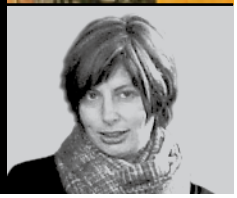

Getting the at risk patient back to work

A strategy

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BACKGROUND
Achieving best outcomes in occupational injury management requires an emphasis upon identifying and managing those factors which – in addition to the medical condition – lead to progression to chronicity. The most studied common musculoskeletal workplace injury is low back pain.

OBJECTIVE
While the majority of patients resume working with minimal medical intervention, this article highlights the early identification and management of factors in the workplace that can result in poorer outcomes for patients.

DISCUSSION
After exclusion of serious red flag conditions, the majority of patients with musculoskeletal injuries can resume suitable work. Factors impacting adversely upon the likelihood of a durable return to work include poor quality workplace relationships, lack of a return to work culture, patient distress regarding their condition, behaviours and beliefs about the injury such as activity avoidance, reliance on passive treatment modalities, pain focus, and time off work. It is acknowledged that workplace factors may appear beyond the influence of general practitioners, but their role is crucial to preventing chronic disability, facilitating patient self management and engaging with the workplace.

Case study

Jane, 36 years of age, has primary responsibility for two young children. She is divorced and works full time in an inbound call centre. You see her on a regular basis for simple self limiting complaints such as respiratory infections and her children's illnesses. Jane frequently reports feeling pressured due to the competing demands of her work and family life. Her work is continually changing: her calls are being monitored for quality and quantity; she is being increasingly required to work flexible schedules; and she feels that her employer does not really understand or support its staff. On this occasion, Jane presents with a history of gradual onset of low back pain over the past few weeks which she attributes to the need to sit for longer periods due to undertaking overtime in the call centre, and a new system of dealing with customer accounts, which she states, was introduced with minimal training.

Your detailed history and examination shows no indicators of serious causes such as tumour, spinal infection or spinal cord compression. Jane states there are no duties for her to do other than full phone based tasks and this involves too much sitting which she cannot do due to pain. She wants you to certify her taking a few weeks off to rest 'until the pain goes away' and wants X-rays and blood tests as she is concerned that there is something 'seriously wrong' with her spine. She has put in a workers' compensation claim and is angry that she has been injured by an uncaring employer.

Jane presents with nonspecific low back pain and highlights the challenges faced by general practitioners in managing what is usually a common problem with a favourable outcome. In a busy practice removed from the worksite, how does the GP engage with the employer to address the workplace issues that could otherwise prevent a good outcome?

Australian workplace and injury profile

The universal aim of workplace safety and compensation legislation is the prevention of injuries in the Australian workplace. Employers have a legal duty of care to provide a healthy and safe workplace and to assist employees to get safely back to work.

In 2004–2005, of the 30 489 claims made in the Victorian compensation system, 57.2% related to musculoskeletal conditions and 23% of all claims related to back conditions.[1]

However, statistics cannot communicate the greatest cost to patients in human terms: the poor social and occupational sequelae of workplace disablement and disengagement.

While most people who have compensable injuries recover well, a greater proportion have poorer health outcomes than those with similar but noncompensable conditions.[2] Furthermore, the likelihood of returning to work significantly diminishes the longer an employee is off work, such that for employees who do not resume working by 6 months postinjury, there is a poor likelihood of return to work in any form. Figures vary, but studies show that by the time there is 3 months work absence, less than 30% of employees will resume working.[3] The patient's workplace is critical for a successful outcome, and the GP is centrally placed to be alert to occupational risk factors for disability as they arise and to positively intervene.

There is strong epidemiological evidence that most workers with low back pain are able to continue working or return within a few days even if not pain free.[4] Moderate evidence exists that temporary provision of lighter or modified duties facilitates return to work and reduces time off work.[4] Hence, the more the GP understands the workplace and mechanisms for supporting return to work, the better the outcome for their patient.

Identifying factors that may lead to disability

For patients such as Jane – having excluded red flag conditions – it is important to assess beliefs and behaviours regarding her condition, workplace factors, and family/social factors.

The yellow flag model[5] is a convenient approach to exploration of such beliefs and assessing during the initial patient assessment to guide management (see the article *Back injuries: getting injured workers back to work* by Low, Lai and Connaughton, this issue).

