

The Treating Physicians' Experiences of the Return-to-Work Process in Thunder Bay

by

Olena Kubrak

A thesis submitted in conformity with the requirements
for the degree of Master of Public Health
Graduate Department of Health and Behavioural Sciences
Lakehead University

© Copyright by Olena Kubrak
September 2011

Abstract

This study explored the experiences of physicians who treat injured workers (treating physicians) and are responsible for providing information to employers and the Workplace Safety and Insurance Board (WSIB) regarding an injured worker's ability to return to work (RTW) following a workplace injury. This study specifically examined the factors that these treating physicians perceived as influential within the RTW process.

Semistructured, face-to-face interviews were conducted during the early part of 2009 with nine general practitioners, four specialists (orthopaedic surgeons) and one physician with expertise in the field of disability management. Interviews were conducted with each treating physician individually in their clinical office. Interviews were recorded and professionally transcribed. A grounded theory approach was used to analyze the findings from these interviews.

The treating physicians identified several factors that I categorized into micro, meso, and macro level factors. At the micro level, the role of the treating physician and the treating physician's view of an injured worker's motivation to return to work and the perception of safe return-to-work emerged as important themes. At the meso level, communication as an overall theme with the frequency of communication, broken telephone syndrome, and facilitated return-to-work coordination as subthemes emerged. Further, at the macro level, the treating physicians revealed that the WSIB process, the social environment of the workplace, and the availability of health care services influenced their experiences with the RTW process and the medical management of the injured workers.

The treating physicians in this study described many challenges to medically managing injured workers following an occupational injury. Improvements were recommended in areas of physician remuneration, stakeholder collaboration, communication between parties,

and facilitation of the RTW process. This study was the first of its kind to interview the treating physicians in a northern Ontario setting. Further research is needed to better understand the experiences of other stakeholders, including injured workers and other health care providers during the RTW process.

Acknowledgements

This thesis would not have been possible without the graduate student award from the Centre of Research Expertise in Improved Disability Outcomes (CREIDO) at the Toronto Western Research Institute, University Health Network. Also, I would like to thank my committee members who supported me along this, at times, challenging path. Dr. Sophie Soklaridis, Dr. David Cassidy, Dr. Elaine Wiersma, and Dr. Joel Andersen. They contributed to this thesis by dedicating their time, knowledge, and expertise.

A special thank-you to my family and my husband for always supporting me and being there for me. Dora Yuen, my friend and classmate who provided guidance and encouragement to me throughout my graduate years.

Lakehead University and its staff members for assisting me and answering any questions I had along the way.

Table of Contents

Abstract	ii
Acknowledgements	iv
List of Tables	vii
List of Figures	viii
List of Abbreviations	ix
CHAPTER 1: INTRODUCTION	1
1.1 Occupational Injuries: Prevalence and Impacts	3
1.2 Disability Management and the RTW Process	5
CHAPTER 2: METHODS	20
2.1 Research Purpose and Questions	20
2.2 Qualitative Research and Grounded Theory	20
Figure I: Treating physicians' perception of the factors that affect the RTW process	23
Figure II: Factors that affect the mix of health human resources and quality of collaboration in interdisciplinary primary mental health-care model (Mulvale & Bourgeault, 2007)	24
2.3 Participant Recruitment	24
2.4 Data Collection	26
Figure III: Individual interview questions	27
2.5 Ethics.....	28
2.6 Data Analysis.....	28
CHAPTER 3: FINDINGS	31
Figure IV: Levels within the RTW process	32
3.1 Macro Level	32
3.1.1 WSIB process.....	33
3.1.2 The Social Environment of the Workplace.....	34
3.1.3 Availability of Health Care Services	36
3.2 Meso Level.....	37
3.2.1 Frequency of Communication.....	37
3.2.2 Broken Telephone Syndrome	38
3.2.3 Facilitated RTW Coordination.....	39
3.3 Micro Level.....	41
3.3.1 Role of the Treating Physician.....	41
3.3.2 The Treating Physician's View of an Injured Worker's Motivation to RTW and Perception of Safe RTW	43
CHAPTER 4: DISCUSSION	46
4.1 Theoretical Framework	47
Figure V: Organization of the RTW stakeholders	48
4.1.1 Macro Level	49
4.1.1.1 The WSIB Process.....	50
4.1.1.2 The Social Environment of the Workplace	52
4.1.1.3 Availability of Health Care Services	55
4.1.2 Meso Level.....	57
4.1.2.1 The Frequency of Communication	58
4.1.2.2 Broken-Telephone Syndrome.....	59
4.1.2.3 Facilitated RTW Coordination	62
4.1.3 Micro Level.....	63

4.1.3.1	The Role of the Treating Physician	63
4.1.3.2	Treating Physicians“ View of Injured Workers“ Motivation to RTW and Perception of Safe RTW	66
4.2	Strengths and Limitations of the Study.....	68
4.2.1	Strengths	68
4.2.2	Limitations	69
	CHAPTER 5: CONCLUSION	70
	References.....	74
	APPENDIX 1	80
	Table I: Claims registered by year of registration (2005 to 2009).....	80
	Physician Demographic Background Checklist: Summary	81

List of Tables

Table I. Claims registered by year of registration (2005 to 2009).....	78
--	----

List of Figures

Figure I. Treating physicians' perception of the factors that affect the RTW process	21
Figure II. Factors that affect the mix of health human resources and quality of collaboration in interdisciplinary primary mental health-care model.....	22
Figure III. Individual interview questions.....	25
Figure IV. Levels within the RTW process.....	31
Figure V. Organization of the RTW stakeholders	47

List of Abbreviations

CMA	Canadian Medical Association
ESRTW	Early and Safe Return to Work
FAF	Functional Abilities Form
GP	General practitioner
HCP	Health care provider
MSK	Musculoskeletal
NEER	New Experimental Experience Rating
OMA	Ontario Medical Association
PubMed	Public/Publisher MEDLINE
RTW	Return to work
SDM	Service Delivery Model
WSIB	Workplace Safety and Insurance Board of Ontario
WSIA	Workplace Safety and Insurance Act

CHAPTER 1: INTRODUCTION

There are approximately 800,000 occupational injuries in Canada each year (Russell, Brown, & Stewart, 2005). Often, the disability resulting from an occupational injury affects a worker's ability to continue working in their preinjury job and necessitates taking time off work for medical reasons. Almost half of all occupational injuries result in workers losing time from work (Russell et al., 2005). Rising costs associated with occupational injuries, estimated at \$10 billion annually in Canada, place increasing demands on workplaces, workers' compensation programs and other insurers to develop a more structured and effective process for assisting workers with occupational injuries in the return-to-work (RTW) process (Guzman, Yassi, Cooper, & Khokhar, 2002). Most Canadians who sustain an occupational injury seek medical attention from their family physicians who are usually the first point of contact following an occupational injury. Workers rely on physicians' expertise for assessment and treatment options (Guzman et al., 2002). Hence, there is a growing need to understand the role of physicians and their experiences in the RTW process.

