

Managing injured workers

Family physicians' experiences

Grant Russell, MBBS, DRANZCOG, FRACGP, MFM Judith Belle Brown, PHD Moira Stewart, PHD

ABSTRACT

OBJECTIVE To understand family physicians' experiences in managing patients within the workers' compensation system.

DESIGN Qualitative study using a phenomenologic approach.

SETTING London and surrounding communities in southwestern Ontario.

PARTICIPANTS Family physicians working in community-based and academic practices.

METHOD In-depth interviews conducted between February and May 2001 with a maximum variation sample of 10 family doctors.

MAIN FINDINGS Few participants enjoyed dealing with workers' compensation problems. Despite the generally straightforward nature of most work related to musculoskeletal injuries, management had to take place within the perceived complexities of the return-to-work process. Suspicion, isolation, and frustration characterized experiences with care of persisting, ill-defined, or complex conditions. Challenged by lack of time, participants were wary when dealing with employers and especially concerned about patient confidentiality. Hence, workplace communication seldom extended beyond the use of standard workers' compensation forms. While appreciative of the input of other professionals within the workers' compensation system, family practitioners were suspicious of external influences on clinical decision making. Participants' perceived commitment to patients conflicted with insurer requirements for adherence to guidelines and pathways of care. Even when patient-doctor relationships were challenged by the effects of an injury, participants saw a clear advantage in maintaining these relationships as a base for future care.

CONCLUSION Although family doctors are integral to management of Canadians with work-related injuries, our findings highlight the complexities of that care. Primary occupational health care extended beyond treatment of injuries into domains of intersectoral communication and patient-doctor relationships. Our findings suggest that workers' compensation authorities could benefit from a better understanding of the dynamics of contemporary family practice and particularly of time and cost barriers to workplace liaison. Communicating with employers would be less threatening if there were an explicit organizational strategy designed to allay family practitioners' anxieties about whether direct liaison with employers is inappropriate advocacy, a compromise to confidentiality, or good industrial practice.

EDITOR'S KEY POINTS

- Management of patients with work-related injuries is the responsibility of family physicians, but their role in this type of care has rarely been studied. This qualitative study describes their experiences in dealing with injured workers.
- Although most of the injuries resolved rapidly, physicians encountered other, more complex problems that prolonged the process and gave these physicians feelings of frustration and isolation.
- Physicians were cautious in dealing with employers, particularly regarding patient confidentiality. Physicians were also uncomfortable dealing with health professionals in the workers' compensation system because of possible conflict of interest. Most physicians thought they should advocate for patients in certain circumstances.

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Canadians suffer 800 000 workplace injuries each year. Half of these lead to time lost from work.¹ As in most other nations, Canadian workers' compensation authorities rely on the contribution of family doctors for early and ongoing clinical care of injured workers.² Mindful that effective early intervention can hasten recovery from musculoskeletal injuries,³ workers' compensation authorities have tried hard to optimize occupational health care in family practice.

Most workers' compensation authorities ask family doctors to combine traditional clinical care with tasks aimed to facilitate return to work (assessing an injury's work relatedness; developing a return-to-work plan; monitoring recovery; and communicating with patients, employers, and the insurer).⁴ The Canadian Medical Association has strongly supported family physicians' involvement in workers' compensation. It sees family doctors as having a vital understanding of patients' role in the workplace, as being a support for employer-employee relationships, and as advising appropriate use of specialist resources.⁵

Views diverge, however, on family practitioners' effectiveness in managing work-related conditions. They have been criticized for poorly documenting workplace exposure,^{6,7} for lack of knowledge of the workplace,⁸ and for overreliance on patients' subjective reports of injuries.⁹ In contrast, family doctors have written of the potential for insurers, employers, and unions to coerce them into meeting organizational financial needs when managing work-related injuries, with the associated difficulties of attributing cause¹⁰ and dealing with confidentiality.¹¹

Despite articulation of these issues, there has been little exploration of the role of family physicians in workplace injury. Several recent reviews have suggested that workers' compensation

providers need a greater understanding of primary occupational health care.¹² This study looked at family physicians' experience of managing work-related injuries.¹³

METHODS

We used the qualitative approach of phenomenology to gain an understanding of how family doctors experience care of patients with troublesome workplace injuries.^{13,14} Data were collected from in-depth interviews with family doctors in and around London, Ont (population 350 000). The city houses the University of Western Ontario (UWO) and several large manufacturing plants and is surrounded by many small rural communities. The Workplace Safety and Insurance Board (WSIB) funds and oversees management of work-related injuries in the province.

