Return-to-Work Approaches

WORK-READY

For People with Soft-Tissue Injuries

Work-Ready Case Studies
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Helen M:
Reassurance, Not X-rays

Helen had been experiencing pain in her low back and right leg, off and on for months. Finally, the 48-year-old hospital cleaner went to her family doctor. It was just becoming too hard to do her job, which included heavy floor-mopping.

Her doctor did a quick examination. There were “no signs of fracture or nerve damage,” he told her and ordered back X-rays (which she brought back to his office the same day). He pointed out to her signs of “degeneration” and “wear and tear” on her X-rays. He prescribed a week off work, with the first few days in bed, plus some anti-inflammatory medication. “Come back in a few weeks if you’re not better,” he told Helen.

Helen left the office quite worried about the changes she’d been shown on her X-rays, wondering if her heavy job had contributed to them, and whether she’d be able to continue at work with such permanent-looking effects on her spine. The doctor had said nothing about any of this.

When she dropped by work, she found she had very few days of sick leave left. A co-worker advised her to go on workers’ compensation. She did. But, after a week of lying around at home, she was still in pain, and very upset about her back. She was afraid to return to work lest the pain and “damage” get worse.

By the time she got another appointment with the doctor two weeks later (he had been away), she was quite depressed about having been home alone and off work for three weeks. She still had pain and wondered why the doctor was “surprised” that her employer had sent him workers’ compensation forms to fill in. Her doctor did his best to reassure her this time that the “damage in her back” was not going to cripple her. But now it didn’t matter. Helen heard about someone whose “spinal arthritis” had left them “in a wheelchair for life,” and as a result, it was very difficult to convince her to go back to work “without a specialist’s opinion.” The first available appointment for a specialist was in two months.

Two months later, when she did manage to see a specialist, Helen was very depressed. By this time, Helen had been off work for three months and had developed features of chronic pain syndrome. In the end, her specialist felt that the underlying original injury was only uncomplicated back strain, and that the original X-rays were largely irrelevant to the case, showing as they did, only the usual aging-related changes for someone of her years.
Helen M: Reassurance, Not X-rays

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What went wrong?

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What might have improved the outcome?

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What went right?
Helen sought professional help for her pain and applied for workers' compensation benefits. The physician appropriately ruled out signs and symptoms of uncommon but potentially devastating conditions (red flags) with a few quick questions and a brief physical exam. Anti-inflammatory medications are indeed a good option to provide short-term pain relief.

What went wrong?
This is a common story. The doctor focused on finding a physical diagnosis for the patient’s pain and missed an important opportunity to prevent disability by not reassuring the patient about her long-term outlook and encouraging her to return to work. More important, the physician made no effort to inquire about, or write a note to her employer recommending, modified or light work for this manual worker. The workplace made no attempt to contact either Helen or her physician. Helen did not ask questions or voice her concerns with her doctor, choosing instead to listen to what her friends and co-workers had to say about her back pain.

Three weeks is far too long a follow-up interval for a new case of low-back pain in a normally active person, especially when absence from work is prescribed as a part of a treatment regimen.

However, perhaps the most serious error committed by the physician was to overstate and dwell on the X-rays, which, it is now well established, correlate very poorly with low-back pain in people of Helen’s age. Indeed, this patient had no clear indication of a need for an X-ray.

Key Research Evidence
- X-rays and other imaging tests correlate poorly with back pain.
- Even a few days of bed rest provide no benefit to people with uncomplicated back pain.

Finally, even a few days of bed rest has now been shown to provide absolutely no benefit to patients with uncomplicated “mechanical low-back pain (strain).” A recent Finnish study showed that as little as two days of prescribed bed rest extends the period of lost time from work, without any faster or more complete resolution of symptoms.

In short, this is a case of inadequate management at the first contact with the health-care system, leading to potentially avoidable disability.

What might have improved the outcome?
In this case, the initial visit needed to include enough time to educate the patient about her essentially good prognosis and encourage her to carry on with her usual home activities. The physician could have created a more permissive environment, which might have encouraged Helen to voice her concerns.

A strong recommendation for immediate assignment for modified work, (involving no mopping, lifting, or bending) should have been made in writing to her employer, with follow-up by the physician in one week to see whether further light duties were still necessary. Designating a contact person at work would have helped Helen and her physician avoid disability.

A study published in the New England Journal of Medicine in 1994 showed that MRI scans of the back are “abnormal” in many people without back pain. Among 98 healthy people without back pain, 64% had disc abnormalities, and 27% had disc protrusions. The same can be said of less sophisticated tests such as regular X-rays and CAT scans.
Helen M: Reassurance, Not X-rays

Tips from the Field

• Prevention of disability should be a goal from the first visit.
• Building a permissive environment for the patient to voice her concerns is essential for effective reassurance.

How do your experience and views match the findings of the Work-Ready researchers?

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How could this case study be improved?

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Allan P., a healthy 29-year-old postal carrier, developed sudden low-back pain and stiffness while lifting his mail bag on his daily delivery route. Immediately after the injury he went to the local chiropractic clinic, where he was examined and X-rayed. The chiropractor explained that Allan had sprained his low back and that “aside from a few misaligned vertebrae,” his X-rays looked normal. After manipulating Allan’s lower back, the chiropractor suggested that he take the rest of the day off, showed him stretching exercises, and advised him to put ice on his back. More important, he recommended that Allan return to work the next day. The chiropractor also told Allan that his pain and stiffness would disappear within the following three weeks and that he would need about eight to 10 treatments to be back to normal.

Allan was skeptical about the chiropractor’s opinion and concerned about the “misaligned vertebrae.” Eighteen months earlier, he had experienced a similar episode of back pain for which he was off work for four weeks. He believed that his back was weak, and became very anxious about being disabled again. The chiropractor told Allan that to prevent further injuries, it would be best for him to wear a “back belt” for the rest of his working life.