In this thesis, I set out to explore how treating physicians experience the RTW process in Thunder Bay. Treating physicians include family physicians, orthopaedic surgeons, and physicians with expertise in disability management. Specifically, I have examined the factors that the treating physicians in Thunder Bay identified as playing a role in their decision-making around the RTW process for their patients who have sustained an occupational injury. The treating physicians shared their experiences of RTW practices, and focusing on injured workers with musculoskeletal disorders. This research does not delve into other causes of work disability, such as occupational illness (see definitions in section 1.1).

There is a need to understand RTW issues in northern communities given that these communities face unique socio-economic challenges that may differ from their southern counterparts. In Ontario, close to 250,000 occupational injuries and illnesses were reported in 2009 (Workplace Safety and Insurance Board, 2009). Between 50 and 80% of these workers are chronically unemployed as a result of their injury. A study conducted in downtown Toronto found that 57% of those individuals who were living on the streets had experienced a workplace injury at some point in their lives (Brotchie & Casey, 2008). In Thunder Bay, a recent study surveyed injured workers and revealed that 78% of them are unemployed and 71% had annual incomes below Statistics Canada's low income cut-off line of \$17,895. This places the majority of these workers below the poverty line for Thunder Bay (Brown, 2008). Financial constraints further affect workers' home life, leading to increased instances of divorce, drug use and suicide risk (Brown, 2008). Workplace injury appears to have particularly strong personal effects on the injured worker. Feelings of isolation, depression and increased stress were among the most common personal effects of workplace injury reported by injured workers in Thunder Bay (Brotchie et al., 2008). Physicians, in turn, might be faced with more complicated and complex cases that would increase their workload and stretch their already limited resources in a northern community. Hence, it is of particular importance to understand physicians' experience of RTW considering the depressed socio-economic climate of this geographic area and the obvious hardship this would place on injured workers and physicians.

In this chapter, I will provide an overview of occupational injuries in Ontario. My focus will be on the RTW process, outlining the role of each stakeholder and their interactions with the treating physician. A systematic review of the role of family physicians in RTW was recently completed (Yuen, 2009). My study identifies and highlights the key concepts that were found in

both the systematic review and the interviews. Finally, I will provide an organizational overview of my thesis and its objectives.

1.1 Occupational Injuries: Prevalence and Impacts

Workplace injuries continue to be a common occurrence in Ontario. The Workplace Safety and Insurance Board of Ontario (WSIB) had received 249,477 claims of workplace illnesses and injuries in Ontario in 2009 and 312,315 in 2008 (Appendix 1, Table I). This decrease in the overall number of claims can be attributed to the heightened awareness of specific occupational hazards, improved preventative practices, and accommodations in the workplace. However, the actual length of absence following an occupational injury or illness appears to be increasing. From 1998 to 2005, Ontario has seen a 38% increase in the proportion of injured workers who continue to be on benefits at 12 months post-injury (Ammendolia, Cassidy, Steenstra, Soklaridis, Boyle, Eng et al., 2009). Overall, the majority of the data pertaining to occupational injuries in Canada are collected by provincial compensation boards, which only track injuries that result in a compensation claim. This underestimates the overall number of injuries because research shows that less than half of all individuals injured at work actually file a claim (Wilkins & Mackenzie, 2007).

At a national level, there is no centralized database that collects statistics related to occupational injuries (Wilkins et al., 2007). Limited estimates of occupational injuries can be obtained through the Statistics Canada's Canadian Community Health Survey (CCHS) that gathers cross-sectional information about the health of Canadians every two years (Wilkins et al., 2007). According to the CCHS, 28.3 percent of all injuries in individuals between the ages of 18-75 years old were occupational in nature.

Occupational injuries can potentially have multiple negative effects on the individual, the sustainability of the insurance system and society as a whole. At an individual level, occupational injury may cause the injured worker to experience some level of disability, either temporary or permanent (Black, Cheung, Curson-Prue, Douple, Guirguis, & Haines, et al., 2000). The term „disability“ is defined by the World Health Organization as “any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.”

(International Classifications of Functioning, Disabilities and Handicaps (ICIDH), WHO, 1980)

In addition to affecting functional abilities of an individual, disability that results from an occupational injury may lead to unemployment when an individual can no longer perform their work duties. There is substantial evidence in the occupational health literature to indicate that unemployment and being away from work due to injury or illness, can negatively affect the general health of an individual (Jin, Shah, & Svoboda, 1995; Westmorland, Williams, Amick, Shannon, & Rasheed, 2005). Jin et al. (1995) conducted a systematic review of the literature on the association between unemployment and negative health effects. They found a strong association between unemployment and increased utilization of mental health and general health care services. In a study looking at the negative impacts of work absence due to illness, Ford et al (2000) identified depression and marginalization as the possible negative outcomes of sickness absence. In addition to negatively affecting the individual, absence from work due to illness can lead to loss of productivity, increased costs associated with rehabilitation and compensation of ill employees, and other economic and social burdens that affect organizations and society as a whole (Waehrer et al 2007).

1.2 Disability Management and the RTW Process

Disability management (DM) first emerged in the United States in the 1980s due to an increasing concern about rising costs of disability claims within self-insured workplaces (Westmorland et al., 2005). Although the idea of reintegrating injured workers into the workplace was evident back in the 1940s, legislation prohibiting discrimination against people with disabilities served as a major push for the emergence of DM in workplaces (Baril et al., 2003). Disability management has been described as a “proactive approach to helping injured or ill employees return to safe and productive work activities as soon as medically possible” (Workplace Health, Safety and Compensation Commission, 1999). Presently, DM is recognized and supported worldwide as a strategy for dealing with disabled and/or injured workers.

Most workplace injuries in Ontario fall under the WSIB. The mission of the WSIB is to “promote workplace health and safety, and provide a workers’ compensation system for the employers and workers of Ontario” (WSIB website, 2010). In addition, their vision is to eliminate all workplace fatalities, injuries and illnesses (WSIB website, 2010). The WSIB is funded strictly by employer premiums and no funding is received from the Ontario Government. The WSIB has introduced a New Experimental Experience Rating (NEER) plan which calculates premium refunds and surcharges depending on an employer’s accident cost experience (WSIB website, 2010). More specifically, every individual claim that is made to WSIB is considered and the related costs taken into account before a decision is made about refund or surcharge to the employer (WSIB website, 2010). Hence, there is an incentive for workplaces to prevent occupational injuries and to cut costs associated with occupational injuries/illnesses.

