition in a global economy requires proficiency.
2. The aging population. (By 2020, 1 out of 3 Americans will be over 50.)
3. Life generally and work specifically are becoming more stressful.
4. The escalating costs of adversarial claims and litigation.
5. The cost of disability when employers continue to pay injured/ill employees who are not coming to work.

The following questions are offered to assist employers to evaluate their DMPs:

In Search of an Organization Strategy:

- Do we have a developed, documented, and operational policy in respect to disability management?
- If yes, what is that policy?
- Is the existing policy still viable?
- Do we truly <u>own</u> the operational policy to manage disability or has it been delegated to a vendor?

Direct Costs:

- Do we have the capability of determining the direct financial costs of the lost time of our employees?
- Who in the organization should be responsible for this report?
- If we do not have the in-house capability, where can we find quality, cost-effective assistance?
- Do we collect data to document absences, causes, and costs?
- If not, who in the organization can develop and implement a collection system?
- If yes, are the data used to plan and change?

Indirect Costs:

- Indirect costs are also critically significant to bottom-line costs. What are the indirect cost factors?
- Have indirect costs been identified and factored in to the lost-time equation?

Disability Management:

- Do we have a DMP?
- If yes, can we request an in-house presentation on the program for the purpose of evaluating it?
- If we determine that what we do is not comprehensive and effective, how can we upgrade it?
- Are there experienced professional resources available to assist in program improvement, and how do we identify these resources?

- Are there exemplary DMPs in well-managed companies, and if so, who are the companies and how can we find out what these exemplary programs look like?

Staff Responsibilities:

- Do we have staff members identified as being responsible for organizing and conducting disability management?
- Do the individuals identified as having responsibilities in the DMP have job descriptions that detail the organizing, implementing, and operating tasks required for a DMP?
- Do we have a projected schedule for the evaluation/creation/implementation of disability management tasks?

Disability Management Components:

- If exemplary DMPs exist, what are the specific components of these programs?
- Given the size of our organization, can the components be prioritized in terms of need for implementation?
- Which of components do we have in place and apply?
- Which specific components should we add to our existing program?

Basic Concepts:

- Is our DMP based on a needs assessment?
- Is a new, more timely, needs assessment required?
- Do we have a coordinating committee in place to plan and monitor our DMP?
- Is the committee inclusive?
- Have we identified community resources to assist in delivering appropriate services in our DMP?
- Do we have written policies and procedures for the DMP?
- Do we perform case management when an employee is injured/ill?
- Do we have specific and flexible employee options in respect to returning to work as soon as possible?

Staff Training:

- Do we sponsor a safety/wellness prevention program for employees (including work-external prevention)?
- Do we perform regular training on our DMP for supervisors?
- Do we complete regular awareness and orientation on our DMP for all employees?

Addendum:

Every company, regardless of size, will benefit from demonstrating proactive assistance to employees. Mid-sized and large companies will have special personnel to focus exclusively on disability management issues. Employers with fewer total employees will not be in a position to have staff dedicated solely to disability management. Nonetheless, small companies are not excused from providing services relating to absentee management. The process and the services remain the same; the only difference is in the scale. Small businesses are as responsible for the issues outlined above as are large employers. As the "neurotic" individual is clearly responsible for personal change, the employer is ultimately responsible for organizational change. Requiring help in facilitating change is nothing to be ashamed of, and help can be found.

One of the most effective models for how Americans can enrich their lives is "Positive Psychology." This concept, developed under the leadership of Dr. Martin Seligman of the University of Pennsylvania and other psychologists under the aegis of the American Psychological Association, is so significant that it requires the serious attention of every adult, as well as the attention of every business and industry leader in America. All exemplary DMPs moving forward will want to be knowledgeable of Positive Psychology and will seek ways to construct future management philosophies and cultures on its tenets.

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The Effective Methods and Materials of Quality Disability Management in the Workplace

by Jasen Walker, Esther Weiss, and Fred Heffner

Introduction:

Disability prevention and management (DPM) is a serious concern to employers who are intent on operating efficient and cost effective businesses. There are well-managed companies in the U.S. that have, for more than two decades, planned and operated quality disability management programs (DMPs) for their employees. They do so because they value their employees and because they seek to maximize profit from their enterprise.

What, then, are the constituent parts of these exemplary DMPs? CEC Associates, Inc., of Valley Forge, PA and Miami, FL, has contributed to the development of effective DMP applications and ideas as well as monitored and reported on which DMP strategies have been successful for some ofAmerica's best run companies. CEC has been in business since 1983. CEC continues to innovate and disseminate practical information and solicit ideas from other program developers on approaches they have found to be productive.

CEC Associates has developed specific DPM concepts and DMP practices that are essential to quality workplace programming, and those concepts and practices include:

- Systems Theory of Managing Disability
- Disability Induction
- Injured Worker Helplessness (and Laziness)
- The Critical Difference between Impairment and Disability
- Disability Proneness
- Occupational Inertia
- Transition to Work

It is important to understand that CEC Associates has reported program findings and endeavored to share these findings with others. First, the company publishes the oldest, continuously running newsletter on workplace issues, The New Worker. Secondly, it has published, in the relevant professional journals, essentially all of the disability prevention and management ideas CEC and its principals, Jasen Walker and Esther Weiss, have developed over the years. Other sources of content information are available from the articles online, www.cecassoc.com/ceus.htm, that assist rehabilitation professionals and disability management consultants to earn the required Continuing Education Units (CEUs) to maintain their certification for CRC, CCM, and CDMS, per the *Code of Professional Ethics* for Rehabilitation Counselors (D.1.e):

Rehabilitation counselors recognize the need of continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their fields of activity. They take steps to maintain competence in the skills they use, are open to new procedures, and keep current with the diverse populations and specific populations with whom they work.

The CDMS *Code of Professional Ethics* also speaks to the importance and necessity of continuing education (RPC 1.21.b):

As a certificant, professional development and growth is necessary for maintenance and building of professional skills and competencies. A certificant who employs or supervisees other certificants and applications will encourage and support professional development activities and opportunities as well as conduct timely performance evaluations and consultations as necessary. Certificants will also be aware of their own professional growth and development needs and seek continuing education, training, supervision, and consultation for themselves.

The CCMC *Code of Professional Ethics* (S2) mandates:

Case Management competence is the professional responsibility of the Board-Certified Case Manager, and is defined by educational preparation, ongoing professional development, and related work experience.

Other sources that CEC has established for employers and rehabilitation specialists include: an online glossary of relevant terms called "Workipedia," regular emails on current workplace issues to clients and other interested professionals, and an online blog presenting similar issues. On its website, CEC has published the only known list of the components of a functional workplace disability management program. These resources are available to all employers, attorneys interested in disability prevention and management, professional rehabilitation specialists, and any party invested in learning more about maintaining the productivity of valued employees.