Two weeks later, Allan’s condition had improved. Although it had been difficult for the first few days, he had remained at work and felt that the daily manipulations had helped his pain and stiffness. Following the chiropractor’s advice, he had bought a back belt that he wore while delivering the mail. The chiropractor discharged him from ongoing treatment, but cautioned him that if he did not return to the clinic for monthly manipulations, his condition would likely deteriorate. He explained that these “maintenance treatments” were necessary to ensure that his lower back joints maintain their flexibility, adding that flexible joints and muscle are unlikely to get re-injured.
Allan P:
Chiropractic Care and Acute Low-Back Pain

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What went right?

The chiropractor recommended a short regimen of manipulation, which is an effective treatment for acute low-back pain. Furthermore, he encouraged the patient to remain at work. Remaining at work and continuing one’s normal daily activities is a key component of a successful rehabilitation program.

U.S. Agency for Health Care Policy and Research panel findings and recommendations

- Manipulation can help patients with acute low-back problems without radiculopathy when used within the first month of symptoms (strength of evidence = B).
- If manipulation has not resulted in symptomatic improvement that allows increased function after one month of treatment, manipulation therapy should be stopped and the patient re-evaluated (strength of evidence = D).
- Lumbar corsets and support belts have not been proven beneficial for treating patients with acute low-back problems (strength of evidence = D)

A = multiple relevant and high-quality scientific studies. B = one relevant, high-quality scientific study or multiple adequate scientific studies. C = at least one adequate scientific study in patients with low-back pain. D = panel interpretation of information that did not meet inclusion criteria as research-based evidence

What went wrong?

This is a scenario commonly seen in chiropractic practice. The use of spinal X-rays, although common among chiropractors, is not indicated for acute low-back pain, unless there are “red flags” suggesting specific pathology such as a fracture or malignancy. “Misaligned vertebrae” is a term commonly used by chiropractors to indicate that the spinal joints need to be manipulated. These “misaligned vertebrae” cannot be detected by an X-ray, and the X-ray is not necessary for the chiropractor to reach a correct diagnosis.

Similarly, the use of a back belt is highly controversial. To date, there is no evidence suggesting that wearing a back belt at work protects against back injuries or lessens a worker’s pain. Furthermore, wearing a back belt may have undesirable adverse effects such as weakening the back muscles, putting strain on the cardiovascular system, or contributing to abdominal hernia. Therefore, prescription of a back belt was not indicated and may have created false hopes while promoting dependency on a device of questionable benefit.

The failure to involve the workplace or even report the injury meant that no measures were taken to find the cause of the injury or to prevent its recurrence (e.g., job redesign or the improvement of lifting techniques by Allan and other mail carriers). Allan was sent back to full duties without consideration of temporary job modification.

Finally, there is no evidence that periodic manipulation protects against future episodes of back pain. In fact, stating that Allan’s condition would deteriorate without manipulation promotes the idea that back injuries are for life. The problem with the two preventive approaches proposed by the chiropractor is that they rely on passive strategies, rather than encouraging the worker to take control of the situation.

What might have improved the outcome?

The main approach used by the chiropractor, a short course of manipulation and encouragement to remain at work, was appropriate. Certainly, his being available to see Allan after work may have contributed to his recovery. However, he did not properly address Allan’s fear of recur-
rent disability. Instead of recommending a back belt and on-going maintenance treatments, the chiropractor should have educated Allan about the very favourable prognosis and natural history associated with his back pain. He should have addressed lifting techniques, and might have suggested an ergonomic assessment to determine if there were more appropriate ways of performing Allan’s job. He should have reassured the patient that although low-back pain tends to recur, it is a self-limiting condition that rarely results in prolonged disability and that in fact, the best treatment is to control the pain and maintain one’s normal activity of daily living.

**Tips from the Field**

- Availability of trained rehabilitation professionals after usual business hours facilitates workers’ ability to continue working while they are receiving treatment and their injuries heal.
- Passive treatments encourage dependence and a sense of helplessness that slows down recovery.

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How do your experience and views match the findings of the Work-Ready researchers?

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How could this case study be improved?

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Ron G: Too Much, Too Early

Ron, a 38-year-old mechanic, works for a large car dealership. Recently, he experienced sharp pain in his back one Monday morning at work when he bent over to lift an awkward and heavy box from the floor. He was unable to continue working because of the pain and reported the incident to his supervisor. The supervisor suggested that Ron go home and take it easy for the rest of the day. Ron remembered a previous episode of low-back pain that had kept him off work for several months a few years ago, and became quite concerned.

Next morning Ron’s back felt stiff and he had sharp shooting pains when he tried to get out of bed. He called his supervisor to let him know that he couldn’t come to work, filed a compensation claim, and went to see his family doctor. The doctor examined Ron’s back, gave him a prescription for Tylenol #3 and suggested he take a few days off work and go back when his pain settled down.

After a week off work, there was some improvement in Ron’s back pain but he continued to be anxious about his future and his ability to do his job. His supervisor called to see how Ron was doing and to find out when he might return to work. He suggested that Ron go for physiotherapy. Ron called his doctor to get a referral and booked an appointment for the following week in a clinic that offered special programs and services for injured workers.

Ron was assessed by the physiotherapist. She explained that he had sprained a muscle in his back. Appointments were booked for the next two weeks for a daily therapy program that included physical modalities, a progressively more intensive exercise program, and education about posture and injury prevention. Work simulation activities were also incorporated.

After a couple of weeks of therapy Ron’s back was feeling better. The therapist suggested that Ron contact his supervisor to see about the possibility of returning to work part-time.

Ron called his supervisor, who seemed quite anxious to have Ron back at work “as long as his back was 100%.” So Ron continued with his daily physiotherapy for two more weeks before returning to work.
Ron G: Too Much, Too Early

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What went right?