Given the economic incentive for decreasing workplace injuries and lost time claims, early and safe RTW (ESRTW) following an occupational injury has become an important focus

of the RTW process. ESRTW is based on the notion that “the longer an injured worker remains out of work, the more difficult it is to bring about RTW” (Murphy & Rosenblum, 2006). A systematic review of the scientific literature on modified work and its effects on employer and employee supported the positive effect of a modified work program. The main finding of this review was that modified work programs facilitate return to work for temporary and permanently disabled employees. Further, the study showed that employees with access to modified work return to work after a disabling injury about twice as often as employees who do not have access to any form of modified duty (Krause, Dasinger, & Neuhauser, 1998). Hence, it is essential to start planning RTW at the onset of injury and support the worker in returning to the workplace. With ESRTW an offer of modified duties can facilitate the process before complete recovery occurs, where medically possible (Eakin, MacEachen, & Clarke, 2003). A Practical Guide for Physicians, by The Physician Education Project in Workplace Health (PEPWH, 2000), advises treating physicians to include a discussion around RTW as one of the treatment goals and encourages them to have this discussion with the injured worker during their first visit (Black et al., 2000).

In an effort to reduce costs associated with workers remaining away from the workplace as a result of an occupational injury, employers have implemented DM programs by devising and applying a comprehensive RTW plan. RTW plans must be individualized to reflect injured worker’s abilities within the context of the duties available to them in their workplace (Westmorland et al., 2005). The initial and essential step in managing disability is assessing, diagnosis, and establishing a treatment plan for the injured worker. This is accomplished by his or her treating physician, ideally immediately after injury onset. Hence, the treating physician is

seen as a „gatekeeper“ to the services available and necessary in order to support injured worker’s recovery and RTW (Ontario Medical Association, 2008).

The goal of DM is successful job maintenance, or optimum timing for RTW for persons with a disability (Westmorland et al., 2005). There are six key elements deemed essential in the DM approach: 1) DM must be workplace-based, not community-based; 2) the employer must be committed to DM; 3) there must be recognition that work overload and lack of participation in decision-making are linked to health and sickness absence; 4) DM promotes labour and management collaboration; 5) DM includes early medical and rehabilitation intervention; 6) injury prevention is a major component of DM (Westmorland et al., 2005). Although prevention is an important element of the DM practice, once an injury has taken place, a process must be activated to minimize further negative effects on the injured worker, the workplace, and the system as a whole. Minimizing negative effects are needed at both the social and economic levels. Carroll et al. (2010) looked at the cost-effectiveness of RTW interventions and found that early interventions, interventions including a workplace component and having an integrated approach with all stakeholders participating in the RTW interventions were most cost-effective (Carroll, Rick, Pilgrim, Cameron, & Hillage, 2010). Hence, a more systematic and integrated approach is required to reduce the burden of lost income and lost productivity, and creating a more supportive environment for the injured worker.

1.21 Legal background

There are various stakeholders in the RTW process who each have specific obligations and responsibilities. Employees are required to report any injury or illness that they have sustained at work to their employer. Treating physicians are required by law to provide a medical report to their patient when requested. The Third Party Reports Policy from College of

Physicians and Surgeons of Ontario states that physicians are required to supply this report to a third party within 60 days of request (Ontario Medical Association, 2008). When completing the standard Functional Abilities Form (FAF) that is used by WSIB to request information, physicians are asked to provide information that is within their knowledge and can reply “I do not know” to questions that are beyond their scope or knowledge (OMA, 2008).

According to the Workplace Safety and Insurance Act, 1997, employers need to make an offer of modified duties to injured workers and be prepared to accommodate them based on the standard WSIB precautions (Service Ontario, 2010). Employers have a duty to cooperate in return to work by:

- (a) Contacting the worker as soon as possible after the injury occurs and maintaining communication throughout the period of the worker’s recovery and impairment;
- (b) Attempting to provide suitable employment that is available and consistent with the worker’s functional abilities and that, when possible, restores the worker’s preinjury earnings;
- (c) Giving the Board such information as the Board may request concerning the worker’s return to work; and
- (d) Doing such other things as may be prescribed. 1997, c. 16, Sched. A, s. 40 (1).

The Human Rights Code (1990) calls for equal treatment of all employees, regardless of their abilities and states, “Every person has a right to equal treatment with respect to employment without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, record of offences, marital status, family status or disability” (Service Ontario, 2010).

In addition to the broader, overarching legislation pertaining to employment and disability, in unionized workplaces, unions implement collective agreements that include statements about disability and workplace injury.

1.22 Roles of Stakeholders in RTW

It is essential to understand the RTW issues from the perspective of each stakeholder before collectively exploring solutions to improve the process. These stakeholders include injured worker, employer, union (where applicable), WSIB, and treating physician(s). Each party has its unique role in the RTW process and all share a common goal of successfully returning an injured worker to his/her optimal functioning at work (Young et al., 2005). For the purpose of this thesis, I will focus on the role of the treating physician and their interactions with these other RTW stakeholders.

1.23 Role of the Treating Physician in RTW

The treating physicians are an integral part of the RTW process; their assessment of an injured worker's functional abilities to resume work duties determines ongoing benefit eligibility. They also serve as „gatekeepers“ of care and play a role in determining the injured worker's RTW date. Both the WSIB and employers rely on these assessments to determine injured workers' fitness to RTW.

The Canadian Medical Association (CMA) has been fully supportive of physicians' involvement in the RTW process specific to dealing with WSIB claims (Russell et al., 2005). CMA acknowledges the important role physicians play following an occupational injury (Russell et al., 2005). The majority of workers (67%) with occupationally acquired disorders of the upper extremities report their primary care physician or their family doctor as their treating physician

(Feuerstein et al., 2003). The Ontario Medical Association (OMA, 2008) outlined the role of the treating physician in „timely RTW“ with the following points:

- 1) Provide medical treatment in order to achieve optimum functionality and discuss with the patient anticipated recovery and healing times early in the course of treatment;
- 2) Support and encourage the patient to participate in a timely return to work program;
- 3) Provide medical report(s) as per the College of Physicians and Surgeons of Ontario requirements;
- 4) Accept overall responsibility for the patient's medical care;
- 5) Request and help coordinate appropriate auxiliary treatment and rehabilitation services; and,
- 6) Protect the patient's medical confidentiality.