We sought to gather a maximum variation sample of male and female participants with varying experience, practice characteristics (academic and non-academic, urban and rural, group and solo), and familiarity with occupational medicine. Potential participants were identified following discussions with faculty and community family physicians associated with the Department of Family Medicine at UWO and by use of the Department's family physician database. Physicians were initially approached through a letter signed by the principal investigator, who contacted the physicians by telephone 1 week later to ascertain their interest in participating in interviews.

Data collection involved in-depth, face-to-face individual interviews. Participants were interviewed in their offices. A phenomenologic approach was used to ascertain physicians' experience with care of acute, but slowly resolving, workplace injuries within the context of the workers' compensation system. Interview content initially followed a written interview guide based on a literature review. The guide was progressively modified in keeping with the iterative process of data collection and analysis. Question sequencing was flexible to allow interviews to be led by participants rather than the researcher.

Dr Russell was a Visiting Professor at the Centre for Studies in Family Medicine at the University of Western Ontario (UWO) in London. Dr Brown is a Professor, and Dr Stewart is a Professor and Director, at the Centre for Studies in Family Medicine at the Thames Valley Family Practice Research Unit at UWO.

The principal investigator conducted all interviews between February and May 2001. Interviews lasted between 45 and 60 minutes and continued until the interviewer obtained a clear picture of participants' experience. Interviews were audio-taped and, along with the interviewer's field notes, transcribed verbatim.

Data were analyzed using the immersion-crystallization method.¹⁴ Transcripts were read independently by the authors to identify key words and themes. Then meetings were held at which emerging themes, patterns, and connections were reviewed and further analyzed using QSR NUD*IST.¹⁵ Differences of interpretation among researchers were resolved by consensus.

Theme saturation was reached after the eighth interview. The remaining interviews allowed for member checking. Participants received a one-page summary of grouped findings with an accompanying invitation to make comments, corrections, or clarifications. Data were also presented at an informal family practice research seminar attended by family practitioners, residents, and academics from UWO and two other Ontario medical schools. Feedback informed the analysis. The study was approved by the Research Ethics Board for the Review of Health Sciences Research Involving Human Subjects at UWO.

FINDINGS

Thirteen family doctors were invited to interviews. Ten participated, and three refused. A female rural doctor did not believe she had a large enough occupational health practice to provide meaningful input, and two urban male doctors had withdrawn from clinical practice.

Participants demonstrated maximum variation in terms of sex (seven men, three women), clinical experience (from 1 to 30 years in practice), and experience in occupational medicine (one worked part-time as an occupational health doctor. Another had participated in formal disability assessments for the WSIB). Two worked in rural areas and two in academic teaching centres. One physician's office

had a partial "walk-in" arrangement where, for several hours each day, patients could visit without appointments.

From these doctors' perspective, care of work-related injuries combined the familiar role of managing musculoskeletal injuries with the complexities of the return-to-work process. Few relished dealing with workers' compensation problems. While participants found care of minor workplace injuries to be relatively straightforward, they were far less comfortable managing persisting, ill-defined, or complex conditions. Challenged by lack of time, they were wary when dealing with employers, especially when they thought such dealings might affect patient confidentiality.

While at times appreciating the input of other professionals in the workers' compensation system, participants were suspicious of external influences upon their clinical decision making. Their preference for patient advocacy and desire to maintain relationships with injured patients were made more difficult by the statutory requirements of what they perceived as a parallel bureaucracy to the normal health care system. While most recognized that the WSIB had implemented useful methods to streamline care for workers with slowly resolving injuries, many felt isolated and frustrated when involved with a system described by one participant as a "quagmire."

Managing injured workers

Participants found most injuries relatively inconsequential with "very little impact on the workplace or on the patient." Their main difficulties stemmed from injuries where cause was unclear or where repetitive strain was the cause. They described diagnostic and management plans broadly consistent with accepted guidelines for managing common musculoskeletal injuries. An exception came with use of x-ray examinations that, to some, became:

...standard in that the patient almost expects them. Which in my training they are not necessary but, you know, when people see a therapist and they come back and say, "My therapist is wondering

why haven't you done x-rays; what's going on?" So I find they are almost inevitable as a starting point.

They valued early, regular clinical review, and described a model of care where investigations and referrals were linked with perceived recovery. Most acknowledged the importance of early referral to physiotherapy. For difficult cases, they welcomed the help provided by physiotherapists and insurer-sponsored evaluation centres.