CEC Associates, Inc., has for many years planned and conducted information workshops for professionals on relevant disability management and vocational rehabilitation issues. All of the workshops have been approved for the specific CEUs needed by the professionals who attend the workshops, including CLEs for attorneys.

It is similarly important to know that CEC Associates welcomes, indeed actively solicits, state-of-the-art methods and materials from all sources that may contribute to the effectiveness of the disability management programming available to employers.

Systems Theory of Managing Disability

Work organizations, not their insurance carriers, can and should deal with preventing injuries. Further, when injuries do happen, employers are specifically charged with preventing (or at least limiting) the employee's loss of time. The critical difference between impairment and disability is often evidenced in the strategy that the employer uses to manage and control employee lost time following injury or illness.

As will be explained below in detail, medical impairment may very well be orthogonal to occupational disability. Medical impairment is defined by physicians; vocational disabilities are assessed by non-medical means.

Further, employers, and not physicians, have the responsibility to make decisions regarding whether or not people can return to work. Of course, individuals should not be encouraged to return to work until they are medically ready to do so. But what does that mean? Does "medically ready" mean the individual can return to his/her pre-accident employment, or that they are physically/mentally capable of meaningful alternative work that can be achieved with or without job accommodation?

Employers and employees need to be responsible for preventing and managing disability. No one else in the system (e.g., physicians, insurance carriers, family) has that responsibility. Whatever the employer-employee contract was before the injury/illness, it must continue after the onset of some significant health problem. Rochelle Habeck, one of the most respected researchers on workplace issues, has written, "Employers need to delegate but not abdicate their responsibilities for disability management."

"Systems Theory" may be an overstated term for what Tom Peters describes as a work environment where there are:

- leaders who create places where people can do the best work of their lives,
- people whose work creates more value for customers than competitors think possible, and
- systems that support seamless execution and promote Wow! outcomes.

Peters gained recognition over 25 years ago with a book titled In Search of Excellence. In it, he introduced a concept called "well-managed companies." Companies that are "well-managed" have, invariably, designed and implemented effective DMPs. Systems theory, however, recognizes that not unlike biological structures, social structures (e.g., business organizations) are complex and multidisciplinary entities that often require a team approach to optimal functioning and management.

Disability Induction

Vocational disability may be defined as “lost time from work following injury and/or illness.” As difficult as it might be to accept, vocational disability can be induced by individuals functioning within the same social and occupational system as the injured employee. Individuals included in this group are physicians, lawyers, employers, insurance adjusters, and even rehabilitation professionals.

The idea that physicians may cause disability in the workplace is not a new idea. The long-accepted term for healthcare-induced disability is iatrogenic. Iatrogenic is defined as the action of a physician, or a treatment or therapy prescribed by the physician. If the physician or treatment causes disabling effects or complications (whether inadvertent or not) the outcome can be classified as iatrogenic.

The basic issue involved here is that physicians diagnose disease and define impairment. With proper tools (e.g., functional capacity evaluation) healthcare personnel may also be capable of describing residual physical capacity, but the employer determines whether or not that impairment precludes the individual from performing, with or without accommodation, specific jobs. Job descriptions specify the tasks required, and if the employer determines that the individual can perform these tasks, he or she is not disabled in the workplace. (This concept is treated separately in this article in a section titled “The Critical Difference between Impairment and Disability.”)

In addition to iatrogenic causes, Walker and others like Dr. Ken Mitchell, a pioneer in disability management, have explained various relationships that may, and do, result in lost time following injury and/or illness. These include bureaugenics, litogenics, and psychogenics

Occupational disability and lost productivity can often be explained by understanding that acquired disability can be encouraged, prompted, influenced, and solicited. That is, vocational disability can be induced.

CEC Associates, Inc., has identified at least four means of disability induction: iatrogenesis, bureaugenesis, litogenesis, and psychogenesis (Walker, 1998). Those means of disability and action are briefly defined below.

Iatrogenic: Iatrogenic disability occurs more frequently than the casual observer might suppose. Low-back surgery, for example, is well known to resolve less often in the injured-worker population. Indeed, for many years, the most renowned neurosurgeon in Philadelphia would not treat compensable back injuries surgically because of the dramatically different “success” rates in the occupationally injured v. non-occupationally impaired populations.

Iatrogenic disability need not be the result only of surgical intervention. Physician induction of disability can often result from mere suggestion. The highly impressionable, all-too-vulnerable patient can hear, or think he heard, the physician say that he was “unable to work.” Physicians unknowingly underestimate, or consciously abuse, the power invested in them by the generally naïve healthcare recipient.

Disability induction through iatrogenic means is sometimes a function of the employer not insisting that healthcare personnel stay within their disciplines and avoid making vocational conclusions. Employers and employees make vocational decisions; physicians diagnose and treat disease.

Bureaugenic: Work disability is often caused by the bureaucracy that surrounds occupational injury and non-occupational disease. Organizational policies and personnel decisions often ignore the consequences of shortsighted and antiquated return-to-work practices. From “you cannot return to work until you are 100%” to “light duty for workers’ compensation recipients only,” return-to-work programs seldom serve both employee and employer. Although the rising costs of workplace disability and the Americans with Disabilities Act (ADA) led to some re-evaluation of these return-to-work standards in the 1990s, the bureaugenic induction of disability remains a significant problem for most work organizations and our country at large. In 2008, the ADA was amended to the Americans with Disabilities Act and Amendments Act of 2008 (ADAAA), which continues to require employers to look beyond the "disability" and evaluate the applicant strictly on the verifiable skills possessed.

Some self-insurers of both workers’ compensation and long-term disability have failed to realize that, as work organizations, they create disincentives for employees to return to work following the onset of injury or illness.

With employees able to receive nearly 70 percent of their income in wage-replacement benefits, the employer has introduced secondary gain, which is an external motivator that the patient assumes to gain sympathy or advantage by exaggerating the symptoms of the condition. The Social Security Administration has recognized that most recipients of Social Security Disability Insurance are of working age, yet few take advantage of the trial work period available to them. The widespread use of managed care organizations in the treatment and rehabilitation of injured workers raises a legitimate question regarding the possibility that managed care adds a layer of bureaucracy to the already complex social and political systems that induce disability in the workplace. Bureaucracies can foster disincentives to getting well and returning to work.

Litogenic: Representing injured or ill employees (or people pursuing economic damages through personal injury litigation), legal advocates hope to demonstrate that their clients have lost potentials to work and earn "a living." Such an argument ensures representation that the plaintiff is disabled. To argue otherwise is a contradiction. Thus, lawyers, in their advocacy of injured employees, pursue economic recovery in claims such as personal injury, workers' compensation, Social Security disability, and long-term disability. These litigations almost always induce or encourage an argument of disability. Even the most ethical lawyers believe that their clients have more to gain if they can prove economic damage secondary to vocational disability.