Over the last decade, the escalating number of disability claims has led to an increased demand for information requested from treating physicians by employers and insurance carriers. In addition, there is a growing recognition that ESRTW has multiple societal and economic benefits. Physicians are asked to provide information related to the injured worker's ability to RTW in a form of functional abilities updates (OMA, 2008). Black et al. (2000) have outlined the role of the family physician when caring for injured workers and identified eight main responsibilities. The family physician's role is to assess, diagnose, treat, develop a RTW plan, monitor, report, communicate, and prevent recurrence of the condition in the injured worker (Black et al., 2000). As part of their assessment, physicians must collect the appropriate medical history, conduct a physical examination, and initiate appropriate medical investigations. Assessment is followed by developing a working diagnosis of the condition, which can inform prognosis. This, in turn, enables the discussion around RTW, and whether there is a need to

refrain from working, or whether the injured worker is able to RTW in some capacity (i.e., modified duties). Physicians are required to communicate progress with other parties during the RTW process, including the injured worker, and provide an initial report followed by periodic updates on the condition and RTW status of the worker (Black et al., 2000).

1.24 Treating Physicians and RTW: Key Concepts

A recent systematic review looking at the role of primary care physicians in the RTW process identified eight main concepts (Yuen, 2009). These include: time and incentives, advocacy, knowledge and education, trust and respect, awareness of external factors, process of care, communication, and collaboration. There were four central concepts that emerged from the qualitative interviews from my thesis work that were also presented in the systematic review by Yuen (2009). These four concepts are: i) perceived role of the treating physician in the RTW process, ii) factors affecting RTW, iii) access to care, and iv) communication.

1.241 Perceived Role of the Treating Physician in RTW

Most physicians perceive the treatment they provide related to RTW as driven by the needs of their patients and believe that their main role is to advocate for them (Russell et al., 2005). Physicians have reported that while they focus on restoring an injured worker's ability to function so that his/her overall quality of life can improve and RTW safely, other stakeholders may primarily be focused on timely RTW (Edlund et al., 2002; Russell et al., 2005). Physicians perceive employers as eager to have the worker back at work, performing regular duties, to avoid incurring additional costs associated with absenteeism (Schweigert et al., 2004). Insurance companies, including the WSIB, strive to eliminate injuries as well as minimize the repayment of benefits to injured workers (Russell et al., 2005). Therefore, physicians' strong focus on their patients can contribute to a conflict of interest among stakeholders. This is particularly true

within the guidelines and care processes that are imposed on treating physicians by the insurers (Russell et al., 2005). Treating physicians have expressed their concerns about patient confidentiality when approached by other stakeholders and hence, ensure that they have their patient's consent when disclosing information to other parties (Beaumont, 2003b; Russell et al., 2005). Treating physicians value the doctor-patient relationship and are seen by other stakeholders, mainly the workplace, as not recognizing the importance of early and safe RTW to address the absenteeism cost issue (Baril et al., 2003).

Physicians have reported that their role in the RTW process was unclear and that they lacked occupational health training (Schweigert et al., 2004). In addition, treating physicians admitted to having little to no knowledge of the injured worker's job demands and the workplaces in general (Schweigert et al., 2004). Although workplace-based RTW programs or services may be available to the injured worker, treating physicians are often not aware of such programs, and this lack of knowledge may further delay RTW (Guzman et al., 2002). Some of the negative outcomes of treating physicians' lack of knowledge include: inaccurate diagnoses, numerous medical tests, inefficient or unnecessary delays in treatment, inappropriate description of work restrictions, or improper rejection of modified duties offered by the workplace (Baril et al., 2003; Beardwood et al., 2005).

1.242 Factors Affecting RTW

Treating physicians have reported that there are several factors that have an impact on the RTW process and care provision to injured workers. Individual worker perception of their injury, lack of motivation to RTW and their overall attitude towards RTW were seen by many treating physicians as major obstacles to timely and effective RTW (Anema et al., 2002). Additional psychosocial barriers to RTW were isolated and include: job dissatisfaction, family and personal

problems, conflicts at work, economic incentives to remain off work, somatisation and mental health issues such as depression (Anema et al., 2002; Baril et al., 2003; Guzman et al., 2002; Pransky et al., 2002). Physicians have identified lack of modified duties and having unsupportive coworkers and supervisors as negatively affecting RTW (Guzman et al., 2002; Pransky et al., 2002). Although treating physicians are aware of the external factors influencing RTW, they are not able to address these issues effectively due to lack of time and resources available to them (Beaumont, 2003a; Beaumont, 2003b; Guzman et al., 2002; Pransky et al., 2002).

Time was another concept discussed by treating physicians. They have reported insufficient time to spend on direct patient care due to the extensive paperwork requested by the insurance company, or the employer (Baril et al., 2003; Clarke et al., 2002; Russell et al., 2005; Schweigert, et al., 2004). Concern about the lack of time to gather sufficient information about the workplace has been identified (Baril et al., 2003). Physicians feel more comfortable managing more straightforward injuries rather than more persistent, ill-defined conditions that commonly result from a workplace injury (Russell et al., 2005). In addition to time shortage, it has been shown that physicians need to be adequately reimbursed for their treatment of patients who sustained workplace injuries (Guzman et al., 2002).

Systemic factors such as time-consuming paperwork and treating physicians' perceived lack of transparency within the compensation system are also seen as major barriers to successful RTW (Guzman, et al., 2002; Russell et al., 2005). Some treating physicians see the WSIB system as a "parallel bureaucracy to the normal health care system" (Russell et al., 2005). As possible solutions to these concerns, treating physicians believe that workplaces need to ensure that modified duties are made available and insurance providers streamline the required paperwork to make it more concise and applicable (Guzman et al., 2002; Reynolds et al., 2007).

Treating physicians have reported a lack of knowledge and education in occupational health, which can make them unsure on how to optimally manage injured workers (Clarke et al., 2002). Some treating physicians have expressed a degree of uncertainty about assessing functional abilities of their injured patients (Clarke et al., 2002). Other stakeholders believe that family physicians not only lack the knowledge about patients' job duties, but also are unaware of the benefit of remaining in the workplace in some capacity after an injury, as opposed to being off work completely (Beaumont, 2003a; Beaumont, 2003b). Furthermore, treating physicians are hesitant about encouraging timely RTW after an injury due to misperceived liability issues, particularly regarding cases when injured workers reinjure themselves after being medically cleared to RTW (Pransky et al., 2002).

In order to improve the RTW process, treating physicians need to be better informed about job demands, benefits of modified duties, and the role that other health care professionals play in RTW (Beaumont, 2003a; Beaumont, 2003b; Friesen et al., 2001). Treating physicians could apply strategies to empower their patients to remain at work when functionally possible and particularly when modified duties are available (Clarke et al., 2002). Other stakeholders also might benefit from education and training initiatives that explain their role in timely and safe RTW (Clarke et al., 2002; Friesen et al., 2001; Guzman et al., 2002; Pransky et al., 2002; Reynolds et al., 2007).

