Return to work after occupational injury

Family physicians’ perspectives on soft-tissue injuries

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ABSTRACT

OBJECTIVE To document physicians’ views about facilitating factors for and barriers to their helping workers recover after occupational soft-tissue injuries and to ascertain physicians’ knowledge and attitudinal barriers to their involvement in return to work.

DESIGN Faxed survey.

SETTING Manitoba family practices and emergency departments.

PARTICIPANTS General practitioners, family physicians, and emergency physicians regularly caring for injured workers.

MAIN OUTCOME MEASURES Physicians’ ranking of facilitating factors and barriers, changes to help their involvement in return to work, and their attitudes and knowledge about return to work.

RESULTS Respondents and nonrespondents were demographically similar; 232 physicians (51.3%) responded. Respondents believed the main facilitating factors were physicians’ ability to explain the nature and prognosis of injuries to workers (69%) and the willingness of workplaces to accommodate injured workers (26%). The main barriers were workers’ misunderstandings and fears about their injuries (70.7%) and non-supportive supervisors and co-workers (20.8%). The most frequently requested change was better workplace job accommodation (48%). Most physicians agreed they had a role in planning return to work and were aware of the effect of job satisfaction, psychosocial elements, and work-related factors. Despite supporting evidence, only one third of physicians stated they would say “try to continue usual activities” to patients with occupational low back pain.

CONCLUSION Most physicians seemed aware of their role in return to work and the effect of occupational factors, but their advice on activity after injury differed from that in practice guidelines.

This article has been peer reviewed.

Cet article a fait l’objet d’une évaluation externe.

Most working people in Canada with work-related health concerns rely on advice from their family physicians. Many workplaces do not provide access to occupational medical expertise, and specialists become involved only when serious disease or disability have already developed.

Pressured by the rising cost of occupational injuries—an estimated $10 billion yearly in Canada—employers, workers’ compensation boards (WCBs), and insurance companies are increasing demands on physicians. Depending on local WCB and related legislation, Canadian physicians are expected to provide medical justification for receipt of compensation benefits, to give an opinion on the work-relatedness of an injury or illness, to determine the length of time a worker should be off work, and to judge the appropriateness of temporary work reassignments. These expectations place Canadian physicians in the awkward position of simultaneously being the main advisor to workers and the gatekeeper for compensation. Particularly difficult to manage are occupational back pain workers’ compensation boards (WCBs), and insurance and insurers have described difficulties in communicating with physicians about RTW.

Numerous practice guidelines address back pain, between back pain guidelines and physicians’ practices stress that physicians should discuss recovery times and early RTW plans with workers, recommend continuation of usual activities as much as possible, and help workers and employers set up appropriate modified duties if required (Table 1). Canadian employers, unions, occupational health practitioners, and insurers have described difficulties in communicating with physicians about RTW. According to Christian, US employers have expressed concerns about lack of physician participation in RTW.

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Table 1. Key messages of the Manitoba Medical Association’s position statement on return to work after illness or injury

Planning to return to work should begin at the first visit. Work and other activities should be encouraged within patients’ evolving capabilities. Physicians should become familiar with the essential physical demands and health and safety hazards of patients’ work and, in particular, any additional risks to the patient, co-workers, or the public because of the medical condition or prescribed medications.

Physicians have a responsibility both to patients and to society. While the emphasis should be on a worker’s capabilities, physicians’ communication to employers commonly focuses on limitations. … When providing a written note to an employer, physicians should consider task limitations, schedule modifications, environmental restrictions, medical aids, and personal protective equipment. … A date should be given at which a patient and his or her work restrictions will be reassessed. Patients are entitled to a copy of all return-to-work notes. Good judgment must be used when recommending restrictions. Inappropriate restrictions can delay healing and could lead to permanent symptoms.

Employers determine the type of work available and whether a physician’s recommendations can be accommodated. Depending on the nature of the medical condition and the work available, a trial return to work can extend over weeks or months.

Medical information obtained from patients or medical colleagues is confidential. This information may be divulged only when authorized by the patient, except when required by law.