Ron consulted his family doctor to rule out any serious pathology. His physiotherapist appropriately reassured Ron about the diagnosis. She provided Ron with some strategies around injury prevention and self care. The physiotherapy program included work simulation. Ron’s supervisor clearly showed concern by contacting Ron while he was off to see how he was coping, and was eager to welcome Ron back to work.

What went wrong?

An intensive, daily program of physiotherapy was probably not indicated given the short duration of Ron’s symptoms. It may have actually prolonged Ron’s recovery and time off work.

Moreover, the supervisor’s insistence on “100% recovery” before workers with back pain return to work was out of date and unnecessarily delayed accommodation for the injured worker. Professional advice may be able to update these views — for example by pointing out that continuing ordinary activity within the limits permitted by pain leads to a more rapid recovery.

The physiotherapist encouraged Ron to contact his workplace about returning to work – but not until the end of his treatment program, which may have further delayed return to function, through focusing the patient’s attention excessively on the problem and even providing an alternative schedule of activities to work itself.

There appeared to have been no contact from the workplace until Ron was off work more than a week. Also, despite Ron’s past history of time lost from work due to low-back pain, and the anxiety noted, little attention appeared to have been paid to these prognostic factors. There was no mention of prevention or modified work options.

What might have improved the outcome?

Ron’s doctor could have reassured Ron about his recovery process rather than simply prescribing medication. This might have alleviated Ron’s fears about his back pain becoming more chronic, and Ron might have felt more confident about getting back to his usual activities and work. Over-the-counter medication could have been recommended rather than medication requiring a physician’s prescription, since the latter often has more side effects and potential for dependency. Given Ron’s previous experience and the anxiety noted, an exploration of psychosocial issues was warranted. If Ron’s fear that he would not be able to work could be alleviated by exploring the options for modifying his job, this should have been pursued immediately.

Key Research Evidence

- Intensive physiotherapy disconnected from the workplace in the acute stage of low-back pain is not indicated, and may even contribute to prolonging recovery.
- Physiotherapy at, or linked to, the workplace in the sub-acute stage of the injury might facilitate recovery.

A study comparing workers receiving intensive early physiotherapy in ‘community clinics’ across Ontario found that there was no advantage from the program compared with usual care. This graph is based on data from Sinclair; S.J., et al. Spine 24 (1997): 2919-31.
The physiotherapist could have provided Ron with back education and pain management strategies and booked a re-check appointment instead of starting intensive physiotherapy so soon after injury. The therapist could have contacted the workplace or encouraged Ron to contact his supervisor as soon as possible to plan his return-to-work. The supervisor, while well-intentioned, should update his views about insisting on “100% recovery.” We now know that the back needs some activity to fully heal.

Closer communication between the health-care providers and Ron’s supervisor could have facilitated an earlier return-to-work if modified work was available at the dealership.

Tips from the Field

- Supervisors’ insistence that the worker needs to be 100% recovered before attempting to return to work might be prolonging the disability.
- Communication between health-care providers, employers and the injured worker to encourage and facilitate an early and safe return-to-work is essential.

How do your experience and views match the findings of the Work-Ready researchers?

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How could this case study be improved?

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Denis H:
Supervisors and Modified Work

Denis is a 42-year-old machine operator in an electronics assembly plant. He had right shoulder pain for several months and the pain was gradually getting worse. His doctor diagnosed a rotator cuff tendonitis (inflammation of a tendon) of the right shoulder and prescribed the following functional limitations for work:

- Avoid repetitive, forceful movements with the right arm.
- Avoid movements of the right arm above the level of the shoulder.
- Do not lift more than 25 pounds with the right arm.

These limitations meant that Denis could not do his regular job. He went to see the plant nurse, who immediately put him on the modified work program that the Human Resources Department had recently established. She contacted Jacques, Denis’s supervisor, to inform him of Denis’s need for modified work.

But the supervisor said he had no appropriate job for Denis and could not accommodate him. He would take him back only when he was able to do his full regular job. Jacques told the nurse he already had another worker on modified duties. There was no way he could maintain production quotas and accommodate another “lame duck” in his department.

As the supervisor, Jacques must ensure that his department produces 1,000 finished product units each week. His efficiency is measured in number of person-hours allocated for production of each 1,000 units and is calculated weekly. Bonuses are paid to supervisors and the workers under their supervision when production quotas are met or exceeded. While other jobs in Denis’s department would not require shoulder exertion, Denis has never done them, and would require training and at least two weeks practice before he could carry out the full workload.

In this plant, costs associated with work absences (workers’ compensation and sick benefits) are charged to the Human Resources budget and not the individual departments.
Denis H:
Supervisors and Modified Work

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What went right?

The human resources department has set up a modified work program and has the support of the nurse. The worker contacted his physician, was diagnosed, and was given specific work restrictions that could be communicated to the workplace. The worker was able to contact the workplace nurse as soon as the problem began, and she in turn contacted the supervisor directly to set up a modified work plan.

What went wrong?

The supervisor faced conflicting expectations. He was caught between production demands and demands for accommodation of injured workers.

The supervisor was evaluated on and rewarded for achieving production quotas; there were no incentives and several disincentives for participating in modified work plans. His department’s productivity (measured as number of products produced per person-hours of labour) would appear lower if he agreed to having workers who did less than the regular amount or worked on a workstation for which they had no experience.

Moreover, if co-workers had to change their work activities to accommodate Denis, there may have been considerable resentment of him and a subsequent drop in morale. This may have occurred if bonus pay was lost because of the lowered productivity of the department as a whole, or if other workers had to increase their workload significantly in order to maintain overall production quotas of the department.

The modified work program in this workplace assumes that re-assignment is the only solution when the current job does not fit the functional limitations of the injured worker. No attempt was made to assess Denis’s job to see whether the force or frequency of repetitive movements of the right arm or the elevation of the right arm above shoulder level could be reduced or eliminated. The Human Resources department set up the modified work program but apparently did not get the staff to “buy into” the program.