Several studies suggest that trust and respect among all stakeholders in the RTW process are important elements and can lead to better results benefiting all parties in the process. Several studies pointed out that it is essential to build trust and credibility among all stakeholders in order to work more effectively when returning injured workers to work (Baril et al., 2002; Clarke et al., 2002; Friesen et al., 2001). Goodwill is another influential factor that affects the dynamics of

the RTW process (MacEachen et al., 2006). One way employers can express their goodwill after an occupational injury occurs is by creating the necessary conditions for a safe and timely RTW (MacEachen et al., 2006). Absence of goodwill jeopardizes worker motivation to cooperate with RTW and can make the worker feel under scrutiny about the validity of their injuries (MacEachen et al., 2006).

1.243 Access to Care

Injured workers have reported difficulties with accessing appropriate assessment and treatment in a timely manner. This further contributed to delays in having necessary paperwork completed by the treating physicians (Baril et al., 2003; Beardwood et al., 2005; Friesen et al., 2001). Other stakeholders have expressed major concerns with wait times for treatment, impediments in communicating information between parties and lengthy treatment periods, which hinder the RTW process (Anema et al., 2002; Baril et al., 2003; Friesen et al., 2001). Regarding the overall treatment process, treating physicians have reported that there is a lack of objective information and a lack of health care access for the patients (Schweigert et al., 2004). It has been shown that injured workers who have early contact with a treating physician are less likely to lose time from work, and if they do, the absence will be shorter in duration (Sears et al., 2007). Early contact with a physician not only helps to ensure that injured workers receive the appropriate assessment and referrals, when necessary, but also that the required paperwork is completed (Sears et al., 2007).

1.244 Communication

Various channels of communication have been identified among stakeholders in the RTW process. These include communication between the treating physician and the injured worker, treating physician and the workplace, injured worker and their workplace, treating

physician and the compensation system, more specifically the WSIB. Treating physicians have reported minimal to nonexistent communication with the WSIB (Russell et al., 2005). The extent of this communication is often insurance forms, which are seen as „burdensome“ (Russell et al., 2005). Physicians are concerned with confidentiality when asked to communicate with the workplace, or the WSIB, but have reported that communicating with other health care professionals, when it does occur, is often quite helpful (Russell et al., 2005). Information provided by physicians on the medical forms is often vague and requires further clarification by other stakeholders (Clarke et al., 2002; Pransky et al., 2002). Several studies have found that lack of communication between the workplace, treating physician and the compensation system may lead to increased difficulties with RTW (Friesen et al., 2001; Kenny, 1995). Physicians have expressed that their preferred method of communication is by fax and, if necessary, phone calls, but majority of communication occurs through the injured worker and via the compensation forms (Reynolds et al., 2007).

Good communication among all parties is fundamental to a successful RTW. Treating physicians need to clearly outline the abilities of the injured worker. Employers, on the other hand, need to communicate the modified duties available, based on the abilities recommended by the physician (Guzman et al., 2002). It has been reported that injured workers are more likely to RTW when treating physicians have an expected RTW date, or encouraged their patient to RTW (Dasinger et al., 2001). However, when underlying physical and psychosocial problems existed in the workplace even this type of communication where physicians encouraged employees to RTW would have a weaker effect on timely RTW (Dasinger et al., 2001).

There is evidence to suggest that collaboration among stakeholders, in addition to good communication, is an important determinant of successful RTW. Physicians believe that working

with other stakeholders, especially the employer, on developing suitable RTW plans will benefit the injured worker and lead to more positive outcomes in their RTW (Reynolds et al., 2007). However, some physicians feel that there is a conflict of interest when it comes to treating injured workers and RTW. Physicians see their main goal as restoring injured worker's functional abilities and improving their overall quality of life. They believe that other stakeholders are strictly focused returning the injured worker back to work (Edlund et al., 2002). For the same reason, physicians are hesitant to engage in full collaboration with the compensation system and even felt "isolated and frustrated" when dealing with the WSIB (Russell et al., 2005). Physicians have expressed uncertainty about their role in the collaboration in RTW (Schweigert et al., 2004), with some physicians determined that they play a role in assessing work disability (Pransky et al., 2002; Reynolds et al., 2007), while others believe that they should not be asked to make RTW decisions (Reynolds et al., 2007). Physicians continue to be asked by insurers and employers to determine RTW abilities of their patients (Reynolds et al., 2007).

Overall, there is strong evidence suggesting more positive outcomes with more collaborative networks among all stakeholders involved in the RTW process (Yuen, 2009). In order to build collaborative networks, it is important to first examine the experiences of each stakeholder in the RTW process. This will allow for a more insightful understanding of the challenges and facilitators that each stakeholder experiences. To date, no study has looked at the RTW experiences of the treating physicians in a northern community in Ontario. Thunder Bay was selected as the location to interview physicians for several reasons. Thunder Bay is the biggest urban centre in northwestern Ontario (City Profile, 2010). Thunder Bay is in a unique position because although it is considered an urban community in Ontario's North, not rural or

remote, it is quite distinct from large urban centres in southern Ontario (City Profile, 2010). Geographically, Thunder Bay falls under the North West Local Health Integration Network (LHIN), which is an organization responsible for planning, integrating and funding many local health services in Northwestern Ontario including hospitals, community health centres, long-term care homes and many others. The boundaries of this region extend from just west of White River to the Manitoba border and from Hudson Bay in the north to the United States border in the south (North West LHIN, 2010). Communities in the Northwestern Ontario are spread across 458,000 square kilometres with portions of the population living in remote areas with road access only in the winter, yet some are only accessible only by air year-round. The population of this region is comprised of individuals of Aboriginal identity (8.3%), Francophone (2.8%), immigrant population (10.5%), yet the majority of the population is English-speaking (84.4%). Fewer Northwest residents have regular medical doctor contact (85.5%) compared to others in the province (91.0%), and only 74.7% individuals aged 12 years and older have had contact with a medical doctor in the past year, as opposed to 81.4% provincially (North West LHIN, 2010). With a population of 122,905, Thunder Bay has a significant shortage of primary care physicians, specialists and other health care professionals.

As a first step to recovery, workers requiring medical attention following an occupational injury usually go to a family physician for assessment, diagnosis, and referral, if necessary. Obviously, inability to access a family physician can affect injured workers' chances for a timely initial assessment and appropriate referral, as well as timely completion of the required WSIB claims forms. Individuals who do not have a family physician are known as "unattached" to a family physician (The Health Analytics Branch, 2008). The treating physicians interviewed for my study estimated that approximately 40 percent of the population of Thunder Bay did not have

a family physician. Data from the Health Analytics Branch of Ontario's Ministry of Health and Long-Term Care support this view. The data indicate that the North West Local Health Integration Network (LHIN) has a significantly higher proportion of unattached population: 13.4 percent, as compared to the provincial average of 7 percent (The Health Analytics Branch, 2008). Thunder Bay, with a population of approximately 122,900, is home to more than 52 percent of the total population of northwestern Ontario (Local Health Integration Network, 2009).