Reports and notes for employers and clinical assessments primarily for the purpose of returning to work are third-party uninsured services. These abbreviated statements are offered here to facilitate interpretation of our study. The official statement is available from the Manitoba Medical Association; a similar document endorsed by the Canadian Medical Association is widely available.

Numerous practice guidelines address back pain, one of the most common causes of work disability. Studies have repeatedly documented discrepancies between back pain guidelines and physicians’ practices in Canada, the United States, and the United Kingdom. In 1996, Sullivan summarized key practice recommendations for Canadian family physicians, recommendations that have been reinforced by the 1999 UK practice guidelines for acute back pain. The key messages are as follows.

- Look for red flags during history and examination.
- In the absence of red flags, no investigations or specialist referrals are warranted.
- Teach patients about the natural history of back pain and reassure them that a quick recovery is likely.
In this study, we aimed to explore the extent to which primary care physicians perceive barriers to their role in helping workers recover after soft-tissue injuries. We surveyed all Manitoba general practitioners, family physicians, community physicians, or emergency physicians. Of these, 320 physicians responded, representing the majority of the practitioners in the jurisdiction. The survey was conducted between November 1999 and April 2000 using a modified Dillman technique, with a response rate of 72%.

The survey questionnaire was developed through meetings with primary care and occupational physicians and with labour, management, and WCB representatives. It was pretested with eight family physicians. The questionnaire took an average of 13.8 minutes to complete (range 12.5 to 14.8 minutes); the content was deemed appropriate after simplification of a few items. Physicians were presented with four possible facilitating factors and four possible barriers to their treating workers with soft-tissue injuries, and were invited to add other facilitating factors or barriers, then rank the relative importance of each.

A subsequent open-ended question asked physicians to list changes that would help them most in treating injured workers.

Physicians’ knowledge and attitudes were explored in two ways. First, physicians were presented with a case of uncomplicated acute occupational back pain and asked to select from a list those initial management strategies that would help recovery and reduce work disability (feedback during development suggested that a case scenario would increase response rate). Second, physicians were asked whether they agreed or disagreed with general statements about work-related disability after soft-tissue injuries. Response options to these two questions related to physicians’ knowledge of or attitudinal barriers to participation in RTW and were derived from medical association statements from the scientific literature, and from a report of interviews with workers, employers, and insurers. The items were presented in random order, and several were reversed to decrease the risk of response bias.

Physicians’ answers were compared with the MMA because it described physicians’ role in the jurisdiction in which this survey was conducted, and with the UK back pain guidelines because they summarized current knowledge at the time of the survey. Global scores are not reported because individual answers are more informative about knowledge or attitudinal barriers.

Survey responses were analyzed with SPSS software (SPSS Inc, Chicago, Ill); \( \chi^2 \) tests compared proportions, \( t \) tests compared subgroup means, and multiple linear regression assessed the association of demographic and practice characteristics with the number of endorsed items related to the MMA statement and UK guidelines. The 95% confidence intervals (CI) for proportions were calculated using the normal approximation method. We compared demographic characteristics of respondents and nonrespondents to assess nonresponse bias. We also compared the responses of early respondents (answered after first contact) and late respondents (those who required reminders), and tested for trends.

**RESULTS**

The College of Physicians and Surgeons of Manitoba had, as of March 1999, 1072 physicians registered as general practitioners, family physicians, community physicians, or emergency physicians. Of these, 320 saw no injured workers in 1998, 249 saw between one and nine workers, and one was known to have left the
province. The questionnaire was thus faxed to 502 physicians. Forty offices responded that the physician in question had retired or moved out of province. Ten physicians were ineligible for other reasons (maternity or sick leave, specialized practice). From the remaining 452 eligible physicians, 83 declined participation, and 137 did not respond. Thus, 232 (51.3%) physicians provided usable answers.