Psychogenic: Psychogenic disability suggests the inability to work because of symptoms caused or produced by mental or psychological factors rather than organic problems. Depression, substance abuse, personality disorders, and psychosis can lead to psychogenic disability. Such "disability" is, unfortunately, often assessed by healthcare professionals who legitimize symptoms manifested following the diagnosis of a disease or disorder that is not necessarily disabling. Psychogenic disability can arise when workers report symptoms secondary to stress that they attach to a particular cause external to them, rather than taking responsibility for reducing the stress. Psychogenic disability is often precipitated by work dysfunction. For an excellent text on psychogenic disability and its causes, we reference Psychiatric Disability: Clinical, Legal and Administrative Dimensions, published by American Psychiatric Publishing, Inc.

Injured Worker Helplessness (and Laziness)

In human endeavors, when individuals perceive an absence of control over the outcome of a situation, some individuals manifest a cluster of behaviors known as "learned helplessness." This is true in all walks of life, and it is prevalent in the workplace, where challenges are commonplace. Those "learning" helplessness manifest problems with motivation and initiating self-help behaviors. A reasonable method of explaining the evident problems of motivating an injured worker toward an occupational recovery in a system that engenders helplessness is found in this same learned helplessness paradigm. One critical aspect of a quality DMP is to understand the concept of learned helplessness, especially as that condition manifests after the onset of occupational injury or disease. To explain problems with worker motivation following lost time injury or illness, Walker has chosen the label of "injured worker helplessness."

To better understand injured worker helplessness, it is important to understand the research behind "attributional theory." Attributional theory ismotivational theory, looking at how the average person constructs the meaning of an event based on his/her motives to find a cause and his/her knowledge of the environment. The theory is based on what the individual "attributes" as the cause of the outcome or potential result. An individual's attributional style (sometimes called an "explanatory style") provides a basis to understanding why people respond differently to adverse events.

While groups of people may experience the same difficult event, individuals in the group interpret (explain to themselves) the outcome differently. People having a "pessimistic explanatory style" tend to view results as negative, permanent, and beyond any chance of remediation.

Unfortunately, so-called disability support systems (i.e., workers' compensation and long-term disability programs) create environments that are often difficult for the injured worker to navigate, and often, within these environments, individuals with injury and/or illness resulting in lost time have an increased likelihood of learning helplessness. This is particularly true if the individual possesses an explanatory style associated with pessimism.

Moreover, these same systems produce another dynamic that might be called "learned laziness." University of Minnesota researchers found that rewarding unconditionally, that is, providing a positive stimulus before a desired behavior is exhibited, leads to an extinguishing of that desired behavior. In other words, if you pay your teenagers for taking out the trash but you begin and maintain a pattern of paying them before they take out the trash, they will cease taking out the trash. Walker has argued elsewhere that many disability support systems, including workers' compensation, are non-contingent reward programs.

With workers' compensation systems being quite socially challenging to injured workers and at the same time non-contingent reward programs, injured workers are likely to learn both helplessness and laziness the longer they remain in those systems. Ergo, Walker and others advocate for rapid vocational rehabilitation and transition-to-work programs.

The Critical Difference between Impairment and Disability

The American Medical Association (AMA) has defined impairment as a change in one's anatomy and/or physiology secondary to disease. Implicit in this definition is the possibility that the impairment may create activity limitations. Impairment is assessed by medical means. The basis for determining impairment is the Guides to the Evaluation of Permanent Impairment published and updated regularly by the AMA. The AMA Guides state categorically that impairment ratings are "not intended for use as direct determinants of work disability."

The Social Security Administration adds to the AMA definition by requiring that the physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by the individual's statement of symptoms.

Physicians are encouraged to rate impairment based on the level of impact that the condition has on the performance of activities of daily living (ADL) rather than on the level of work disability.

Unlike impairment, disability is the inability to meet the physical and/or mental demands of employment, for which a person may be otherwise qualified. Disability is, therefore, defined by non-medical means by a professional trained in the assessment of employability. An individual's employability can be changed through a number of factors: selective job placement, workplace accommodations (as mandated by the ADA/ADAAA), and retraining.

By confusing impairment with disability, employers, insurance carriers, other employees, social and economic systems, and the community in general suffer substantial losses in both human and financial terms. The medical community, the public, the legal system, and even employers often misunderstand the important distinction between impairment and disability.

To further complicate the issue, each state, in its unique workers' compensation legislation, has its own definitions of impairment and disability. This is not to suggest that the important differences between these two conditions can vary markedly in terms of who is responsible for what, but employers will do well to research their workers' compensation legislation for guidance.

Disability Proneness

Building on the concepts of Behan, Hirschfeld, and Weinstein, Walker elucidated the phenomenon of "disability proneness." Behan and Hirschfeld were occupational medicine physicians who worked with injured workers from automobile assembly companies in Detroit in the early 1960s. Essentially, these pioneering researchers in workplace issues described the vulnerability of a specific segment of the workforce to what they defined, in great detail, as the "disability process." They concluded that injured employees can exhibit "disability without disease" or accident (1966).

Borrowing on this concept, Weinstein delineated the "process of disability" in 1978. Rather convincingly, Weinstein graphically portrayed the stages of the disability process. Weinstein reasoned that the troubled worker faced with negative feedback regarding his or her performance would eventually reach a stage where

so-called “tension build-up” would become overwhelming and viewed as “unacceptable disability.” Weinstein argued that an accident or illness, seen retrospectively as an “explanatory event,” would allow the unacceptable disability to become acceptable and stabilized with medical explanations, diagnostic studies, and eventually unnecessary interventions, such as surgery or chronic pain management involving crippling medications.

What Walker discerned from the initial research conducted by these men is that a psychologically vulnerable person can manifest lost time secondary to disease or injury that is not necessarily occupationally significant, or even that there is no disease at all. Under certain circumstances, employees with particular personality characteristics can manifest lost time following injury or illness, even though the disease process does not represent vocationally limiting impairment or occupational disability. He showed that one can track the history of such individuals and predict their proneness to become “disabled” in terms of their continuing to be productive employees. The definition posited by Walker is that disability proneness is a predisposition in an employee toward disabling disease or injury. Understanding the individual’s history can help the rehabilitation specialist to predict the course of events for them in terms of their going-forward workplace behavior.