The Government of Canada is committed to improving access to primary health care services by making access the central point of the health care system (Romanow, 2002). In Ontario, primary health care (first-contact services) is currently at the forefront of health care reform. As a solution to the issue of access, the Ontario government has initiated province-wide implementation of family health teams (MOHLTC, 2011). Family health teams (FHTs) are community medical centres employing family physicians, nurse practitioners, registered nurses, social workers, dieticians, and other professionals, and they provide primary health care based on the needs of the community (MOHLTC, 2011). A report by the Health Council of Canada (2009) identified 150 FHTs across Ontario. These centres are especially critical for people who do not have a family doctor.

To add to the challenges that could potentially affect injured workers, there are only seven major employers in Thunder Bay who employ over 1,000 workers. These include one acute care hospital (2,500 workers), municipal and provincial government (3,704), education sector (5,871), and complex continuing care services (1,700). Other smaller employers include telecommunications, construction and services sectors with majority offering manual labour positions (Thunder Bay Community Economic Development Commission, 2011).

CHAPTER 2: METHODS

2.1 Research Purpose and Questions

Little is known about the role of Northern Ontario treating physicians in the process of RTW. The purpose of this study was to understand challenges they face in caring for their injured patients, their role in the RTW process and systemic factors that are implicated in the treatment of injured workers. Since the role of Northern physicians and the RTW process is not well documented in the literature, an exploratory, grounded theory approach was deemed to be an appropriate methodology to explore their experiences. This thesis addressed the following research question: How do the treating physicians experience the RTW process in Thunder Bay?

The objectives of my thesis were:

1. Examine the organizational and systemic factors that treating physicians identify as playing a role in their decision-making around the RTW process;
2. Compare expected and actual roles of the treating physicians;
3. Identify physicians' perspectives on what the barriers are to timely and effective RTW;

2.2 Qualitative Research and Grounded Theory

Qualitative research designs aim to explore phenomena in their natural settings by gaining insight and depth through interviewing and observation (Creswell, 2007). The focus is on the meaning, reality, perceptions, and opinions of participants rather than on gathering numerical data (Kvale, 1996). Hence, qualitative research examines qualities of constructs and is based on the belief that reality is socially structured and influenced by a multitude of variables or situational constraints that shape reality (Denzin, 2005). Unlike quantitative research, qualitative

inquiry explores the processes and meanings of entities and does not measure these in terms of quantity, amount, intensity, or frequency (Denzin, 2005). There are various approaches in qualitative research including narrative, phenomenology, grounded theory, ethnography and case study (Creswell, 2007). This study was conducted according to a grounded theory approach.

Grounded theory is a qualitative design used to construct a theory (Creswell, 2007) and is guided by the promise of advancing emerging ideas (Charmaz, 2006). Data is gathered directly from the participants who have experienced the process being studied hence the theory is “grounded” in the data which allows the researcher to remain closely connected to the topic of interest and develop an integrated network of theoretical concepts. In grounded theory, there is an attempt to generate, discover, or develop a theory by collecting data from participants who have lived the process (Creswell, 2007). A key aspect of grounded theory is the researcher’s attempt to understand the issues under investigation from the participants’ point of view and their ability to relay the meaning of people’s experience (Kvale, 1996). For instance, a researcher studying perceptions of treating physicians of the RTW process would go directly to the treating physicians to ask them about their experiences. Grounded theory is ideally used when exploring a systemic series of actions all directed to some outcome (Denzin, 2005). Grounded theory methods are described as systematic yet flexible principles for gathering and analyzing qualitative data with the goal of constructing theories that are „grounded“ in the collected data (Charmaz, 2006). This methodology was utilized to conduct an in-depth exploration of how the treating physicians experience the RTW process in Thunder Bay, focusing on their perceptions related to this process.

Research in the field of disability management has looked at different aspects of the disability experience. Qualitative, quantitative, and systematic review approaches have been

utilized to explore various topics that relate to disability, particularly how it affects workers. For my thesis, I conducted a literature search of relevant and current articles on disability management. The main databases searched to find articles were PubMed, ScienceDirect, and PsycInfo. The Lakehead University online library search engine was used to find articles. Keywords used when searching included occupational injuries, occupational health, disability management, injured workers and family physicians, vocational rehabilitation, and return-to-work. Relevant journals such as Occupational Medicine, Canadian Family Physician, Journal of Occupational Rehabilitation and Disability and Rehabilitation were researched. The literature search started in September 2008 and was ongoing until August 2010.

From the literature review, the Mulvale and Bourgeault's (2007) collaborative mental health framework was instrumental in helping me to conceptualize my findings, and helped me to develop a theoretical framework for the RTW process that I explored in my study (see Figure I).

