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.

RÉSUMÉ

OBJECTIF Documenter l'opinion des médecins sur les facteurs qui facilitent ou entravent leurs efforts pour aider les travailleurs à se rétablir des lésions professionnelles des tissus mous, et sur les connaissances et attitudes qui penvent les empêcher de contribuer à leur réinsertion au travail.

MÉTHODOLOGIE Enquête par télécopieur.

CONTEXTE Cabinets de médecine familiale et départements d'urgence du Manitoba.

PARTICIPANTS Omnipraticiens, médecins de famille et médecins pratiquant à l'urgence ayant régulièrement à traiter des accidentés du travail.

PRINCIPAUX PARAMÈTRES MESURÉS Importance relative attribuée par les médecins aux facteurs qui facilitent ou entravent le retour au travail; changements susceptibles de les amener à mieux contribuer à ce retour; et attitudes et connaissances de ces médecins concernant la réinsertion au travail.

RÉSULTATS Les répondants et les non-répondants avaient des caractéristiques démographiques semblables; 232 médecins (51,3%) ont accepté de participer. Les principaux facteurs jugés favorables par les répondants étaient la capacité du médecin d'expliquer au travailleur la nature et le pronostic de sa blessure (69%) et la volonté du milieu de travail de faire une place adéquate au travailleur blessé (26%). Les principaux obstacles étaient le manque de connaissances et les craintes du travailleur concernant sa blessure (70,7%) et le manque de support de la part des patrons et compagnons de travail (20,8%). Le changement le plus souvent souhaité était une plus grande flexibilité du milieu de travail dans l'attribution des tâches (48%). La plupart des médecins convenaient qu'ils avaient un rôle à jouer dans la planification du retour au travail et étaient conscients de l'effet de facteurs comme la satisfaction à l'ouvrage, les éléments d'ordre psycho-social et d'autres facteurs reliés au travail. Malgré les preuves en ce sens, seulement le tiers des médecins déclaraient qu'ils conseilleraient à un travailleur souffrant de lombalgie professionnelle «d'essayer de poursuivre ses activités habituelles».

CONCLUSION La plupart des médecins semblaient conscients de leur rôle dans le retour au travail et de l'influence des facteurs d'ordre professionnel, mais leur recommandation sur l'activité permise après une blessure différait de celle préconisée dans les guides de pratique.

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Most working people in Canada with work-related health concerns rely on advice from their family physicians.[1] 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[2]—employers, workers' compensation boards (WCBs), and insurance companies are increasing demands on physicians.[3] 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.[4] Particularly difficult to manage are occupational back pain and other soft-tissue injuries, conditions in which workers' impairment is hard to quantify.

Much has been published in recent years to assist family physicians who treat patients with occupational soft-tissue injuries,[5-7] noting that physicians' interactions with patients affect return-to-work (RTW) outcome.[8-11] The Canadian Medical Association,[12] the Manitoba Medical Association (MMA),[13] and other provincial medical associations have published policy statements on physicians' roles in RTW. These statements 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**).[12,13] Canadian employers, unions, occupational health practitioners, and insurers have described difficulties in communicating with physicians about RTW.[14] According to Christian,[15] 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 discusses 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[13]; a similar document endorsed by the Canadian Medical Association is widely available.[12]

Numerous practice guidelines address back pain, one of the most common causes of work disability.[16] Studies have repeatedly documented discrepancies between back pain guidelines and physicians' practices in Canada,[17-19] the United States,[20,21] and the United Kingdom.[22] In 1996, Sullivan[23] summarized key practice recommendations for Canadian family physicians, recommendations that have been reinforced by the 1999 UK practice guidelines for acute back pain.[24] 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.

- Encourage exercise and activity at levels tolerable to patients.
- Avoid bed rest
- Keep use of medication minimal.
- Note that spinal manipulation can be helpful in the first 4 weeks in the absence of radiculopathy.

Despite the acknowledged pivotal role of Canadian primary care physicians in RTW and the many published statements and practice guidelines, Canadian physicians' views on this issue have not been systematically researched. We therefore surveyed Manitoba physicians to answer two questions: What do primary care physicians see as facilitating factors and as barriers to helping workers recover after soft-tissue injuries? Do any knowledge or attitudinal barriers interfere with physicians' involvement in RTW?

METHODS

We surveyed all Manitoba general practitioners, family physicians, and emergency physicians who saw at least 10 workers with injury claims in 1998 and were in active primary care practice in Manitoba at the time of the survey (according to records of the WCB and the College of Physicians and Surgeons of Manitoba). The cutoff on the number of workers seen was arbitrary but was chosen because we were interested in the opinions of physicians actively involved in occupational injuries. Physicians who see fewer than one injured worker monthly likely devote most of their time to non-clinical duties or have part-time or specialized practices.

The survey was conducted between November 1999 and April 2000 using a modified Dillman technique[25]: physicians first received communication from the MMA describing the study and then the survey questionnaire (by fax, or by mail if fax was unavailable) and three reminders sent 3, 6, and 16 weeks later. The University of Manitoba Health Research Ethics Board approved the study.

The two-page questionnaire was developed through meetings with primary care and occupational physicians and with labour, management, and WCB representatives. It was then 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[12,13]; from the scientific literature[24,26-28]; and from a report of interviews with workers, employers, and insurers.[14] 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 statement[13] because it described physicians' role in the jurisdiction in which this survey was conducted, and with the UK back pain guidelines[24] 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); χ^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.[29]

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).

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

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

**x^2 test with Yates correction for proportions, Mann-Whitney U test for medians.*

†Median (interquartile range).