Some of the contributing factors to disability proneness, as delineated previously by Walker, include:

- anger in the workplace
- the effects of depression
- substance abuse
- employee (and injured worker) helplessness
- workplace dysfunction
- workplace conflict

Occupational Inertia

One fundamental aspect of the physical world and biological systems as well is the law of **inertia**. There two distinct states of inertia: (1) a body in motion will continue in motion until some force is brought to bear to halt the motion, and (2) a body that is at rest will remain at rest unless some force is brought to bear that will start a motion.

Both of these definitions of inertia play a critical part in workplace dynamics, including disability management. First, an individual will remain in habitual motion in the workplace, unless impeded by an external (or internal) force to stop. In the case of the employee, the stimulus to stop could come from a personal decision or from a supervisor, a promotion, or a separation. In many instances, once separated, the individual will remain at rest exhibiting no forward motion (initiative). There will be no effort to start (or restart) the forward motion. That is, the individual will remain unemployed until an equal force is exerted to move the individual to secure alternative work.

While there are different reasons why in-motion becomes no-motion, one of the most frequent reasons is an injury or illness that “kicks” the employee out of the trajectory of continuing employment. Once the in-motion inertia stops and the person leaves work, he or she tends to settle into a “disabled” pathway characterized by little resistance to it. The longer this process continues without intervention or rehabilitation, the chances of vocational recovery decrease significantly because of the immutable law of occupational inertia.

Similarly, vocational rehabilitation professionals are cognizant of what might be called “career inertia.” That is, some employees have a tendency to remain in a career trajectory uninterrupted unless an equal or opposite force is encountered. While in some cases, this may be a desirable state, knowledgeable employers are constantly working to vitalize their workforces with new challenges and opportunities of enrichment to constantly churn the career inertia state. Doing so benefits the employer as well as the employee. (Traditionally, few people have chosen to deliberately switch careers. This general tendency appears to be changing as more and more individuals, especially the better educated, are opting for career changes.)

In short, the law in physics of inertia (both forms) holds an instructive analogy for employers in terms of workplace policies and procedures. Workers in motion and workers not in motion may require attention and intervention to fulfill the imperatives of a viable, and indeed vital, business.

Exemplary workplace management continually develops and applies methods to counter vocational inertia. In the case of no-motion inertia, the remedial applications are generally built around motivational concepts developed specifically for occupational applications.

Corporate Systems Strategies Can Prevent and Interrupt the Dynamics of Disability Proneness and Lost Time

There are a number of human capital strategies to deal with disability proneness that have been deemed essential to exemplary and truly integrated DMPs. To be "truly integrated," these strategies must not become corporate silos operating independently in a bureaucratic fashion. Most of these programs can be effectively operated by a disability management team, led perhaps by a human resource professional, and integrated not only with each other, but also into the very fabric of the workplace.

1. Safety/Wellness programs

For mid- to large-sized companies, the essential correctives to injury proneness are aggressive and continuing Safety and Wellness programs. (For smaller companies, understanding the basics of what these formal programs include is the minimum, essential ingredient.) Ergonomics, smoking cessation, relaxation/meditation methods, stress management techniques, nutrition classes, and other such prevention strategies are made a regular part of the operational process. In Pennsylvania, for one, employers get a 5 percent discount on their workers' compensation premiums if they implement safety programs. If the work organization maintained a philosophy that all accidents could be prevented, and successfully acted on that philosophy, no one would be injured.

2. Communication Skills training for all supervisory and front-line management personnel

Whether a supervisor is attempting to teach a concept or intervening in a dispute, how well that supervisor interpersonally communicates is key to continuing productivity and morale. The most vital element in effective management and supervision – communication – must be learned. Unfortunately, most of us are "taught" communication styles from our first supervisors, our parents, and more often than not, these are ineffective in the workplace.

In The Assertive Manager, Elaine Zuker wrote, "Communication is the cornerstone of business. Managers use many different channels to communicate with others, and [they] spend between 50 percent and 90 percent of their day in communication of one kind or another. Communication is a set of skills you learn."

Most communication between front-line supervisors and subordinates is verbal. Listening and sending messages are more complex than we realize. Listening is an art that takes some of us many years to learn. When another's behavior is unacceptable to us, the messages that we send them to change their behavior can be destructive rather than constructive to the relationship. Of course, no one wants to be told that their behavior is unacceptable. Learning to listen is tough, and learning to confront appropriately is probably even more difficult. Instead of acquiring and consciouslylearning listening and confrontation skills, most of us who engage in interpersonal communication at work follow our idiosyncratic styles of relating to others, and whether we want to admit it or not, we probably communicate like our parents communicated with us.

3. Employee Assistance Programs

The EAP is a basic process designed to assist management to identify and resolve an individual worker's problem that interferes with work. EAPs are most effective when they can identify and address problems before they manifest themselves as such. Effective EAPs provide "24/7" access (including telephone access). The functions of an effective EAP, in chronological order, are supervisory training, assessment, consultation, referral, and crisis management. The stages of how these functions develop are awareness of the problem, predicting consequences, identifying causes, and applying corrective resources. The more effective EAPs are "broad brush" and recognize that personal problems that interfere with work behaviors are highly variable and not limited to substance abuse alone.

Since prevention and early intervention are the objectives, EAPs must be constructed with the philosophy that supervisors are on the front line. Supervisors must receive specialized training in how to recognize potential problems and when, where, and how to refer the worker to the EAP component for services. Training supervisors in small companies is as important as training them in larger companies: the difference is in the referral source. Referral sources for small companies are frequently community-based resources. Safety/Wellness and EAP coordinators are responsible for designing the supervisor training, initiating it, and conducting follow-up training in regularly scheduled intervals.

In fact, because many of the causative factors in EAP cases are family-related (including domestic violence), model EAP services are available to family members as well. That is, the family may be a cause of the problem and will have to be treated along with the employee. In any event and in all cases, the familial unit will be affected by the employee's dysfunction and will have to be brought into the referral/treatment process to optimize outcomes.

- The objectives for Safety/Wellness programs and EAPs for employers include:
- Fostering improved health outcomes for employees and their families.
- Promoting an optimum quality of life for the employee and his or her family.
- Increasing workplace productivity.

The specific services of the EAP include:

Professional assessment of issues related to mental health, substance abuse, the workplace environment, and other challenges to major life activities of the employee or family members.

- Immediate, personal counseling (for employees and family members).
- Referral to either treatment or support services.
- Implementation of pre- and post-stress management assistance.
- Application of return-to-work strategies, especially with transition-to-work methods.

The overriding interest for employers in operating Safety/Wellness programs and EAPs is to put prevention and early intervention policies in place. While the value of the services that flow from such policies may, on first blush, appear to benefit the employee most, the greater value accrues to the employer.

4. Managerial Mediation Training

Since anger plays such a significant role in workplace injuries, the single most productive intervention is managerial mediation. Generally, strife in the work site is between co-workers or between an employee and his or her supervisor. Since this condition is a commonplace event, there has been, for more than a decade, a strategy to deal with it. The strategy is called managerial mediation training.