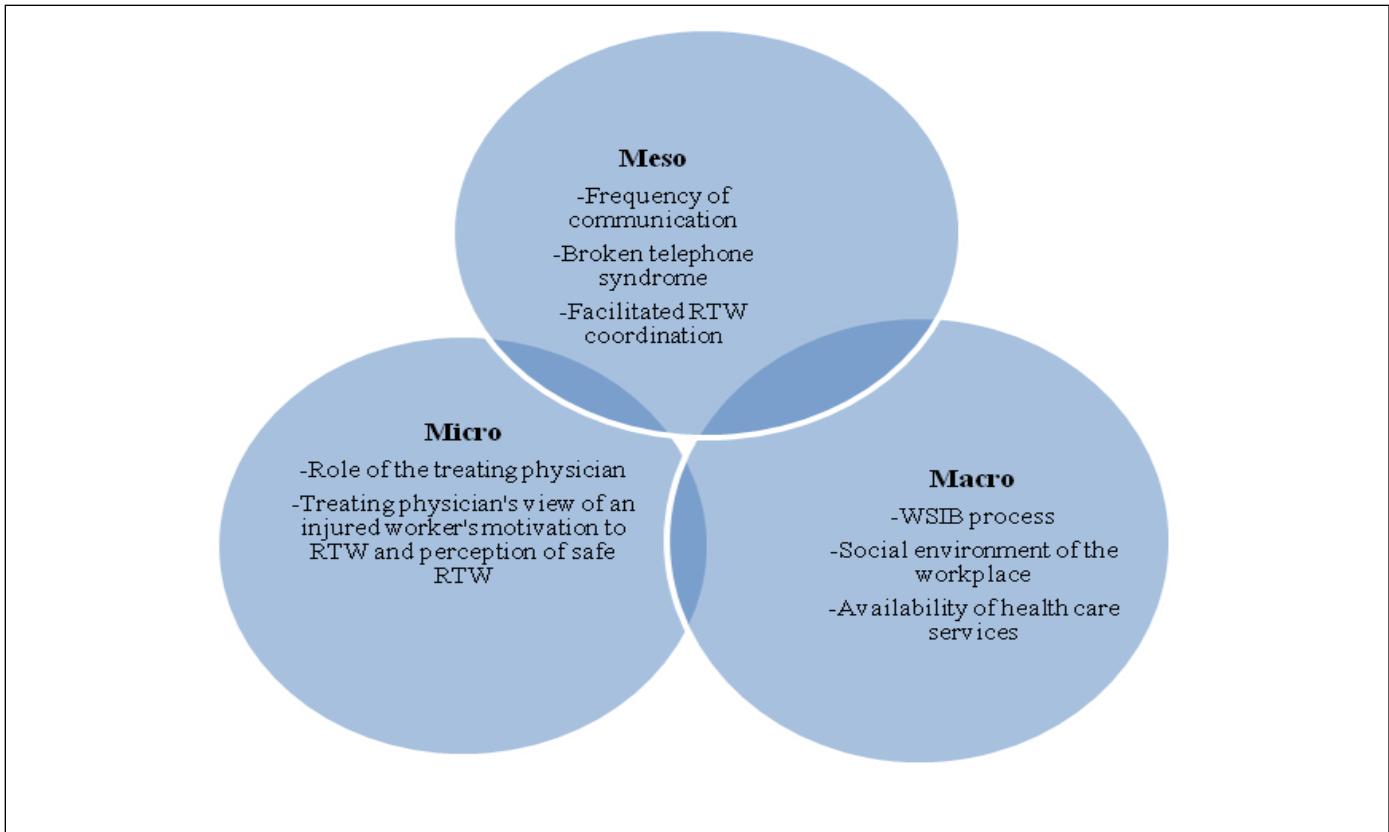


Figure I: Treating physicians' perception of the factors that affect the RTW process

Mulvale et al.'s (2007) proposed theoretical framework was instrumental in framing the findings of my research (see Figure II).

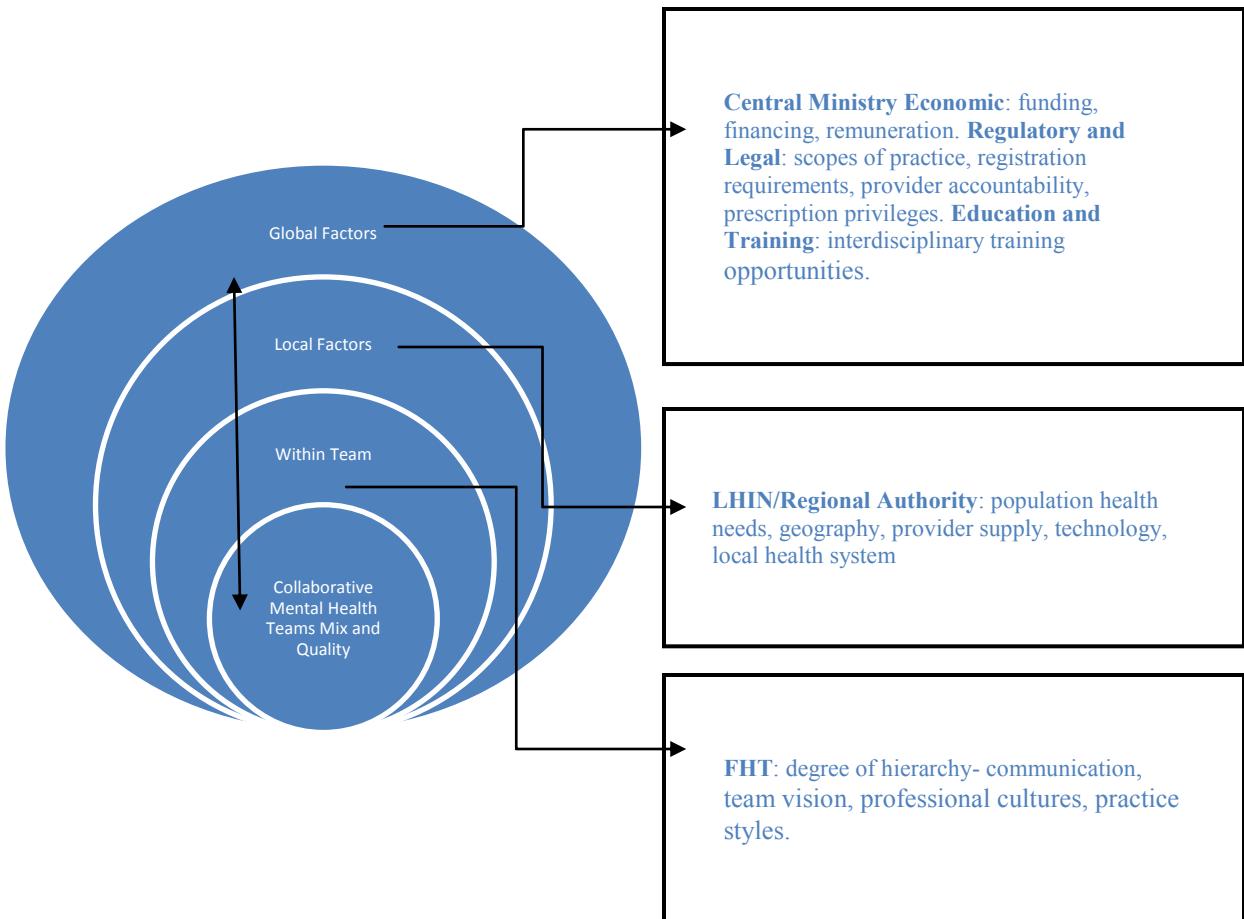


Figure II: Factors that affect the mix of health human resources and quality of collaboration in interdisciplinary primary mental health-care model (Mulvale & Bourgeault, 2007)

2.3 Participant Recruitment

There are various approaches to recruiting participants in qualitative research. Sampling types include: maximum variation, homogenous, critical case, theory based, confirming and disconfirming cases, snowball or chain, extreme or deviant case, typical case, intensity, politically important, random purposeful, stratified purposeful, criterion, opportunistic, combination or mixed, and convenience (Creswell, 2007). These strategies are also known as „purposeful“ sampling within qualitative research, which means that participants are selected strategically based on characteristics that will allow for understanding of the research question.