There were no statistically significant differences between respondents and nonrespondents (Table 2), other than 60.8% of respondents versus 70.9% of nonrespondents practised in Winnipeg, the main metropolitan area in the province (P = .03). Of the 232 respondents, 5.7% worked in academic settings, 61.7% practised full time, and 18.3% provided emergency care. More than half the respondents (57.4%) practised in groups and 35.3% considered their practices rural. There were no significant differences between the responses of early and late responders or between those of physicians practising in and outside Winnipeg.

Facilitating factors and barriers
Physicians’ ability to explain the nature and prognosis of injuries to workers was ranked by 69% (CI 63, 76) of respondents as the main facilitating factor in treating workers with occupational soft-tissue injuries; 26% (CI 20, 32) considered the willingness of the workplace to accommodate injured workers as the main facilitating factor. Communication between physicians and the workplace, and between physicians and insurers, was considered a major facilitating factor by only 1.6% (CI 0, 3.3) and 1.1% (CI 0, 2.6) of respondents, respectively.

Most physicians (70.7%, CI 64, 77) considered the main barrier to treating injured workers was workers’ misunderstandings and fears about injury; 20.8% (CI 15, 26) thought the main barrier was non-supportive supervisors and co-workers. Lack of time or reimbursement for RTW planning and the administrative demands of a work injury were considered the main barrier by only 3.3% (CI 0.7, 5.9) and 0.5% (CI 0, 2.0) of respondents, respectively.

When asked directly, 194 physicians volunteered 19 changes they believed would help in treating injured workers. The most frequently mentioned change (48% of respondents, CI 41, 55) was to increase the willingness and ability of workplaces to accommodate injured workers. Physicians also mentioned the need for better education of patients and the public (24.2%, CI 18, 30); increased availability of physiotherapy and occupational therapy (20.6%, CI 15, 26); improved communication between workers, the workplace, and insurers (17.5%, CI 12, 23); and the need for more time and better reimbursement for physicians to participate in RTW planning (11.8%, CI 7, 16).

Knowledge and attitudes
Table 3 reports the proportion of physicians who thought the management strategies we listed would help recovery and reduce work disability in uncomplicated occupational back pain. Table 4 reports physicians’ agreement with general statements about work-related disability after soft-tissue injuries.

More than 80% of physicians believed that prescription medications and discussing recovery time, work demands, and hazards with workers would hasten recovery from uncomplicated back pain (Table 3). More than 80% of physicians agreed with the UK guidelines that x-ray examinations, injections, back belts, and referral to specialists are inappropriate for uncomplicated acute low back pain. Two thirds (65%) said they would recommend back exercises, 41.3% would refer for intensive physiotherapy, and 34.8% would recommend brief bed rest. Most respondents (96.5%) would not recommend manipulation. Only one third endorsed recommendations in both the MMA and UK guidelines that physicians advise patients to try to continue usual activities.

Table 2. Characteristics of physicians who responded to the survey and who did not

<table>
<thead>
<tr>
<th>CHARACTERISTIC</th>
<th>RESPONDENTS N=232</th>
<th>NONRESPONDENTS N=220</th>
<th>P VALUE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practised in Winnipeg</td>
<td>60.8%</td>
<td>70.9%</td>
<td>.03</td>
</tr>
<tr>
<td>Median no. of workers with injury claims seen in 1998</td>
<td>36 (20-64)†</td>
<td>36 (20-69)</td>
<td>.50</td>
</tr>
<tr>
<td>≥16 injured workers seen in 1998</td>
<td>50.9%</td>
<td>50.6%</td>
<td>1.0</td>
</tr>
<tr>
<td>Median no. of years since graduation</td>
<td>19 (13-26)†</td>
<td>19 (12-31)</td>
<td>.41</td>
</tr>
<tr>
<td>Certificated by the College of Family Physicians of Canada</td>
<td>31.9%</td>
<td>26.3%</td>
<td>.23</td>
</tr>
<tr>
<td>Graduated on or before 1980</td>
<td>54.5%</td>
<td>55.2%</td>
<td>.96</td>
</tr>
<tr>
<td>Canadian medical graduates</td>
<td>64.6%</td>
<td>60.1%</td>
<td>.39</td>
</tr>
<tr>
<td>Female</td>
<td>22%</td>
<td>20.1%</td>
<td>.73</td>
</tr>
</tbody>
</table>