The specialized methods and materials of mediation in the workplace are those that were developed in conflicts outside of this environment. There are now mediation (conflict resolution) services available through most court systems and counselors specializing in marital/divorce conflicts and even in nation-to-nation conflicts: President Carter (2002 Nobel Peace Prize recipient) brought in mediation specialists when he worked on the Middle East conflict.

These methods of mediation have long since been adapted to workplace disagreements and are called managerial mediation training (Dana, 1990). Workplace supervisors are trained in the specialized methods of mediation and are required to bring the methods to those conflict situations that, if left unaddressed, would likely escalate. The process is designed to bring "mutual acceptance" to the disputants in the conflict.

Unmanaged employee conflict is arguably the largest reducible cost in organizations today. It is estimated that over 65 percent of work performance problems result from strained relations between employees – not from deficits in an individual's skills or motivation.

Federal legislation, notably the Family and Medical Leave Act (FMLA) and the ADA/ADAAA, requires disputants under the direction of the Equal Employment Opportunity Commission (EEOC) and the Department of Justice to engage in mediation before they will sanction litigation.

Lastly, we recommend that various members of an organization develop a team approach to integrated disability management. When delivered in an integrated fashion and managed by an interdisciplinary team that is led by a human resource professional, these human capital strategies can be the core of a proactive, integrated DMP. True integration of disability management requires primarily the delivery of human resource programs and secondarily activation of lost time benefits programs.

Creating and Operating a Transition-to-Work Program

To succeed at returning an employee to work, a planned, specific, and documented strategy or plan is needed. The "plan" is created through the composite input of all the principals in a situation, and the "transition-to-work plan" is developed as a joint effort. Essential members of a disability management team include the following:

- The employee
- The employee's immediate supervisor
- A representative of the medical profession
- A representative of the bargaining unit (if applicable)
- A risk manager/human resources specialist
- A case management professional

It is not essential that all team members physically meet to develop the plan. A draft plan (strategy) can be given to the treating physician, for example, for input or, at least, consent in the form of an approval signature. A communications protocol for getting treating physician input is a critical feature of the procedures that need to be developed.

Employers may also want to consider individuals with specific expertise as consultants to the construction of a given transition plan. For example, individuals with experience in ergonomics, a specific disability (e.g., hearing impairment), and/or job redesign could represent cost-effective additions to the team in appropriate cases.

Caveat:

It will be absolutely essential that the rehabilitating/transitioning employee understands the return-to-work program that is being designed for him/her, that he/she has had an opportunity to help to shape the plan, and that he/she accedes to the plan's objectives.

Sample Corp, Inc.

Transition-to-Work Plan

Employee Name _____

Employee Address _____

Telephone: _____

Date: _____

Treating Professional: _____

Address: _____

_____

Telephone: _____

Summary of present treatment plan:

_____

_____

_____

_____

_____

Summary of Functional Capacities (See attached for comprehensive Functional Capacity Evaluation):

_____

_____

_____

_____

_____

Functional Capacity Update:

Changes (as determined by the attending physician) in the Functional Capacities as of _____(date).

_____

_____

_____

_____

_____

Changes (as determined by the attending physician) in the Functional Capacities as of _____(date).

_____

_____

_____

_____

_____

Start date of transition: _____

Projected # of weeks in transition: _____

Projected date of transition completion: _____

Employment Option:

_____ Same job

_____ Same job with accommodation

_____ Different job

_____ Different job with accommodation

Job Title: _____

SAMPLE JOB CONTENT (JOB DESCRIPTION) FORM

BASED ON THE ESSENTIAL FUNCTIONS OF THE JOB

Job Title**: Mold Press Operator**

Job Objective(s):

To heat cure-ring seals per specifications and ensure 100% quality control

Essential Job Functions (Functions essential to attaining the Job Objectives):

- **Places compound (unfinished ring seal) onto loading board and stripper plates; loads compound onto mold**
- **Sprays lube over each mold using circular motion to ensure complete lubrication of mold**
- **Operates (pushes button to hydraulically activate) mold press to ease bottom molds up into stripper plate and to close presses**
- **Cleans flashing off molds; removes and inspects press**

Job Standards (Minimum qualifications needed to perform essential functions):

- **Repetitive fine manipulation; prolonged standing; able to lift loading board (23 lbs.) from shoulder height to above shoulder**
- **Pushing/pulling (43 lbs. resistance) stripper plate and knockout table**
- **Exposure to mold release mist and high temperatures; repetitive reaching waist to shoulder level; ability to discern imperfections of seals; ability to read process and attribute charts; ability to count time spent on press; ability to generate attribute chart information; tolerance to work alone with minimum or no supervision**

Job Location (Place where work is performed): **Mold Press Department**

Equipment: **Compound loading board; compound; stripper plate rings; lube (water and mold release solution); lube sprayer; attribute chart; heat press; air hose**

Note: A commercially available test called the Transitional-to-Work Inventory is available from The Psychological Corporation. This is a Worker Analysis Scale designed to facilitate the job placement of workers with severe disabilities.

Transition Objective:

_____

_____

_____

_____

_____

The objective should be stated in measurable terms. The objective must include precisely which job the employee is being readied for, the specific date by which the readiness preparation is intended to be achieved, and the job performance standards that will be expected. If an accommodation is involved, it needs to be specified in the objective.

A sample objective might look something like this:

To prepare {the employee named above} to be able to perform the job of Mold Press Operator. {The employee} will be able to perform, with or without a reasonable accommodation, each of the essential functions given in the Mold Press Operator Job Description (See Attached). The transition-to-work plan sets the number of weeks to achieve readiness at 12 weeks. The plan includes incremental length-of-day durations and exertion levels (See Attached). The output standard for parts produced per hour is set at 14 which is to be achieved incrementally over the 12 weeks prescribed in this plan. The spray gun used in this job will be suspended on a spring 8 inches above the employee's shoulder as he {she} stands before the mold.

Planned Schedule of Incremental Work:

Week	Projected Activity (Hours/Week)	Achieved Activity (Hours/Week)

Weekly Strength/Exertion Review:

Week:	Strength Level	Exertion Level

Job Restructuring:

Ergonomic Considerations:

_____

_____

_____

_____

_____

Assistive Devices:

_____

_____

_____

_____

_____

Employee-Requested Accommodation(s):

_____

_____

_____

_____

_____

Comments by Employee Regarding the Transition Plan

_____

_____

_____

_____

_____

Supervisor's comments in terms of the job, the transitioning employee, and specific aspects of the "plan."