On his part, Denis could have spoken about his shoulder pain much earlier to enable his supervisor to re-examine the situation before it became a lost-time claim.

Key Research Evidence

- Departments are less likely to co-operate with health and safety initiatives that appear to conflict with their production demands and rewards.
- Ergonomic assessments conducted to identify physical job demands and hazards will facilitate management of workers with musculoskeletal disorders.

What might have improved the outcome?

If Denis’s regular job could have been modified to reduce demands on his shoulder, he might have been able to continue doing his job and not need re-assignment. If physical hazards were reduced or eliminated, Denis would also be at lower risk of re-aggravating his shoulder.

Reducing or eliminating these hazards may prevent the development of similar disorders in other workers, and thus reduce overall health and safety costs in the long run. A plant-wide ergonomic assessment might be appropriate.

Supervisors need to be included, and their point of view taken into account, in planning and implementing modified work programs. Health and safety issues, such as accommodation of modified work duties, should be clearly built into their job description. The necessary training should be provided, and clear measures of performance established upon which they can be evaluated.

These measures should not conflict with performance measures of production, i.e., productivity must be measured in ways that take into account the savings associated with accommodating modified duties of workers with musculoskeletal problems.

Supervisors should have clear incentives to incorporate health and safety initiatives into their day-to-day responsibilities. Senior management must make it readily apparent that the company values such functions and that if supervisors carry them out well, they will be rewarded. Some companies include health and safety and workers’ compensation costs and savings into
**Tips from the Field**

- Including supervisors in planning and implementing modified work programs is essential to their success.
- The best return-to-work programs will be ineffective if staff do not “buy into” the program.

the budgets and overall evaluation of each production department, rather than attributing them to a separate department such as Human Resources. Other companies have found it helpful to set up rehabilitation job banks, consisting of tasks that could be completed by workers with certain types of injuries while they recover fully.

An essential part of any new return-to-work program is to obtain collaboration and buy-in from employees, supervisors, and senior managers.

### References


Shirley L: 
Job Demands and Work Environment

Shirley L. is 58 years old and was employed as a unit assistant in the medical intensive care unit of a large inner-city teaching hospital. Six months ago, Shirley strained her lower back while trying to lift a bed (which caught in a floor crack) as she was pushing it onto an elevator. Shirley was in great pain after the incident and visited her physician later that day. He examined her, determined that she had a soft-tissue injury, gave her medication for pain, and suggested that she take “some time” off work.

Shirley filed for workers’ compensation benefits. Her claim was accepted, and benefits were paid until she left the country for a vacation three weeks later. Upon return from vacation, a medical review determined that she was still unfit to return to work and benefits resumed.

She began physiotherapy eight weeks after the injury. At this time Shirley’s physician stated that he thought her job was too physically demanding. The hospital’s Human Resource Department and Occupational Health Unit responded by reviewing Shirley’s injury history and sick-time records. They found that over the past five years she had experienced three time-loss injuries due to lifting and transferring patients, resulting in a total of 117 days lost from work.

The two administrative units agreed that the job appeared to be beyond Shirley’s physical capabilities, and began to review the job demands for a unit assistant. The review showed that Shirley was required to work 12-hour shifts, days and nights. One of her tasks was to turn patients in bed. During a typical night shift, patients were turned an average of 30 times; during a typical day shift 10 to 15 times. Shirley’s unit had the highest demand level. Due to the workload on the unit, other staff members were often unavailable to help with turning patients. Although lifting equipment was available to the unit, it was difficult to use because of the cramped environment. The hospital had plans for remodelling the unit, but funding for the project was not available.

To help Shirley increase physical strength and work tolerance, the hospital and the compensation board agreed to provide a supernumerary graduated return-to-work placement on a pediatric medical unit for six weeks while the Human Resources Department searched for a suitable permanent placement. The board paid Shirley’s wages for the six weeks that she worked as an extra to the unit. By the end of the placement, Shirley was able to work an eight-hour shift on the pediatric unit. At this point the workers’ compensation board deemed her fit for work and stopped her benefit payments. Shirley applied for long-term disability benefits; however, this was also refused.
Shirley L:
Job Demands and Work Environment

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What went right?
Shirley did not delay seeking help, pain relief was given promptly and the initial workers' compensation claim was accepted. There was collaboration between the Occupational Health Unit, the Human Resources Department, the worker's original unit, the placement unit, and the workers' compensation board. Income support was maintained during the time that physical limitations were defined and the process of job accommodation was initiated. A job-task analysis for unit assistants was completed, and extra work placements for gradual return-to-work were available. The worker was kept at work by placing her in a job that was within her physical capacity.

What went wrong?
Shirley's physician was vague about the length of time she should be off work and no date was set to review her problem. Shirley was not given information on exercises she could start on her own, and her physiotherapy was delayed because of her holidays. The work environment could not be modified and unit staffing could not be increased because the hospital lacked funds. Floor cracks and a cramped working environment were safety hazards that were not addressed. Compensation payments were stopped halfway through the process of finding a permanent alternative work placement.

Key Research Evidence
- Assessment of job demands and work environment is essential when dealing with repeated injuries.
- Offering modified or alternate work appropriate to physical capabilities helps recovery.

What might have improved the outcome?
Shirley could have started some light exercises soon after her injury, commencing a more intensive physiotherapy program once she had been absent from work for four weeks. Clear communication and reassurance from the physician that pain will be controlled and that return-to-work will not be harmful is important.