*x² test with Yates correction for proportions, Mann-Whitney U test for medians.  
†Median (interquartile range).
Most physicians thought that job satisfaction and other psychosocial and work-related factors affect RTW after occupational soft-tissue injuries (Table 4). A full 88.6% agreed that physicians have an important role in RTW planning, and 94.3% thought that physicians’ awareness of employers’ RTW programs would help recovery. Furthermore, 90.7% agreed that good communication among clinicians, employers, insurers, and injured workers can greatly mitigate disability. Half the physicians endorsed the MMA recommendation that the well-being of co-workers be considered before recommending RTW.

Physicians who graduated after 1980 from a Canadian medical school, those certified by the College of Family Physicians of Canada, and those practising in groups tended to endorse more of the items related to the MMA statement and the UK guidelines; however, these differences were small. Results from multivariate regression analyses showed that physician and practice characteristics accounted for less than 12% of the variability.

**DISCUSSION**

Despite the acknowledged importance of treating physicians in the RTW process, little research has been published on physicians’ perspectives on this topic. Most physicians in our study believed that their own ability to explain the nature of the injury and prognosis was crucial for addressing workers’ fears and helping recovery. This is consistent with studies that found that physicians’ ability to set reasonable expectations for recovery was important and that doctor–patient relationships can indeed be undermined if unrealistic expectations lead to frustration. A recent media campaign to influence fear-avoidance beliefs about back pain reduced both the number and cost of compensation claims in Australia.

### Table 3. Proportion of physicians who believed specific interventions would help recovery and reduce work disability among workers with uncomplicated low back pain of 2 days’ duration

<table>
<thead>
<tr>
<th>Questionnaire Item</th>
<th>Number/Respondents</th>
<th>% (95% Confidence Interval)</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription medication</td>
<td>189/230</td>
<td>82.2 (77.2, 87.1)</td>
<td>Acetaminophen and NSAIDs are compatible with UK guidelines</td>
</tr>
<tr>
<td>Tell worker expected recovery time and set date for re-assessment</td>
<td>187/230</td>
<td>81.3 (76.3, 86.3)</td>
<td>Compatible with MMA statement</td>
</tr>
<tr>
<td>Ask worker about job demands and hazards</td>
<td>185/230</td>
<td>80.4 (75.3, 85.6)</td>
<td>Compatible with MMA statement</td>
</tr>
<tr>
<td>Back exercises to perform at home</td>
<td>151/230</td>
<td>65.7 (59.5, 71.8)</td>
<td>Not compatible with UK guidelines</td>
</tr>
<tr>
<td>Writing a note to employer to suggest work accommodation</td>
<td>144/230</td>
<td>62.6 (56.3, 68.9)</td>
<td>Compatible with MMA statement</td>
</tr>
<tr>
<td>Referral for intensive physiotherapy</td>
<td>95/230</td>
<td>41.3 (34.9, 47.7)</td>
<td>Not compatible with UK guidelines</td>
</tr>
<tr>
<td>Rest in bed for a few days, then increase activity</td>
<td>80/230</td>
<td>34.8 (28.6, 40.9)</td>
<td>Not compatible with UK guidelines</td>
</tr>
<tr>
<td>Try to continue usual activities at home and at work</td>
<td>76/230</td>
<td>33.0 (27.0, 39.1)</td>
<td>Compatible with UK guidelines and MMA statement</td>
</tr>
<tr>
<td>Provide diagnosis and other medical information to employer</td>
<td>52/230</td>
<td>22.6 (17.2, 28.0)</td>
<td>Not compatible with MMA statement</td>
</tr>
<tr>
<td>Wear a supportive back belt</td>
<td>27/230</td>
<td>11.7 (7.6, 15.9)</td>
<td>Not compatible with UK guidelines</td>
</tr>
<tr>
<td>X-ray examination to rule out fracture and reassure worker</td>
<td>25/230</td>
<td>10.9 (6.8, 14.9)</td>
<td>Not compatible with UK guidelines</td>
</tr>
<tr>
<td>Rest at home for a few weeks to allow healing</td>
<td>11/230</td>
<td>4.8 (2.0, 7.5)</td>
<td>Not compatible with UK guidelines</td>
</tr>
<tr>
<td>Short course of spinal manipulation</td>
<td>8/230</td>
<td>3.5 (1.1, 5.8)</td>
<td>Compatible with UK guidelines</td>
</tr>
<tr>
<td>Trigger point, or corticosteroid injections</td>
<td>6/229</td>
<td>2.6 (0.5, 4.7)</td>
<td>Not compatible with UK guidelines</td>
</tr>
<tr>
<td>Referral to specialist</td>
<td>3/230</td>
<td>1.3 (0, 2.8)</td>
<td>Not compatible with UK guidelines</td>
</tr>
</tbody>
</table>