_____

_____

_____

_____

_____

Comments by Bargaining Unit Representatives Regarding the Transition Plan

_____

_____

_____

_____

_____

Signatures to the Plan

Employee: _____ (Signature)

_____ (Typed Name)

_____ (Date)

Supervisor: _____ (Signature)

_____ (Typed Name and Title)

_____ (Date)

Union: _____ (Signature)

_____ (Typed Name and Title)

_____ (Date)

Medical: _____ (Signature)

_____ (Typed Name and Title)

_____ (Date)

Personnel: _____ (Signature)

_____ (Typed Name and Title)

_____ (Date)

Quantitative and Qualitative Outcome Measures:

All newly implemented management concepts need to be evaluated for effectiveness. The Transition-to-Work program is no exception.

To measure the process quantitatively, the base standards need to be documented. Until Workers' Compensation costs began to skyrocket, many companies did not return most injured/ill workers to the company. Outsourcing was the typical approach. In those cases, return-to-work programs were rare or nonexistent, and there were no baseline data to measure how effective the program was or how much it saved.

What a company does in terms of its disability programming is financially significant, and if there is no extant database of information, a data-gathering procedure should be designed and activated simultaneously with the transition program.

Questions that should be answered as a result of the data gathered include such things as:

- Number of total cases per year
- Short term disabilities (STD) cases per year
- Long term disabilities (LTD) per year
- Total hours of lost time (and by wage/salary categories
- Number of cases by breakouts (injury, same/different job, accommodation required, length of time on job after transition, female vs. male, department within the company, transition cost by department, injuries by department, etc. etc. etc.)
- Type of injury/illness
- Cases by length of transition
- Costs of transition
- Case management statistics

Flexible Return-to-Work Options Bridge the Gap Between Injury and Full Duty

The April 5, 1997, issue of the Pennsylvania Bulletin was given over to a "Statement of Policy" on Act 57 of the Workers' Compensation Act. This statement was created by the Department of Labor to "explain and enforce the provisions of the WC act." That is, these statements indicate what standards employers will be held to in terms of Act 57 compliance.

Section 306(B)(2) of Act 57, the Pennsylvania Workers' Compensation Act, states:

If the employer has a specific job vacancy the employee is capable of performing, the employer shall offer such job to the employee.

The language in Pennsylvania's workers' compensation law challenges employers to have pro-active return-to-work programs, and there are compelling reasons every employer should want to do so to:

1. save significantly on workers' compensation costs, and
2. reduce exposure to disability discrimination lawsuits under the Americans with Disabilities Act of 1990.

Over the past several years, employers have frequently resolved their injured worker situations by asking Vocational Rehabilitation specialists to find new jobs for these workers. Now, studies of this approach to workplace injuries have shown that a return-to-work program is by far more effective for employers than

traditional outsourcing. In fact, a return-to-work program in a medium-sized company reduces lost-time indemnities by 20 to 40 percent. In addition to these significant cost-of-doing-business savings, return-to-work programs:

- provide an opportunity for the employee to be productive while he/she is recovering
- accelerate reintegration into the workforce and help the employee feel positive about his/her life
- preclude employers from becoming "disability hostages."

To assist employers who are not presently sponsoring return-to-work programs in their work organizations, CEC Associates, Inc. offers a comprehensive program to:

1. create a return-to-work program and
2. train professional staff to implement it.

Job Analysis and Job Accommodation: The Baseline Challenge for Employers in the ADA/ADAAA

By Jasen M. Walker, Ed.D., C.R.C., C.C.M.

While the Americans with Disabilities Act (ADA) addresses a number of issues under five[1] separate "Titles." The Title that most directly impacts employers is Title I. The essential idea of "Title I: Employment" is the requirement that employers make **reasonable accommodations that are not an undue hardship so that any qualified individual with a disability can perform the essential functions of a job.**

Notably, in 2008, the ADA was amended. Under the Americans with Disabilities Act and Amendments Act of 2008 (ADAAA), employers are required by law to follow specific guidelines from the ADA/ADAAA on pre-employment testing, essential functions, and reasonable accommodations. The legal test is whether or not the applicant can perform the "essential functions," or core duties, of a job. The ADA/ADAAA makes it illegal to give pre-employment medical testing and base hiring decisions on the outcome of those tests. Unlike medical tests, using standardized abilities and aptitude testing for pre-employment screening is not illegal. In fact, to identify what could be relevant "job-seeking attitudes and behaviors," employers should consider using pre-employment assessment products.

What this means to employers who want to comply with Title I is that they need to know precisely what the "essential functions" of the jobs in their companies are. In cases that go to either mediation or litigation on a Title I complaint against an employer, the issue of the essential functions of the job in question will be central to the case.

Many employers, of course, have always had "Job Descriptions" for their jobs. Unfortunately, in most cases these traditional Job Descriptions do not specifically identify the essential job functions in terms of the precise physical demands of the job, the environmental conditions under which the job is performed, and/or the minimum general educational development level required for the job. Further, traditional Job Descriptions rarely make a distinction between those functions of the job that are "essential" and those that are tangential or "non-essential" functions.

To create a meaningful, comprehensive, and defensible Job Description (or Job Content[2]) document, employers must do a "Job Analysis." The Job Analysis process is a close observation and documentation of the actual functions of each specific job to identify the physical requirements of the job. Physical requirements analysis includes the percent of time on the job involving each of the following:

Standing	Lifting	Stooping	Balancing	Feeling	Near Vision	Depth Perception
Walking	Carrying	Crouching	Reaching	Talking	Mid Vision	Visual Discrimination
Sitting	Pushing	Climbing	Grasping	Hearing	Far Vision	Field of Vision
Reclining	Pulling	Kneeling	Handling	Tasting	Color Vision	

Each of these physical requirements has to be measured in terms of the specifics that are present in a job. For example, if a job requires lifting, carrying, and pushing, the pounds to be lifted or carried have to be determined, and the percent of time each of these physical requirements occurs in a work period has to be determined.

The environmental conditions inherent in a job are also measured in the percent of time involved. Environmental conditions that are significant to the essential job functions include: exposure to weather; extreme cold; extreme hot; dust, fumes, and gases; wet and/or humid weather; noise; and vibration.

Cold and hot conditions are measured in terms of temperature ranges. Potential hazards are also identified and documented in the Job Contents. The machines, tools, equipment, work aids, materials, and products used in the job functions are also identified.

Finally, the mental requirements of a specific job are established in terms of the ability needed on the job to reason, to use math, and to use language. The Dictionary of Occupational Titles (or DOT), a publication of the U.S. Department of Labor, provides a scale for employers to use to determine mental requirement.