Apart from clinicians with an interest in occupational medicine, few indicated that evaluations of the workplace went beyond "asking the patient, 'what's your boss like?'" While their general attitude to employers was positive, they believed that some employers manipulated the return-to-work process: "Some firms will almost blackball the employee if they are off on compensation. I had guys with broken arms who have no lost time!"

Participants spoke at length about managing patients with slowly resolving injuries. Patients were occasionally reluctant to participate in return-to-work plans and spoke of the importance of attitude, viewing it as a factor over which they had some influence. Many believed the signs of a troublesome injury were apparent "by about the second or third visit." As time passed, many felt increasingly frustrated as they saw themselves trying to gain control of a deteriorating situation:

Well, you know it goes through stages.... It seems to be all patients think and talk about. And the visits are particularly long in that the patient feels you don't believe them, so they come with frantic details to convince you that this is really hurting.

One participant spoke of her increasing isolation while trying to deal with a situation.

It's become increasingly... clear that you are *not* going to solve the problem for them.... So you can imagine having somebody coming in on your list and you go "Oh boy, here she comes again." I have done all the medications and all the splints and the specialists and everything. And she will say "Guess what? My wrist is hurting." And you go "oh" [sighs].

Working with employers

Despite the difficulties associated with delayed recovery, participants were acutely sensitive to external influences on what they saw as their core responsibilities in patients' recovery. They spoke at length about their experiences with other parties within the workers' compensation system. While some welcomed the opportunity to work with employers: "Because then I feel more like a partner in a team," their general attitude was one of wariness, particularly about confidentiality. For most participants, workplace communication went no further than using the standard workers' compensation forms. While filling out forms was seen as a burden ("I find that a lot of time is spent on the administrative stuff rather than the actual client care"), many were hesitant about going further.

Patients rarely asked participants to contact workplaces; as one doctor stated, "I can't think of the last time I was asked." He recalled, "There have been a couple of occasions over the years where I have tried to contact employers, and I have run into difficulties with confidentiality about the patient and who you are telling it to."

Industry liaison was also influenced by time pressure: "I'm busy enough without fostering any further business." One participant remarked, "Who has the time to pick up the phone and call the health and safety guy? You know, it's much easier just writing a prescription for something."

One practitioner responded to a question concerning his willingness to communicate with employers by saying, "I don't see it as my job." He went on to say:

I regard my job as to deal with the person who presents themselves to me to make a diagnosis and prescribe treatment and possibly to go as far as prognosis and to assist in advising this person about what kind of work they would be able to do. And then the patient embarks on a liaison with the employer to work out what they can do.

Another spoke of her response to a large local employer's tendency to telephone the family practice:

...and ask my secretary, “Can the doctor write a note to get the patient to go back to work?” You know, if I feel strongly, I say no. I just say no, you know; if I think... it is *possible*, [however,] I will go along with that. I hate it when I make a decision and someone tries to make me change my mind. I can be stubborn about things like that.

Working with other health professionals

While seeing potential advantages in communicating with the nursing and medical specialists involved in the workers compensation system, participants had concerns about conflict of interest, especially with work-based physicians who:

...will often call you and ask for information. And I find that a little disturbing because they often approach it as, “You’re a colleague, can you tell me this?” I’m very wary of that. I’m certain they are very allied with the company. Their agenda is clearly to get this person back to work without any restrictions. They will often push and use their collegiality to do that.

The WSIB has used nurse case managers to establish liaison with clinicians in difficult cases. While welcoming occasional suggestions for specialist referral, most believed that nurse case managers were “Just like having another hand in a big frustrating case. And I don’t find it helpful. I just find that it’s another hand in the pot that I don’t really need.” Several thought that a nurse case manager’s intervention compromised patient-doctor relationships by challenging the care doctors were providing.

Some patients come in and say, “This nurse case practitioner called me and went over my case, and they are wondering why I never had an MRI scan.” And all of a sudden I’m getting this after knowing this person for years. Now I have to spend a couple of visits explaining why I haven’t done an MRI scan and why they don’t need one and eventually having to order it anyway because the patient has got it in their head that they need it done.

While they acknowledged difficulties faced by the WSIB, most believed that the insurer lacked an understanding of how to collaborate effectively with family doctors. This was compounded by an impression that “many physicians in the community aren’t particularly interested in work-related injuries and see the WSIB as an adversary.”