*MMA statement—Manitoba Medical Association Position Statement on Early Return to Work After Illness or Injury, NSAIDs—non-steroidal anti-inflammatory drugs, UK guidelines—systematic review of scientific evidence performed for The Royal College of General Practitioners Clinical Guidelines for the Management of Acute Low Back Pain.*
Return to work after occupational injury

We found that Manitoba physicians understood the importance of the willingness of employers, supervisors, and co-workers to accommodate injured workers. In fact, better workplace accommodation was the number one change requested by physicians. Evidence shows the effectiveness of work accommodation in decreasing occupational disability. A recent study of 325 injured workers in California found that workers with proactive primary treating physicians were 34% more likely to return to work at any given time after occupational back pain. Proactive physicians were defined as those who gathered or imparted information about workers’ jobs, preventing reinjury, and returning to modified work. Nevertheless, when physical and psychosocial factors at the workplace were taken into consideration, the value of the proactive message disappeared. This suggests that doctor-patient communication about the workplace will not facilitate RTW unless the workplace is accommodating. Most Manitoba physicians agreed they had a role in RTW and recognized the importance of psychosocial and work-related factors

Table 4. Proportion of physicians who agreed or strongly agreed with general statements about work-related disability after soft-tissue injuries

<table>
<thead>
<tr>
<th>QUESTIONNAIRE ITEM</th>
<th>NUMBER/RESPONDENTS</th>
<th>%  (95% CONFIDENCE INTERVAL)</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worker satisfaction with job helps recovery</td>
<td>227/230</td>
<td>98.7 (97.2, 100)</td>
<td>Supported by research¹⁴</td>
</tr>
<tr>
<td>Repeated injury should trigger workplace intervention</td>
<td>225/231</td>
<td>97.4 (95.4, 99.5)</td>
<td>–</td>
</tr>
<tr>
<td>Physicians’ awareness of employer’s return-to-work and other programs will help recovery</td>
<td>216/229</td>
<td>94.3 (91.3, 97.3)</td>
<td>–</td>
</tr>
<tr>
<td>Employee’s reluctance to try modified work requires assessment of personal and workplace issues</td>
<td>209/230</td>
<td>90.9 (87.1, 94.6)</td>
<td>–</td>
</tr>
<tr>
<td>Good communication among clinicians, employers, insurers, and injured workers can significantly decrease disability</td>
<td>206/227</td>
<td>90.7 (87.0, 94.5)</td>
<td>–</td>
</tr>
<tr>
<td>Physicians have an important role in return-to-work planning</td>
<td>203/229</td>
<td>88.6 (84.5, 92.8)</td>
<td>–</td>
</tr>
<tr>
<td>Patients’ belief that hurt equals harm often hinders recovery</td>
<td>196/230</td>
<td>85.2 (80.6, 89.8)</td>
<td>Supported by research¹⁴</td>
</tr>
<tr>
<td>Patients are entitled to a copy of all return-to-work reports</td>
<td>170/231</td>
<td>73.6 (67.9, 79.3)</td>
<td>Compatible with MMA statement¹³</td>
</tr>
<tr>
<td>Personal and family difficulties are common reasons for not returning to work</td>
<td>158/231</td>
<td>68.4 (62.4, 74.4)</td>
<td>–</td>
</tr>
<tr>
<td>Workplace conflicts are very common reasons for not returning to work</td>
<td>155/229</td>
<td>67.7 (61.6, 73.7)</td>
<td>–</td>
</tr>
<tr>
<td>Intensive clinical treatment during the first month after injury decreases disability</td>
<td>139/228</td>
<td>61.0 (54.6, 67.3)</td>
<td>Not supported by research⁹</td>
</tr>
<tr>
<td>Employers determine whether physicians’ recommendations for modified duties can be accommodated</td>
<td>130/227</td>
<td>57.3 (50.8, 63.7)</td>
<td>Compatible with MMA statement¹³</td>