With this understanding of the details that go into producing a valid job description, we can take a look at what it means for employers. Title I of the ADA says that an employer needs to base a job offer on the applicant's qualifications to perform the essential (not the marginal or non-essential) functions of a job, with or without accommodation. The ADA/AADAAA does not require that employers do job analyses or have job descriptions or list job contents for the jobs in their companies.

Disability management specialists should be aware of this pertinent legislation and its implications for their clients and companies with which they work. According to The CDMS *Code of Professional Conduct* (RPC 1.05):

Certificants shall be knowledgeable about and act in accordance with federal, state, and local laws and regulations, including procedures related to the scope of their practices regarding client consent, confidentiality, and the release of information.

But any case of discrimination under Title I (as opposed to the other titles of the act) that reaches litigation will revolve around what the essential functions of the job are and whether or not the particular applicant is qualified for the job on the basis of his or her ability to perform the essential functions, with or without accommodation. And employers will not be permitted, in litigation, to determine the essential functions after the fact. The essential job functions and their documentation must have existed at the time of the application and have served as the basis on which the employer decided the applicant was not qualified for the job or could not perform, with or without accommodation, at least one of the essential functions of the job in contention.

Establishing the essential functions of a job allows an injured worker to gain an increased sense of autonomy in their journey to return to work. Rehabilitation counselors are to encourage autonomy in their clients, according to the CRCC *Code of Professional Ethics* for Rehabilitation Counselors (A.1.d):

Rehabilitation counselors respect the rights of clients to make decisions on their own behalf. On decisions that may limit or diminish the autonomy of clients, decision-making on behalf of clients is taken only after careful deliberation. Rehabilitation counselors advocate for the resumption of responsibility by clients as quickly as possible.

Case managers are also provided standards for relationships with clients. According to the CCMC *Code of Professional Conduct* (S10):

Board-Certified Case Managers (CCMs) will maintain objectivity in their professional relationships, will not impose their values on their clients, and will not enter into a relationship with a client (business, personal, or otherwise) that interferes with that objectivity.

All employers with 15 or more employees, who are interested in complying with the provisions of Title I of the ADA/ADAAA, should have job descriptions that were created using methods discussed above. To do this, they will need to make a commitment to do job analyses and to create job descriptions based on the essential functions of each job.

Since the analysis is based on actual observations and the measurements of specific job functions (as opposed to someone's creative listing of what the employer would like the job applicant to accomplish), employers will need to train the appropriate staff professionals in the job-analysis process. It is important to note, however, that the employer gains much more than simply compliance with Title I by producing job descriptions based on analysis. For one thing, when employers hire new employees, whether they are individuals with disabilities or not, they now have a detailed description of the job to share with the applicant at the time of employment. Expectations for both the employer and the new hire are now based on detailed measurements of the actual events of a job. This serves as a basis for the hiring decision, the decision of the applicant as to whether or not to take the job, and as a basis for the evaluation of job performance after employment.

Additionally, essential-job-function descriptions become tools with which employers can manage disability resulting from occupational injury or lost-time illness. Job descriptions permit employers to more effectively communicate with treating physicians about essential job requirements, and job descriptions serve as a framework from which job modification might be made to quickly re-employ a worker who is temporarily or partially disabled as a result of accident or illness.

For their part, job applicants with disabilities need to be aware of the Title I provisions so that they can compete for a job based on the essential functions of that job. Job applicants with a disability need to insist, at the time of application, that the employer produce the essential functions (in the form of a job description or job contents form) for the job in question. Applicants failing to do so will not have met their obligation under the ADA/ADAAA to compete in the marketplace. When the employer does produce a job description based on job analysis at the time of application, the burden is on the applicant with a disability to demonstrate that he/she can perform, with or without accommodation, the essential functions of that job.

Notes:

1. THE SPECIFIC TITLES OF THE ADA:

Title I: Employment
Title II: Public Accommodations
Title III: Transportation
Public Bus System
Public Rail System
Privately Operated Bus and Van Companies
Title IV: State and Local Government Operations
Title V: Telecommunications

2. SAMPLE JOB CONTENT (JOB DESCRIPTION) FORM:

Job Title: Mold Press Operator

Job Objective(s): To heat cure-ring seals per specifications and insure 100 percent quality control

Essential Job Functions (Functions essential to attaining the Job Objective):

- Places compound (unfinished ring seal) on to loading board and stripper plates, loads compound onto mold
- Sprays lube over each mold using circular motion to insure complete lubrication of mold
- Operates (pushes button to hydraulically activate) mold press to ease bottom mold up into stripper plate and to close presses
- Cleans flashing off molds, removes, and inspects press

Job Standards (Minimum qualifications needed to perform essential functions):

- Repetitive fine manipulation; prolonged standing, able to lift loading board (23 lbs.) from shoulder height to above shoulder
- Pushing/pulling (43 lbs. resistance) stripper plate and knockout table
- Exposure to mold release mist and high temperatures, repetitive reaching waist to shoulder level, ability to discern imperfections of seals; ability to read process- and attribute-chases; ability to count time spent on press; ability to generate attribute-chase information; tolerance to work alone with minimum or no supervision.

Job Location (Place where work is performed): Mold Press Department

Equipment: Compound loading board; compound stripper plate ring; lube (water and mold release solution); lube sprayer, attribute chart, heat press; and air hose.

Analyzing and Describing Jobs: Useful Procedures in the Rehabilitation of Injured Workers

By Jasen M. Walker, Ed.D., C.R.C., C.C.M.

The Americans with Disabilities Act (ADA) introduced new concepts to employers in terms of working with individuals with disabilities. Two of the most significant concepts are the "essential functions" of a job and "reasonable accommodation." In this article, essential functions and the process that determines them as well as job analysis are discussed as the single most important step employers must take in their efforts to develop and maintain an effective approach to disability management in the workplace. In 2008, the act was amended to the Americans with Disabilities Act with the Amendments Act of 2008.

Introduction

Title I of the ADA/ADAAA says that an employer needs to base a job offer on the applicant's qualifications to perform the essential (not the marginal or non-essential) functions of the job, with or without accommodation. What this means to employers who want to be in compliance with Title I is that they first need to know precisely what the "essential functions" of jobs in their company are.

Many employers, of course, have always had "job descriptions" for their jobs. Unfortunately, in most cases, these traditional job descriptions do not specifically identify the essential functions in terms of the precise physical demands of the job, the environmental conditions under which the job is performed, or the minimal general educational-development level required for the job. Further, traditional job descriptions rarely make a distinction between those functions of the job that are "essential" and those that are tangential or "non-essential" functions.