Figure 1: Once a worker has been off work for more than a few weeks, communication and co-ordination between a large number of people becomes necessary for successful return-to-work. Often a designated co-ordinator or case-manager might facilitate the process. Adapted from Frank, J.W., et al. “Disability Resulting from Occupational Low Back Pain, Part II: What Do We Know about Secondary Prevention? A Review of the Scientific Evidence on Prevention after Disability Begins.” Spine 21 (1996): 2918-29. Reproduced with permission.
Educational and practice sessions on back protection techniques could be introduced into the workplace, along with regular safety scans of the work environment by the workers to identify problem areas and generate possible solutions. The hospital could adopt a policy on handling patients, and could allocate a budget for safety issues, such as the redesign of problem areas, modification of beds and stretchers, and the purchase of safety equipment.

Payment of benefits could have continued during the time that a permanent alternative work placement was being established. The union (if there was one) could have been more pro-active about workload, understaffing, and the hazards related to the cramped environment.

**Tips from the Field**

- Some organizations have found it helpful to designate a case manager, whose job is to facilitate appropriate communication and co-ordination among the parties involved in the return-to-work program.

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**References**


Maria R:  
The Family Doctor: Advocate or Obstacle?

Maria R. is a 33-year-old production worker in a small manufacturing plant. She is a single mother, with three young children who are minded by a neighbour when Maria is at work. Two months ago, Maria sustained a back injury when lifting a box filled with metal screws. Her family doctor, Dr. M., who has known her family for many years, diagnosed the problem as back strain. He asked Maria about her job, and she told him that she had to bend and lift parts during much of the day. He suggested that she take a couple of weeks off and return to his office at the end of that time.

Dr. M. knew of the demanding family situation Maria was in, but was not aware of the modified work possibilities within her company. He felt that she needed this opportunity to rest and get back on her feet. After two weeks, Maria was still reporting significant pain and Dr. M. extended her leave, hoping that full recovery would allow her to return to work successfully in the near future. However, there has been no change, and Maria remains off work at the present time, six weeks after her injury.

The company where Maria works has an active modified work committee, composed of representatives of management, the health and safety committee and the occupational health nurse. Marg, the occupational health nurse, has made several attempts to contact Dr. M., to explain the program and the work options available to Maria – options that would not involve lifting, bending, or other actions that could impede her recovery.

Marg has inquired about the reasons for Maria’s continued absence, and whether she could return to modified work. She feels that Dr. M. sees such attempts as questioning his professional judgment. It is difficult for her to reach him by telephone. When she did get through, Dr. M. said curtly that the information she was seeking was confidential, and he was not at liberty to share it with her.

Marg is frustrated in her attempts to resolve the situation. She is aware of Maria’s domestic situation, and has suggested that she might want to see a counsellor in the company’s Employee Assistance Program (which is fully confidential) to help talk through her problems. Maria has not done this. Dr. M’s lack of knowledge about possibilities within the employment setting, and resistance to communicating openly with the employer, continue to deter Maria from returning to full earning capacity.
Maria R:
The Family Doctor: Advocate or Obstacle?

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What went right?

Dr. M. has an on-going relationship with the worker, but did not ask about job demands. The fact that Maria’s company has a well-established return-to-work program, with active involvement by both labour and management parties, provides a structure to successfully manage work injuries. The Employee Assistance Program (which is fully confidential) could provide additional help for Maria in handling the stresses inherent in her dual roles as parent and wage-earner. The occupational health nurse has made repeated attempts to contact Maria and her doctor.

What went wrong?

Dr. M. appeared out of touch with current practice in occupational health, or at least was not cognizant of the flexibility of the employer’s return-to-work program or other company benefits. Because Maria had on-going pain and distress, he thought she would benefit from resting at home until she was pain-free. In fact, research with acute low-back pain patients shows that those who are encouraged to continue their normal activities as much as possible benefit in terms of pain levels and physical functioning.

While the workplace has a return-to-work program, it is not clear that this was conveyed to Dr. M. The doctor did not use the opportunity offered by the occupational health nurse to seek information on modified work or usual job demands to recommend temporary or permanent accommodation to Maria’s job.

Unfortunately, Maria has now passed the acute phase. More concerted efforts at return-to-work programming are now required in order to prevent the injury from becoming chronic.

Key Research Evidence

• Doctors’ access to accurate and comprehensive information on modified work possibilities and other employee benefits available to their patients might help the return-to-work process.
• Innovative Continuing Medical Education can improve knowledge, co-operation and working relationships between local business and health practitioners.

A recent high-quality study conducted among employees of the City of Helsinki in Finland showed that workers with acute back pain fared much better if continuing with regular activities rather than bed rest was recommended. The graph is based on data from Malmivaara, A., et al. “The Treatment of Acute Low Back Pain — Bed Rest, Exercises, or Ordinary Activity?” New England Journal of Medicine 332(6) (1995): 351-5.

What might have improved the outcome?

There is a clear need for improved communication between the workplace and local care providers. Some communities have instituted partnerships between the health-care community and local business in order to reduce workers’ compensation costs and improve worker health. A combination of Continuous Medical Education, plant tours, case conferencing and Continuous Quality Improvement techniques have been used. This has resulted in increased health-care provider familiarity with workplace environments and ergonomics, improved communications and a co-ordinated approach, fewer lost-time days, more modified duty days, and significantly decreased medical and compensation costs.

Workplaces that have established return-to-work programs should have letters outlining the program, its mechanisms, and rationale available to send to practitioners such as Dr. M. Alternately, such documentation may be taken by the wor-
Tips from the Field

- A brief description of modified work options should be available for workers to take with them when they visit their physicians about injuries.
- Sometimes sending a letter or setting up a meeting with the physician (paid for by the employer) may be a more effective way of reaching busy practitioners than trying to reach them by telephone.

References


How do your experience and views match the findings of the Work-Ready researchers?

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How could this case study be improved?