Family physicians’ role

Many reflected on the importance of family physicians in management of work-related injuries. They thought their knowledge of patients’ context was a vital aspect of their clinical care. While aware of statutory requirements to cooperate with industry and insurer to facilitate return to work, most saw their ultimate responsibility as oriented to the needs of patients.

I feel I’m not hired by the employer; I am hired by the patient. You know, I have employees myself, and I certainly don’t want to think of a patient getting away with it. But I try to do what’s best for them.

Their views diverged on the subject of advocating for patients with both the workplace and other parts of the workers’ compensation system. Several mentioned their readiness to write letters on patients’ behalf when patients felt they were entitled to more compensation or when they were attending a review tribunal. Although several participants saw themselves as confining their activities to documentation and advice on return to work, most felt differently: “Even though we should be non-biased and be there to document injuries, I don’t think you can escape being an advocate for the patient.”

Another participant highlighted the fine balance needed, both during management of the case and following resolution.

Because, as a family physician, you have to continue to work with this person after the injury. And there may be fear by family physicians about being too tough that the patient is going to either

not be compliant or leave or you know you run into a relationship problem. ...You work with the patient, knowing you have to carry on with the relationship.

DISCUSSION

This is one of the few studies of primary care of injuries involving workers' compensation not funded by workers' compensation authorities. It provides insight into important aspects of family physicians' experience of dealing with workers' compensation problems. While participants saw themselves guiding patients' recovery and important to successful return to work, they often found themselves trying to balance patients', employers', and insurers' needs. While willing to cooperate with other participants in the system, they were cautious when dealing with outside agencies and protective of their clinical independence. Other studies have documented barriers to communication between different providers within the occupational health system,^{16,17} family physicians' reservations about the objectivity of occupational physicians,^{18,19} and clinicians' limited time.²

Our study has illuminated the nature of an internal contradiction for family doctors managing injured workers within the workers' compensation system, one that could lie at the heart of some of the difficulties in primary occupational health care.^{20,21} The contradiction rests in McWhinney's concept of "the unconditional relationships between family physicians and their patients, [where there is] a commitment... to a person no matter what may befall them."²²

Commitment to the patient was a core value across the varied work settings of the physicians we interviewed. Our participants' experiences suggested that this aspect of the culture of family practice conflicts with insurer requirements for family physicians to adhere to pathways of care, particularly those requiring liaison with other contributors to the workers' compensation system. Even when patient-doctor relationships were challenged by the effects of an injury, family physicians saw a clear


advantage in maintaining relationships as a base for future effective health care.

These findings suggest that workers' compensation authorities could benefit from a better understanding of the dynamics of contemporary family practice. In a practical sense, it would be wise for insurers to address time and cost barriers to liaison with workplaces. For example, some workers' compensation authorities reimburse primary care physicians for time spent speaking with employers concerning management of injured workers. Such communication could be made less threatening with an explicit strategy designed to allay participants' anxieties about whether direct liaison with employers is inappropriate advocacy, a compromise to confidentiality, or good industrial practice.

Limitations

Transferability of the study findings to other settings is limited by the fact that the participants all practised in southwestern Ontario within the domain of a single workers' compensation insurer. Although the sampling technique included an awareness of the need to search for alternative and disconfirming cases, we might not have captured attitudes held by other practitioners. Specifically, no perspectives were sought from participants working in walk-in clinics or community health centres. While phenomenology is an ideal technique for capturing experience, other methods are better able to examine guideline implementation or the effectiveness of care.

Conclusion

These findings highlight the complexities faced by family doctors in caring for injured workers. Their experience suggests that optimal occupational health care goes beyond clinical care into the domains of patient-doctor relationships and intersectoral communication. 

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Contributors

All the authors developed the methodology for the article. Lead author Dr Russell developed the concept for the study, conducted most of the interviews, analyzed data, and wrote drafts and the final version of the article. Dr Brown participated in data analysis and reviewed drafts of the manuscript. Dr Stewart helped develop the concept, assisted with data analysis, and reviewed drafts of the manuscript.

Competing interests

None declared

Correspondence to: Dr Grant Russell, Primary Health Care Research, Evaluation and Development Unit, Department of General Practice, University of Western Australia, 328 Stirling Hwy, Claremont, Western Australia 6010; telephone 61+ 08 9384 8633; fax 61+ 08 9384 6238; e-mail russellg@cyllene.uwa.edu.au

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