Job Analysis and Description

Andrew and Dickerson[1] define the job analysis as the examination of what a worker does, why it is done, how it is done, and the skill needed. Job analysis provides systematic and detailed information about a job; what the worker does in relation to data, people, and things. The process of observation, interview, and study identifies job duties, responsibilities, purpose, qualifications for employment, equipment and materials used, relation to other jobs, training required, and physical demands.[2]

In a visit to a work site, the rehabilitationist who is trained in the techniques of analyzing jobs can analyze a job in a quick and informal manner. Job analysis as a technique is a major source of data and a procedure that those involved in vocational rehabilitation should know.

Once a job analysis is completed, the gathered data can be arranged in job-description form. A complete job description can:

- provide the physician with a thorough understanding of the physical demands of the job;
- provide the physician, rehabilitationist, employer, and employee with a workable "blueprint" to which the individual parties can refer when discussing ways to modify work so that it matches the residual abilities of the employee;
- serve as formal and legal documentation as to the physical and mental requirements of "available work";
- serve as an actual vocational assessment of a worker's experience and abilities in lieu of a "hypothetical" evaluation, which is generally performed when the evaluator is denied permission to examine the workers' compensation claimant.[3]

The importance of the first two uses of the job description is self-evident. Safely returning the injured employee to gainful activity is necessarily the goal of every genuine rehabilitation effort. The third and fourth uses are adopted in contested workers' compensation claims that require the services of a vocational expert.

Workers' compensation litigation frequently requires that the defendant employer produce evidence that appropriate work is available to the claimant. When possible, an analysis can be conducted to ensure that the job is commensurate with the claimant's mental and physical capabilities. From the analysis, a job description is constructed and forwarded to the physician for review and approval.

At times, this may not be necessary as the physician has clearly detailed the worker's residual physical capacities. At other times, however, non-specific recommendations such as "no heavy lifting" or "no repetitive bending" can be clarified by the physician's response to a job description. Notwithstanding the clarity of the physician's recommendations, the approved job description bridges the gap between vocational and medical evidence.

Claimant counsel in Pennsylvania workers' compensation claims may refuse to permit the direct-vocational evaluation of clients. As a result, the skilled evaluator can perform a so-called "hypothetical" examination utilizing file documentation of some sort. An alternative is to conduct a job analysis when possible.

Should claimant counsel refuse to cooperate in allowing a personal examination of the claimant, the vocational evaluator can perform an on-site job analysis. By thoroughly analyzing the claimant's job, the vocational expert can develop at least a partial picture of the claimant's demonstrated skills and aptitudes. A job search or labor-market survey based on this analysis and the known medical limitations would likely follow.

Essential Functions

The ADA/ADAAA does not require that employers do job analyses or that they have job descriptions for the positions in their companies. However, any case of discrimination under Title I that reaches litigation will revolve around what the essential functions of the job are and whether this particular applicant is qualified for the job on the basis of his or her ability to perform the essential functions, with or without accommodation.

Employers will not be permitted, in litigation, to determine the essential functions after the fact. Documentation must have existed at the time of the application and have served as the basis on which the employer decided the applicant was not qualified for the job or could not perform, with or without accommodation, at least one of the essential functions of the job.

Since the analysis is based on actual observations and the measurements of specific job functions (as opposed to someone's creative listing of what the employer would like the job applicant to accomplish), employers will need to train appropriate staff professionals in the job analysis process.

It is important to note, however, that the employer gains much more than simple compliance with Title I by producing job descriptions based on analysis. For one thing, when an employer hires a new employee, whether he or she is an individual with a disability or not, the employer now has a detailed description of the job to share with the applicant at the time of employment. Expectations for both the employer and the new hire are now based on detailed measurements of the actual events of a job. This serves as a basis for the hiring decision, the decision of the applicant as to whether to take the job, and for the evaluation of job performance after employment.

Additionally, essential-job-function descriptions become tools with which employers can manage disability resulting from occupational injury or lost-time illness. Job descriptions permit employers to more effectively communicate with treating physicians about essential-job requirements, and job descriptions serve as a framework from which job modification might be made to quickly re-employ a worker who is temporarily or partially disabled as a result of accident or illness.

These specific descriptions can also aid Disability Management Specialists in providing accurate forensic evaluation. As stated in The CDMS *Code of Professional Conduct*, RPC 3.01:

When providing forensic evaluations for an individual or organization, the primary obligation of certificants shall be to produce objective findings and opinions that can be substantiated based on information and techniques appropriate to the evaluation, and as required by applicable case law within the appropriate jurisdiction, which

may include assessment of the individual and/or review of records. Certificants shall define the limits of their reports or testimony, especially when an assessment of the individual has not been conducted.

For their part, job applicants with disabilities need to be aware of Title I provisions so that they can compete for a job based on the essential functions of that job. Applicants with a disability need to insist, at the time of application, that the employer produce the essential functions (in the form of a job description or job contents form) for the job in question. Applicants failing to do so will not have met their obligation under ADA/ADAAA to compete in the marketplace. When the employer does produce a job description based on job analysis, the burden is on the applicant to demonstrate that he or she can perform, with or without accommodation, the essential functions of that job.

Rehabilitation counselors also need to be aware of these obligations, so that they can uphold C.1.e. of the CRCC *Code of Professional Ethics* for Rehabilitation Counselors, which states, "Rehabilitation counselors are knowledgeable about local, regional, and national systems and laws, and how they affect access to employment, education, transportation, housing, financial benefits, and medical services for people with disabilities. They obtain sufficient training in these systems in order to advocate effectively for clients and/or to facilitate self-advocacy of clients in these areas."

Case managers must also be legally compliant, as stated within the CCMC *Code of Professional Conduct* (S12), which states:

Board-Certified Case Managers (CCMs) will be knowledgeable about and act in accordance with federal, state, and local laws and procedures related to the scope of their practice regarding client consent, confidentiality, and the release of information.

New Technologies

More and more, job analysts are taking advantage of video technology to describe jobs. As job analysis becomes a more accurate science, the hand-held video camera increases in value as a tool for reliable communication of work-related data and the modification of work when necessary. A video sequence of a job or task can be replayed so that the employer, physician, and/or ergonomics expert can adopt methods to do the job in less taxing, safer, and more efficient ways.

Some companies that have developed their own return-to-work programs have created film libraries of their "light duty" pool for review by physicians and, at times, workers' compensation referees. Video technology will accurately account for important considerations, such as posture and movement, when describing a job in dynamic terms.

Summary

In summary, the job analysis and the job description are useful tools to the skilled vocational rehabilitationist. Job analysis involves the examination of what a worker does and why and how it is done. The job analysis and its product, the job description, often serve as a critical step in safely returning a worker to employment. In addition, the job analysis can provide the vocational expert with an alternative to the traditional "hypothetical" evaluation when a personal interview with the workers' compensation claimant is refused.

As job analysis becomes more commonly practiced, its usefulness will expand. Presently, job analysis and job description are integral parts of the process of vocational evaluation and rehabilitation.

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