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Randy T: An Adversarial Organizational Climate

Randy T. has been employed for nine years as a welder in a large manufacturing plant. Six months ago, he began to experience shoulder pain, and filed a workers' compensation claim. His family doctor diagnosed an inflamed and “degenerated” shoulder, and completed the required forms, indicating that Randy should avoid overhead work. The claim was not allowed since there was doubt whether the shoulder condition was due to work or an old sports injury. The collective agreement in the plant required that Randy “bump” a worker of less seniority in order to return to a modified job. His relatively low seniority (Randy is only 35 years old) narrowed his options significantly, and he has been unable to return to work. Also, the bumping requirement makes accommodating injured workers unpopular in the plant.

In a climate of intense competition for the consumer dollar, management has been trying to reduce costs and increase efficiency. Many components of the production process have been contracted out to external suppliers, including several jobs that allowed for a measure of worker control of the pace of work and timing of rest breaks. Union-management relations are adversarial, and initiatives introduced by management are seen as suspect. In the past, absenteeism rates have been high, so management instituted a system of close monitoring of absences across the plant site by a centralized department, with daily meetings and updating of electronic personnel files, and reporting to head office in the United States. A nurse employed in that department maintains regular contact with the injured worker. Union spokespeople complain that the approach is too aggressive and that the company should not harass workers who are injured on the job.

Until a year ago, each department had a union placement co-ordinator, appointed by the company. This person took an active role in helping injured workers and their supervisors develop modified work placements. Under the new system, the union’s role in the process is less active, the process less local. Accommodation of workers like Randy is more easily avoided by supervisors in a setting where workers on compensation have traditionally been seen as “cherry picking,” or using their claim to gain access to desirable jobs.

Randy has told his family doctor that he feels the company is pushing him to return to work before his shoulder has healed. The doctor’s communications with Randy’s employer are terse and relatively uninformative, and include restrictions that appear rigid to the employer. All parties involved seem to have reached an impasse, with no immediate solutions to the problem of Randy’s absence in sight.
Randy T:
An Adversarial Organizational Climate

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What went right?

A company nurse kept in contact with Randy during his absence. Regular, caring contact by a nurse, supervisor, or case manager is a feature of successful return-to-work (RTW) programs. However, given the adversarial climate in the plant, a call from Randy’s supervisor, a union representative, or a known and trusted nurse from his own unit might have been received more positively.

What went wrong?

An integral feature of successful RTW programs is that both union and management are fully involved in their development and ongoing operation, and committed to their success. In the adversarial climate in the plant, this was not achieved, and the lack of bipartite problem-solving has led to lack of cooperation with the program, and inconsistent responses to problems.

The fact that the collective agreement requires bumping of another employee for job accommodation may work against acceptance of the return-to-work program by Randy’s co-workers. Companies in which successful return-to-work programs have been developed may use non-regular work placements as long as modified work is required, so that co-workers are not displaced, production pace is not affected, and hostility towards the injured worker is avoided.

Clearly, the occupational health nurse’s role in this firm had become too narrow and insufficiently arm’s-length from management, at least in the minds of the employees. She was thus unable to effectively carry out a key occupational health professional function: the facilitation of RTW. Instead of acting merely as an “absence policeman” for the company, she should have been monitoring this case closely. She needed, for example, to ensure that adequate rehabilitation was being offered. Most of all, she should have been actively negotiating appropriately modified work for Randy, by communicating with his doctor, the workplace (ideally through a disability management co-ordinator, reporting to a bipartite RTW committee), and the insurer.

A key issue in this case may have been the failure of the doctor’s report to convince the worker’s compensation board to accept the claim as work-related, so that a private disability insurer became involved. In some settings, this can cost a union more than management, leading to low motivation for management to bring the worker back to work. A medical consultant’s opinion, however, might well have led to a successful appeal to the compensation board. In some jurisdictions, Randy’s situation may also have contravened laws regarding the workplace’s “duty to accommodate” after injury or illness, or even human rights legislation regarding the permanently disabled.

Key Research Evidence

- The use of supernumerary positions to accommodate injured workers removes the need for “bumping,” and has been shown to be effective in helping workers return to work.
- Full commitment by both union and management is crucial to the success of return-to-work programs.

What might have improved the outcome?

To have improved this dysfunctional situation, someone had to convince both management and labour that the laissez-faire approach was both unnecessarily costly to the organization and harmful to employee health and functioning – i.e., that change is a “win-win” solution.

The occupational nurse and/or union health and safety co-ordinator could have begun this process by calling a case conference with all parties, ideally including at least telephone participation by Randy’s doctor and the insurer. In some progressive jurisdictions, insurers are beginning to be smart about this and pay physicians standardized fees for such meetings. In cases of prolonged disability marked by total impasse, this may be the only way to obtain participation from self-employed, fee-for-service private practitioners.

Confronting everyone with the dismal failure of RTW in this case and presenting a new approach as described above might get the ball rolling. Eventually however, both management and union must make a commitment to a policy of routinely returning all injured workers to employ-
Tips from the Field

- An organization with highly adversarial labour relations, where workers feel that the company sees production as more important than worker well-being, is unlikely to succeed in return-to-work programming.

- In such adversarial situations, it might be necessary to involve a neutral third party to convince both management and labour that working together in return-to-work programming is in their best interests.

In many companies, participation of the union (or other worker representative, in the case of non-unionized settings) in return-to-work programming is being written into the company’s mission statement and/or collective agreements. This practice establishes a firm foundation for full participation of both parties, and promotes constructive problem-solving in the on-going development of the program. Actively involving unions in workplace accommodation can help address resentment from co-workers.

References


How do your experience and views match the findings of the Work-Ready researchers?

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How could this case study be improved?

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Jennifer J: Worker Issues in Return-to-Work

Jennifer J. is 47 years old and has been working as a parts assembler in the provincial telephone corporation for the past 16 years. She has alternated between soldering electronic circuit boards and acting as quality control supervisor in the same area.