</tr>
<tr>
<td>Patients’ belief that passive treatments will help often hinders recovery</td>
<td>123/226</td>
<td>54.4 (47.9, 60.9)</td>
<td>Supported by research²⁴</td>
</tr>
<tr>
<td>Co-workers’ well-being should be considered before recommending return to work</td>
<td>116/227</td>
<td>51.1 (44.6, 57.6)</td>
<td>Compatible with MMA statement¹³</td>
</tr>
<tr>
<td>Return-to-work plans should be made only after a few visits to a physician</td>
<td>73/230</td>
<td>31.7 (25.7, 37.7)</td>
<td>Not compatible with MMA statement¹³</td>
</tr>
<tr>
<td>Few workers will recover on their own within a month after a soft-tissue injury</td>
<td>36/228</td>
<td>15.8 (11.1, 20.5)</td>
<td>Not supported by research⁹</td>
</tr>
<tr>
<td>Extensive clinical testing during the first month after injury decreases disability</td>
<td>23/228</td>
<td>10.1 (6.2, 14.0)</td>
<td>Not supported by research⁹</td>
</tr>
<tr>
<td>Employers’ contacting workers soon after injuries will prolong disability</td>
<td>15/230</td>
<td>6.5 (3.3, 9.7)</td>
<td>–</td>
</tr>
</tbody>
</table>

MMA statement—Manitoba Medical Association Position Statement on Early Return to Work After Illness or Injury.¹³
in this process. Lack of awareness of RTW issues did not seem to be a substantial obstacle to their involvement.

Merrill and colleagues, in a survey of 55 American physicians, noted concerns about administrative paperwork and poor reimbursement for work-injury management. Both seemed relatively minor concerns for Manitoba physicians. Similar to our findings, American physicians were reluctant to establish direct communication with employers. While most physicians agreed that good communication among those involved and physicians' awareness of employers' RTW programs would decrease disability, few considered these major issues or seemed willing to increase communication with insurers and workplaces. Christian stated that US employers believe that lack of incentives and physicians' lack of knowledge could explain their limited involvement in RTW; respondents in our survey, however, seemed well aware of occupational factors in RTW and only 11.8% said there was a need for more time and better reimbursement for physicians.

We found discrepancies between research summarized in the UK guidelines and physicians' answers on advice about activity and manipulation for back pain. Many physicians would recommend back exercises, intensive physiotherapy, or brief bed rest rather than activity as tolerated. Evidence strongly supports attempts to continue usual activity (assuming the activity itself is not hazardous and ergonomically inappropriate). It is unclear whether a previous campaign by the WCB of Manitoba promoting exercise was responsible for this finding or not. Use of manipulation remains controversial among physicians. While the UK guidelines concluded that manipulation is effective, Australian physicians were reluctant to make referrals to chiropractors, and the Australian guidelines state that evidence is inconclusive.

Our findings have important implications for improving the primary care of workers with soft-tissue injuries and for continuing medical education. First, interventions to enhance the role of primary care physicians in RTW after soft-tissue injuries might need to address both worker-physician interaction in a physician's office and appropriate accommodation for injured workers in the workplace. Second, physicians' responses suggest that continuing medical education should concentrate on the evidence supporting continuation of activities after soft-tissue injuries and on developing physicians' skills in reassuring workers effectively.