Knowledge and attitudes

Table 3[13,24] 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**[9,13,24] 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.[24] 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.[13]

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

QUESTIONNAIRE ITEM	NUMBER/RESPONDENTS	% (95% CONFIDENCE INTERVAL)	REMARKS
Prescription medication	189/230	82.2 (77.2, 87.1)	Acetaminophen and NSAIDs are compatible with UK guidelines[24]
Tell worker expected recovery time and set date for re-assessment	187/230	81.3 (76.3, 86.3)	Compatible with MMA statement[13]
Ask worker about job demands and hazards	185/230	80.4 (75.3, 85.6)	Compatible with MMA statement[13]
Back exercises to perform at home	151/230	65.7 (59.5, 71.8)	Not compatible with UK guidelines[24]
Writing a note to employer to suggest work accommodation	144/230	62.6 (56.3, 68.9)	Compatible with MMA statement[13]
Referral for intensive physiotherapy	95/230	41.3 (34.9, 47.7)	Not compatible with UK guidelines[24]
Rest in bed for a few days, then increase activity	80/230	34.8 (28.6, 40.9)	Not compatible with UK guidelines[24]
Try to continue usual activities at home and at work	76/230	33.0 (27.0, 39.1)	Compatible with UK guidelines[24] and MMA statement[13]
Provide diagnosis and other medical information to employer	52/230	22.6 (17.2, 28.0)	Not compatible with MMA statement[13]
Wear a supportive back belt	27/230	11.7 (7.6, 15.9)	Not compatible with UK guidelines[24]
X-ray examination to rule out fracture and reassure worker	25/230	10.9 (6.8, 14.9)	Not compatible with UK guidelines[24]
Rest at home for a few weeks to allow healing	11/230	4.8 (2.0, 7.5)	Not compatible with UK guidelines[24]
Short course of spinal manipulation	8/230	3.5 (1.1, 5.8)	Compatible with UK guidelines[24]
Trigger point, or corticosteroid injections	6/229	2.6 (0.5, 4.7)	Not compatible with UK guidelines[24]
Referral to specialist	3/230	1.3 (0, 2.8)	Not compatible with UK guidelines[24]

MMA statement—Manitoba Medical Association Position Statement on Early Return to Work After Illness or Injury,[13] 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.[24]

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.[9] A recent media campaign to influence fear-avoidance beliefs about back pain reduced both the number and cost of compensation claims in Australia.[30]

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

QUESTIONNAIRE ITEM	NUMBER/RESPONDENTS	% (95% CONFIDENCE INTERVAL)	REMARKS
Worker satisfaction with job helps recovery	227/230	98.7 (97.2, 100)	Supported by research[24]
Repeated injury should trigger workplace intervention	225/231	97.4 (95.4, 99.5)	–
Physicians' awareness of employer's return-to-work and other programs will help recovery	216/229	94.3 (91.3, 97.3)	–
Employee's reluctance to try modified work requires assessment of personal and workplace issues	209/230	90.9 (87.1, 94.6)	–
Good communication among clinicians, employers, insurers, and injured workers can significantly decrease disability	206/227	90.7 (87.0, 94.5)	–
Physicians have an important role in return-to-work planning	203/229	88.6 (84.5, 92.8)	–
Patients' belief that hurt equals harm often hinders recovery	196/230	85.2 (80.6, 89.8)	Supported by research[24]
Patients are entitled to a copy of all return-to-work reports	170/231	73.6 (67.9, 79.3)	Compatible with MMA statement[13]
Personal and family difficulties are common reasons for not returning to work	158/231	68.4 (62.4, 74.4)	–
Workplace conflicts are very common reasons for not returning to work	155/229	67.7 (61.6, 73.7)	–
Intensive clinical treatment during the first month after injury decreases disability	139/228	61.0 (54.6, 67.3)	Not supported by research[9]
Employers determine whether physicians' recommendations for modified duties can be accommodated	130/227	57.3 (50.8, 63.7)	Compatible with MMA statement[13]
Patients' belief that passive treatments will help often hinders recovery	123/226	54.4 (47.9, 60.9)	Supported by research[24]
Co-workers' well-being should be considered before recommending return to work	116/227	51.1 (44.6, 57.6)	Compatible with MMA statement[13]
Return-to-work plans should be made only after a few visits to a physician	73/230	31.7 (25.7, 37.7)	Not compatible with MMA statement[13]
Few workers will recover on their own within a month after a soft-tissue injury	36/228	15.8 (11.1, 20.5)	Not supported by research[9]
Extensive clinical testing during the first month after injury decreases disability	23/228	10.1 (6.2, 14.0)	Not supported by research[9]
Employers' contacting workers soon after injuries will prolong disability	15/230	6.5 (3.3, 9.7)	–

MMA statement—Manitoba Medical Association Position Statement on Early Return to Work After Illness or Injury.[13]

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.[31] 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.[8] 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.[8] 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

in this process. Lack of awareness of RTW issues did not seem to be a substantial obstacle to their involvement.

Merrill and colleagues,[32] 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.[32] 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[15] stated that US employers believe that lack of incentives and physicians' lack of knowledge could explain their limited involvement in RTW[15]; 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).[27,28,33]

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,[24] Australian physicians were reluctant to make referrals to chiropractors,[34] and the Australian guidelines state that evidence is inconclusive.[35]

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.[29] 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.[36] 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.

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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 recovering 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 de médecins de famille du Manitoba 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 d'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 la 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 aimeraient voir plus d'empressement de la part du milieu de travail à réintégrer 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; supervised the research group; and contributed to study conception and design, to interpretation of data, and to acquiring funding.* **Dr Khokhar** *served as the key link to family physicians in the study, revised and approved the final version of the article, and contributed to study design and interpretation of data.*

Competing interests

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