Jennifer recently injured her right shoulder (rotator cuff strain – possibly a minor tear) by tripping over some debris on the floor while trying to prevent a stack of circuit boards from falling. She has been off work on workers’ compensation for the past 17 weeks. At the six-week point her doctor suggested that she try going back to work on the modified work program offered in her workplace, but she insisted it was too painful. He has now recommended again that she make the attempt.

The occupational health nurse at the workplace had phoned Jennifer several times during her absence. She called again to set up a meeting to plan her return-to-work program. Present at this meeting were Jennifer’s union representative, the compensation board adjudicator, her supervisor from the plant, the occupational health nurse, the occupational health physician and the occupational therapist who had just completed an ergonomic evaluation of the workplace.

During the last five years prior to her injury, Jennifer had three workers' compensation claims: for two back injuries and one shoulder/neck injury. She has taken off one or two sick days every month since returning to work after her last injury eight months ago. Over the past six months she has been late for work at least once a week. Just prior to this injury, she was warned by her supervisor that she needed to improve her attendance and overall performance or she would be disciplined (placed on probation).

The modified return-to-work program was designed to place Jennifer as a “buddy” in a supernumerary position until she was able to work full hours with full duties. Generally this was a six-to-eight week program with gradually increasing hours and job duties.

Jennifer attended regularly the first week, and missed one day the second week. During week three, she called the occupational health nurse to say that she had seen another physician at a walk-in medical clinic who had given her permission to be off work for two weeks.
Jennifer J:  
Worker Issues in Return-to-Work

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What went right?

Jennifer appears to have received appropriate medical care from her own physician, and regular benefits from the workers’ compensation board, which started without needless delay. The occupational health nurse maintained regular contact with Jennifer, and the workplace seems willing to help her return to work.

Jennifer was offered a modified work program when she was ready to return to work. The team worked well together in setting up and revising the return-to-work plan.

What went wrong?

The physician postponed recommending modified work until six weeks after the injury, and Jennifer refused to try modified work at her doctor’s first suggestion. This may have contributed to the problem. Most soft-tissue injuries need earlier efforts to facilitate successful return-to-work. It is unclear whether functional abilities and/or work restrictions were identified during the first attempt to set up a return-to-work plan.

The physician at the walk-in clinic did not communicate with the occupational health team regarding Jennifer’s return-to-work program before giving her permission to be off work. Jennifer’s leave was extended with little knowledge of her history and current efforts to help her return to work.

Although Jennifer had given consent to the return-to-work program, she had not discussed any difficulties in the return-to-work process other than to report pain. Nevertheless, she appeared to be resisting or sabotaging the success of the return-to-work plan by missing days and by “doctor shopping.”

It is conceivable that Jennifer is experiencing significant difficulties in keeping up with her job, and that possible causes have not been addressed. Is there reason to suspect an imbalance between abilities and job demands? Are psychosocial and/or family issues making it difficult for her to continue working?

Lastly, waiting 17 weeks post-injury to set up a meeting of the return-to-work team is perhaps too late. To encourage a more successful outcome, the team should have been convened when Jennifer first refused to engage in the return-to-work program at six weeks, if not sooner.

What might have improved the outcome?

Given Jennifer’s history of injuries, she could have been assigned a workers’ compensation board case manager who was skilled in anticipating possible delays in the return-to-work plan. A case manager with this experience would have known how to address the delays with earlier rehabilitation intervention — including the psychosocial help she appeared to need.

Jennifer’s recurrent injuries and absences in the past, and her initial refusal to try modified work, should have indicated to the physician that referral for additional interventions such as occupational or physical therapy or counselling might have been in order. Her doctor should have explored other issues such as family relationships or personal/psychological issues.

Considering her deteriorating work performance, her employer (supervisor or occupational health nurse) could have referred Jennifer for counselling concerning family and/or workplace concerns. Furthermore, a representative of the workplace could have addressed her options and the consequences of her apparent lack of interest in returning to work.

Jennifer could have asked her doctor for help regarding her difficulties at work and/or at home, rather than keeping silent about these issues. Jennifer was given numerous opportunities during the return-to-work program to ask for help and discuss any issues that might have been interfering with her work performance. She chose not to take advantage of them.

Key Research Evidence

- A history of repeated injuries and reluctance to try modified work are indicators of a need for further intervention.
- Psychosocial and other non-work issues are often part of real-life return-to-work situations and need to be addressed, for example, by referring the individual to professional counselling.
Tips from the Field

- In the context of deteriorating work performance, one or more illness or injury leaves may reflect an imbalance between abilities and job demands, or the presence of workplace and/or psychosocial problems.

- Being up-front and addressing concerns and issues early often works better than ignoring performance and psychosocial concerns.

References


How do your experience and views match the findings of the Work-Ready researchers?

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How could this case study be improved?

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Jerry J: Restructuring and Job Accommodation

Jerry J. has been working as a kitchen helper (Dietary Aide II) at a large personal care home for the past 13 years. He injured his back when, while carrying a full warming pan, he slipped on food that had been spilled on the floor. Although he experienced immediate pain in his lower back, he completed his shift, working one more hour.

The next day Jerry called in to say he could not work because of pain in his back and left leg. He filed a workers' compensation claim. Jerry went to his family physician several times but despite medical treatment, the symptoms persisted.

Six weeks after the injury, the leg pain was so severe that Jerry was unable to stand for more than two hours. He was still off work and had not yet begun to receive workers' compensation benefits. Jerry discussed the situation with Laura, the occupational health nurse at his workplace. When Laura phoned the compensation board on Jerry's behalf, the adjudicator could not identify a reason for the delay in payments. He also seemed unaware that the employer had a return-to-work program that could help Jerry return to modified duties. Jerry began to receive benefits two weeks later.

At this point, Jerry was referred to an orthopaedic specialist and sent for a CAT scan. The waiting time for his appointment with the specialist and the scan added up to seven weeks. He was eventually diagnosed with a large herniated disc and surgery was recommended. Jerry waited another four weeks for surgery, which helped the pain. Although permanent restrictions limited lifting to 25 pounds, Jerry was reinstated in his previous position with permanent job accommodation that would allow him to defer the heaviest lifting to his co-workers. By this time, he had been off work for 32 weeks (eight months).