**Study limitations**

Our findings should be interpreted in light of at least four limitations. First, with a 51.3% response rate, there is a risk of nonresponse bias; that is, answers might not be representative of all Manitoba physicians. We believe this is unlikely because there were no great demographic differences between respondents and nonrespondents and there were no significant trends in response profile between early and late respondents. Further, the only statistically significant difference between respondents and nonrespondents (location of practice) was not associated with differences in response profile. Second, our choice of putative facilitators and barriers might have influenced the results. Options presented in our questionnaire were the result of extensive discussions with physicians and occupational stakeholders, however, and respondents had a chance to add others. Third, while we found that physicians endorsed many items compatible with the MMA statement and UK practice guidelines, we do not know whether physicians' practices adhere to them. Fourth, we cannot exclude desirability bias; that is, surveyed physicians might have chosen answers thought to be more desirable instead of answers closer to their beliefs. Observation of practice or qualitative research methods would be required to further explore this possibility.

**Conclusion**

Manitoba primary care physicians believe physicians' abilities to explain the nature of injury and dispel worker fears and accommodating injured workers in the workplace are the crucial factors for RTW after soft-tissue injuries. Most physicians were aware of their role in RTW and the effect of occupational factors, but their advice on activity after injury differed from that in evidence-based practice guidelines.

**Acknowledgment**

We acknowledge the advice on survey questionnaire design provided by the Manitoba Medical Association (sections of Family Practice and Preventive Occupational and Environmental Medicine), the Manitoba Federation of Labour, the Employers Task Force on Occupational Safety and Workers Compensation, the WCB of Manitoba, and the University of Manitoba Family Medicine Research Interest Group. This research was part of the Primary Care and Occupational Disability Study, a project funded through a research grant from the WCB of Manitoba.

Dr Kim Minish, Co-manager for the research project from the WCB of Manitoba, helped make this study possible and provided insightful comments for interpreting findings. We are indebted to Ms Lynn Gauthier for collecting and capturing survey data and for preparing the manuscript.
Editor's key points
• This survey of Manitoba family physicians examined their views on what facilitated return to work following soft-tissue injury at work.
• Respondents thought that physicians’ ability to explain the nature and prognosis of an injury to workers and the workplace’s ability to accommodate recoverying workers were the most important facilitating factors.
• Most thought that the greatest barriers to return to work were workers’ fears about injuries and unsupportive supervisors or co-workers.
• Family physicians would like to see more willingness to accommodate injured workers back at work and increased availability of physiotherapy and occupational therapy.
• Despite good research and promotion of the message that workers return to “usual activities,” only one third of physicians recommended this strategy to workers with occupational low back pain.

Points de repère du rédacteur
• Cette enquête cherchait à connaître l’opinion des médecins de famille de l’Ontario sur les facteurs susceptibles de faciliter le retour au travail des patients qui avaient subi des lésions des tissus mous au travail.
• Les facteurs jugés les plus favorables par les répondants étaient la capacité du médecin à expliquer au patient la nature et le pronostic de sa lésion et la capacité du milieu de travail de faire une place adéquate au travailleur durant sa guérison.
• La plupart des répondants étaient d’avis que les principaux obstacles à sa réinsertion au travail étaient les craintes du travailleur concernant sa blessure et le manque de collaboration de la part des patrons et compagnons de travail.
• Les médecins de famille aimaient voir plus d’emprunt de la part du milieu de travail à réintegre le blessé et souhaiteraient une meilleure accessibilité aux services de physiothérapie et d’ergothérapie.
• Même si le message préconisant le retour du travailleur «à ses activités habituelles» est bien fondé et bien diffusé, le tiers seulement des médecins recommandent cette stratégie aux travailleurs souffrant de lombalgie professionnelle.

Contributors

Dr Guzman contributed to study conception and design, to analysis and interpretation of data, and to acquiring funding, and he wrote, revised, and approved the final version of the article.

Drs Yassi and Cooper revised and approved the final version of the article.

References


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Return to work after occupational injury