Table 1. 'A STRATEGY'

Activity maintenance
Self management
Time to actively listen and discuss issues
Review strategically/red flags excluded
Aligning interventions and expectations between all parties
Task knowledge/return to work focus
Explaining the patient condition
Goals setting
Yellow flags assessed and actioned

Workplace factors

Specifically, returning an employee to a workplace in the absence of the following may lead to a poorer outcome and a greater need for GP intervention:

- Alternative duties encouraged to promote medically suitable return to work
- Buffer exists to allow return to work if there are conflict issues
- Communication between supervisor and patient is open and accessible
- Doctors who treat the patient are seen as part of the return to work process
- Environment is a welcoming return to work culture
- Follow up issues raised to ensure outstanding issues are resolved
- Genuine interest, ongoing contact and support for injured employees.

Next steps

The first consultation sets up positive expectations that recovery will occur, return to work is part of the therapy and the goal, and there is a framework for achieving goals centred on the patient and their active participation.

A strategy

An approach that addresses both the patient's individual and workplace needs is summarised by the acronym 'A STRATEGY' (*Table 1*). Because a holistic approach is critical to patient management, all factors are included but the focus will be on the doctor-patient-workplace nexus.

Activity

Prolonged rest to treat back pain is harmful; it is associated with loss of muscle strength, cardiovascular

deconditioning, bone mineral loss, and sense of being ill. Within the first 2 weeks, prescription of specific types of exercise is not as critical as the patient continuing to keep mobile in order to avoid excessive rest and the sick role.[6] In addition to your activity prescription, discuss how work tasks are a form of activity and the rationale for duties (see *Tasks* below).

Self management

This provides the patient with better control over their symptoms, reduces distress, and increases likelihood of normalisation of usual functioning. There is good evidence that patients who adopt active self management have less long term disability.[7]

Time

Adequate time can be a challenge for busy practitioners, but it ensures that relevant barriers to recovery are adequately explored rather than being missed. In addition to exploring beliefs, finding out details about the patient's work in terms of technical tasks (content) and relationships (context) helps uncover potential issues and explore positive return to work strategies.

Review (red flags excluded)

This is vital to ensure that patients feel supported in their rehabilitation – which in many cases may involve minimal medical intervention. Failure to progress needs to be identified early and key messages reinforced. One of these is that the strategy allows for review and renegotiation of recommendations if circumstances change. The review can include a discussion with the workplace contact to reaffirm activities and actions undertaken. Stalled progress needs to exclude red flag conditions (see the article by Low, Lai and Connaughton, this issue).

Aligning interventions and expectations

The expectation of recovery and return to usual functioning is set from day one. Avoid giving disability messages such as 'you'll never do physical work again'. It is also critical that any practitioners to whom you refer patients provide consistent messages regarding the importance of activity and patient self management, while addressing the patient's psychosocial distress.

Tasks/return to work focus

Employees who remain at work do not lose their social connections with peers, remain mobile, and have a far better long term prognosis. Considerations for setting up suitable tasks are presented in *Table 2*.

The medical certificate is written such that the interventions or modifications recommended are part of the overall strategy to achieve specific outcomes. For example, where major conflict issues prevent a return to work, the GP can recommend urgent workplace mediation, and the patient may be able to work temporarily in another area while the relevant issues are being addressed. Explore all avenues for communication with the workplace's key people responsible for ensuring return to work (eg. supervisor, occupational health nurse, human resource contact).

There is evidence that a well communicated and cooperative approach with commonly agreed goals is associated with better outcomes.[8]

For most patients a worksite visit is not needed. However, the GP may consider this necessary if significant workplace barriers prevent early resumption of tasks either due to workplace reluctance or patient concerns. If GPs do not feel able to undertake such a visit, they can recommend via their medical certification that an occupational physician or suitably qualified rehabilitation provider carry out the assessment.

In addition, most compensation systems now include specialist in house medical staff whom doctors may ring if recommendations need to be progressed, there are concerns about the person not being back in the workplace, or to request further referrals.

Explanation

Fear and distress are significant risk factors for chronicity. Explain that hurt and harm are not the same; the high incidence of low back pain and overwhelmingly favourable prognosis indicate that their own likelihood of recovery is high. Again, link these concepts to the work tasks recommended.

Goal setting and plan

The patient needs to leave the first consultation with a clear expectation that recovery of function is the goal. They need to be armed with a plan of action of what activities are prescribed and why, and their own role in the rehabilitation process.

If alternative duties are prescribed, convey to the patient that this is a strategy to ensure return to full function and are not outcomes in themselves. They will be time limited and frequently reviewed in order to prevent disability through failure to progress. It is important to not continue such duties without a clear end point for review.

In order to avoid entrenchment of long term partial disablement, communicate a clear strategy that time

limited reviews will occur; 8–12 weeks of modified tasks should be maximal and should trigger review.