During the year prior to Jerry's injury, there had been talk of a company reorganization, particularly in the food services area. By the time he came back to the modified work program, the restructuring had begun. Within the next three months, only a skeleton staff remained in food services. All others had been laid off. Approximately 25% of the workers were able to “bump” others within the union and maintain a job.

Although Jerry had sufficient seniority to enable him to remain a part of the skeleton staff or “bump” someone else in another department, he did not have training that would qualify him for positions such as nutritional counsellor, clerk or even maintenance worker within the personal care home. This, combined with his lifting restrictions, prohibited him from qualifying for other jobs within the physical plant. Jerry was out of a job!
Jerry J: Restructuring & Job Accommodation

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What went right?

Jerry acted appropriately by seeing his doctor and filing a workers' compensation claim. The occupational health nurse helped Jerry to get compensation benefits. The compensation board adjudicator assigned to Jerry, however, appeared to take on a rather passive role – leaving all the return-to-work suggestions to the occupational health nurse.

The workplace had a well-established modified return-to-work program. A plan to reinstate Jerry in his previous position with permanent job accommodations was suggested.

What went wrong?

The physician gave little guidance with regards to physical and functional activity, nor did he refer to any therapies to assist with physical function. Questions could also be raised about the lengthy waiting periods for the delivery of health-care services (orthopaedic consultation, CAT scan, surgery); was this normal for all patients and if so, why? The workers' compensation payments were delayed, and the adjudicator did not demonstrate an interest in facilitating recovery.

In response to the current health management trends and funding cuts, the organization restructured all dietary delivery services, resulting in the loss of all the dietary aide positions.

Nobody tried to set up a retraining program for the dietary workers. The company and the union failed to follow through on their duty to accommodate injured workers.

What might have improved the outcome?

Although the restructuring of the organization was not directly amenable to intervention by the health-care providers or compensation board adjudicators, it should have been taken into consideration when planning the return-to-work program for and with Jerry. Jerry had known about the possibility of the changes prior to his injury, and could have been more pro-active in taking steps for retraining or finding alternate work within the workplace. The adjudicator could have addressed this in the return-to-work plan for Jerry, by either alerting him to the need to plan for change in his working situation or by recommending a work hardening program to upgrade his physical abilities.

The Human Resources Department and the managers planning the restructuring could have reached out to workers on leave due to injuries to suggest that they consider preparing themselves for alternative placements. The union could have advocated on behalf of the workers for employer in-house training for alternate jobs for dietary workers.

In several jurisdictions, the workers' compensation board has provided additional funding to speed up diagnostic tests and treatments, decreasing lengthy waiting periods. Many companies have found it helpful to have a designated case manager to problem-solve around delays and speed up processing claims and setting appointments.

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**Key Research Evidence**

- Even when all the parties directly responsible for the return-to-work of individual workers are “onside,” workplace or other societal changes may impede successful rehabilitation.

- Consideration of restructuring plans and other major changes at the workplace should be part of rehabilitation plans for individual workers.
**Tips from the Field**

- Delays in processing claims and obtaining appropriate tests and treatments often prolong disability.
- A designated person whose job is to facilitate and speed up the process may help recovery.

**References**


The Work-Ready Project

Project Sponsorship:
This work was co-sponsored by the Health Evidence Application and Linkage Network (HEALNet), the Institute for Work & Health (IWH), and the National Institute of Disability Management and Research (NIDMAR). HEALNet is a member of the Networks of Centres of Excellence Program, which is a unique partnership among Canadian universities, Industry Canada and the federal research granting councils. The Institute for Work & Health is an independent not-for-profit research organization that receives support from the Workplace Safety & Insurance Board (WSIB) of Ontario. NIDMAR is a labour-management initiative based in British Columbia whose mandate includes education and training, research and policy development. The views expressed in this manual are those of The Editors and not necessarily those of the sponsoring organizations.

Acknowledgments:
The Editors wish to acknowledge the contribution of the HEALNet Work-Ready Research Group, comprised of the provincial working groups listed below, and Arlene Ward in the creation of the three-part teaching package Return-to-Work Approaches for People with Soft-Tissue Injuries. The Editors also wish to thank the stakeholders who shared their thoughts with us; their wisdom and candour enriched our understanding of the issues and, we think, the quality of the product.

Ontario Project Working Group
John Frank – family physician/epidemiologist
Claire Bombardier – rheumatologist/epidemiologist
Judy Clarke – psychometrist/anthropologist
Donald Cole – occupational physician/epidemiologist
Pierre Côté – chiropractor/epidemiologist
Jaime Guzmán – rheumatologist/epidemiologist
Deirdre McKenzie – physiotherapist/program evaluator
Vicki Pennick – occupational health/community health nurse

Quebec Project Working Group
Susan Stock – occupational physician/epidemiologist
Raymond Baril – anthropologist
Suzanne Deguire – sociologist
Marie-José Durand – occupational therapist/epidemiologist
Patrick Loisel – orthopaedic surgeon/epidemiologist
Michel Rossignol – occupational physician/epidemiologist

Manitoba Project Working Group
Annalee Yassi – occupational physician/epidemiologist
Juliette Cooper – occupational therapist/rehabilitation research
Margaret Friesen – occupational therapist/adult educator

Canadian Workshop Facilitator
Arlene Ward – vocational rehabilitation specialist/adult educator

Address correspondence to:
Institute for Work & Health, 250 Bloor Street East, Suite 702, Toronto, ON M4W 1E6  or
National Institute of Disability Management and Research, 3699 Roger Street, Port Alberni, BC V9Y 8E3
Web sites: http://iwh.on.ca http://nidmar.ca

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