The need for long term redeployment to another job or part time hours can be considered if this is medically required. Or, if nonmedical barriers such as deconditioning, fear, anger, mood disturbance, or conflicts within the workplace are interfering with resumption of full duties, they need to be actively managed with the long term goal still being return to full time hours of work.

Table 2. Suitable duties – considerations

Job factors	Potential recommendations
Tasks Demands for mobility, strength, climbing, lifting, carrying, dexterity, stooping and bending, intellectual and perceptual skills **Working environment** Temperature, noise, hazard exposures **Organisational/social factors** Working alone, dealing with the public, team outcomes, need for deadlines and overtime **Ergonomic aspects** Lighting, use of equipment and controls, workstation design and height	Avoid the use of regular rest breaks (which denote inactivity) but rather focus on restorative breaks in which another task is undertaken hourly for 5–10 minutes to allow for changes of posture Restrictions can be considered depending upon the job in areas of: – stooping – bending – lifting capacity (eg. max 10 kg or 5 kg on a repetitive basis) – sitting tolerance – static tolerance In sedentary jobs in which there is ongoing customer contact (ie. call centres) it is useful to recommend frequent postural respite allowing calls to be taken sitting or standing alternating with some task variation such as filing, faxing, getting up to go to a printer Overtime should not be recommended while undertaking a staged return to work
Temporal factors Shiftwork, hours of work, early starts, break provision	At a minimum recommend working 3 days per week, 4 hours per shift. The rationale is that this establishes a baseline for capacity, allows sufficient time for re-engagement with peers, and avoids setting up inevitable unproductive outcomes and therefore failure – reinforcing disability Progressing hours should occur rapidly to avoid disability reinforcement, ie. the expectation is to resume usual duties within 8 weeks or review is needed It is best to ensure a full day's work is achieved over at least 3 days rather than part days over 5. This ensures tolerances are reached and avoids the entrenchment of part days spread over a week In shift workers, day time work can be preferable in some cases temporarily as greater potential for adequate support, supervision and range of tasks
Interpersonal Reporting lines, quality of communications, relationships with peers	If relationships are poor, ensure recommendations include reference to setting up communication channels, and that outstanding human resource issues are managed separately to, but concurrent with, the clinical condition This can include strategies for recommended mediation, ensuring the return to work encompasses the employee meeting with supervisor to develop negotiated and agreed strategy plan which includes duties to be undertaken, support, helpful feedback advice and actions to be taken if difficulties arise Recommend if specialist services such as a rehabilitation provider would be helpful to negotiate and support the return to work if there are complex industrial issues present
Safety critical aspects of work Could safety be compromised to self or others due to a medical condition?	For high safety, critical demand jobs in which the distracting effects of pain may pose an unacceptable risk, promote temporary tasks in which existing skills can be used such as support role without primary safety responsibility or avoid temporarily driving or operating heavy machinery

Yellow flags

At each assessment these need to be reviewed and addressed. The New Zealand Guidelines Group provides useful guidelines in assessing yellow flags (www.nzgg.org.nz).

When progress stalls

Psychosocial factors are the main determinants of disability and are significant predictors of prolonged work absence due to simple low back pain.[8,9] Having excluded the uncommon scenario that a red flag condition has developed, consider referral for multidisciplinary specialist pain management intervention. Ensure that this is aligned to your treatment plan in that it is focused upon and linked to the workplace outcomes; includes physical activation and cognitive approaches which identify and replace unhelpful beliefs regarding self efficacy; and promotes self management and positive coping strategies. Treat comorbidities such as depression and anxiety disorders, which can coexist and delay functional recovery.

Resources for GPs

All practitioners can request a kit from their relevant state or territory workers compensation authority which details what resources are available to doctors, what services can be charged for, and where to go for advice. For those GPs who see patients from local industry on a regular basis, a phone call to the employers from whom referrals arise is recommended. Many such employers will pay for a doctor's time to understand the job environment and what duties can be provided to assist in return to work of its employees.

The Victorian Workcover Authority provides guidelines outlining how to get best outcomes working with allied health professionals (www.workcover.vic.gov.au/).

Summary of important points

- General practitioners have a powerful and positive role to play in preventing workplace disability.
- Identifying risk factors for chronicity are as critical as managing the clinical condition alone.
- The primary goal is to ensure all strategies are geared toward maintaining patients in suitable work.
- The longer the patient remains off work the lower their likelihood of resuming work.

Conflict of interest: none declared.

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