For this study, both convenience and snowball sampling strategies were used to recruit potential participants. The initial recruitment strategy involved approaching family physicians with an active practice in Thunder Bay directly, i.e., mail-out and/or drop-off in person a package with the study letter and consent. I utilized the “Doctor Search” engine on The College of Physicians and Surgeons of Ontario website to generate a list of physicians. The two main criteria used to search physicians included “Location of Practice”, Thunder Bay, and “Physician Type”, family doctor. This search generated 160 entries. After a thorough review of these contacts, only physicians with a primary and active practice in the city of Thunder Bay were selected. This resulted in a total of 38 family physicians. Eighteen letters were mailed to physicians and 20 were dropped off in person at offices. In one instance, email contact was made with a physician who has expertise in disability management and who agreed to participate in the study. For the most part, this strategy proved to be ineffective. Second strategy was employed after the initial one failed to recruit participants. One family physician was approached during a personal medical appointment and was interested in participating in the study (convenience sampling). This physician then recommended another family doctor working in the same office (snowball sampling). Snowball sampling was used as individuals with knowledge about the process in question know other individuals in the community with similar knowledge and helped to refer those for the study. Snowball sampling is valuable when a researcher can identify cases of interest from individuals who know information-rich participants (Creswell, 2007). No further contacts were made following the three interviews. I attempted to gain access to potential participants through the Northern Ontario School of Medicine at Lakehead University, but no database of physicians in the community existed through the local medical school.

Peer-to-peer recruitment proved to be the most effective way of recruiting physicians for the study. I emailed the President of the Thunder Bay Medical Society, a prominent anaesthesiologist. He sent out emails to the members of the medical society, which resulted in increased response from various physicians, more specifically family doctors, and orthopaedic surgeons. This strategy was successful as the president of the medical society served as a „champion“ who assisted in recruitment through peer-to-peer contact. Initial sampling targeted family physicians, but was later extended to include orthopaedic surgeons due to interest expressed by this group and their involvement in the RTW process. A total of nine family physicians, four orthopaedic surgeons, and one physician with expertise in disability management participated in the study.

2.4 Data Collection

Semistructured, one-to-one interviews were selected as a data collection method as opposed to other traditional ways of collecting qualitative data such as focus groups. Semistructured interviews involve a meeting with a participant, at which time the investigator has a general guide of questions. Although, there is structure to the discussion, the investigator permits flexibility to allow participants to deviate from the general flow of the interview (Creswell, 2007). The interview method was chosen because it was more convenient for scheduling as arranging a meeting time would be a challenge and a barrier to getting a group of participants together.

The interviews were based on thematic questions used to facilitate discussion about the RTW process. The interview guide developed for this study consisted of questions pertaining to the systemic and organizational elements in the treatment of injured workers and the process of RTW. Questions were based on information gathered in the literature review and were modified,

as needed, to ensure that the treating physicians had the opportunity to discuss issues that may not be directly related to the question while keeping within the limits of the research focus (see Figure III).

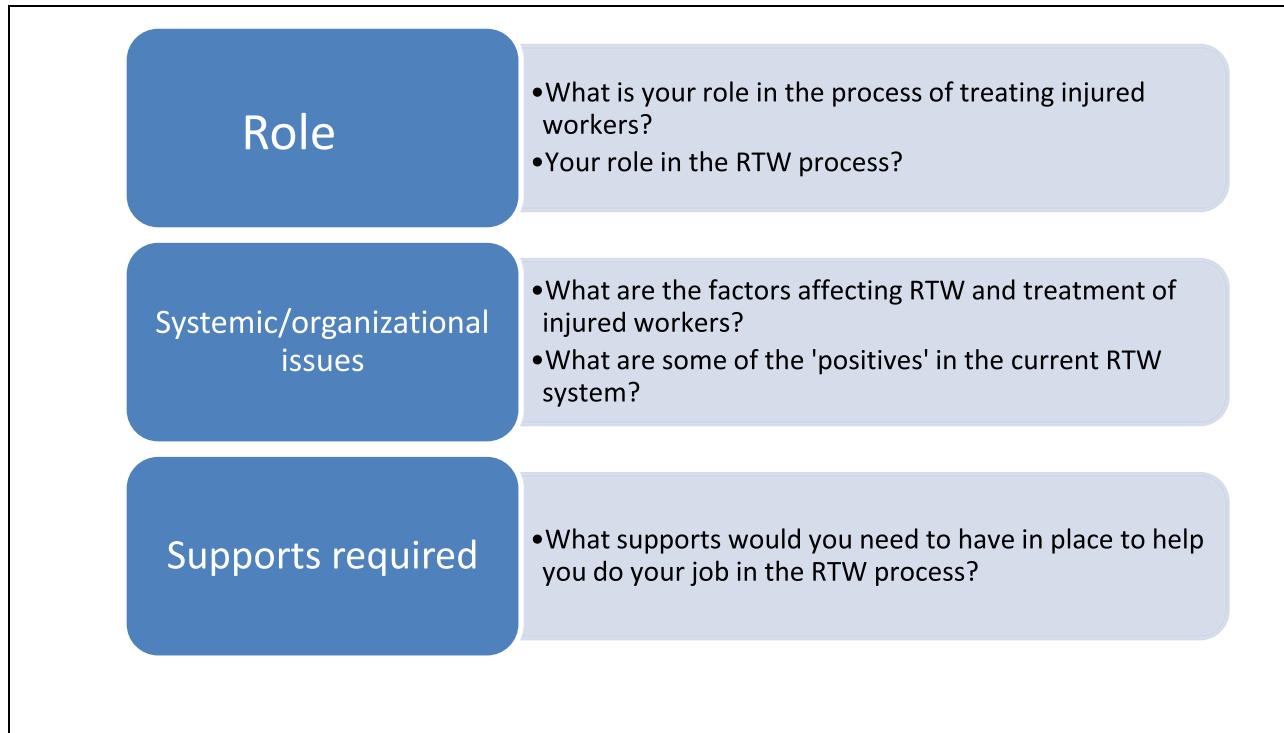


Figure III: Individual interview questions

One-to-one interviews were conducted in a setting that was most convenient for the treating physicians. I interviewed each treating physician in his or her own office. This eliminated any traveling and scheduling conflicts. The interviews took place from October 2008 to May 2009. The treating physicians were informed that each interview would not take more than 45 minutes of their time unless they wished to discuss for longer. In those cases, interviews were allowed to exceed the 45-minute time limit.

Interviews were digitally recorded and transcribed verbatim by a medical transcriptionist. Each treating physician who participated in my study received a \$30 gift card to Chapters/Indigo upon completion of the interview.

The treating physicians were also asked to complete a demographic background checklist (see Appendix 1: Physician Demographic Background Checklist: Summary). The goal was to include practitioners with varying backgrounds, including males and females, experience in treating injured workers, and practice characteristics such as academic, nonacademic, urban and rural, and their specialization.

2.5 Ethics

Ethical approval was received from the Research Ethics Board at Lakehead University prior to initiating study. Physicians were asked to sign a consent form prior to the interview that advised against using names of patients or any other identifiable information about their patients. They were asked not to reveal their name or any details about their identity. Interviews were digitally recorded and the treating physicians' names did not appear on any recordings as per consent. Everyone was assigned a number and interviews were traced to a specific number. All physicians interviewed used discrete language to protect identity of their patients.

2.6 Data Analysis

Interview data was analyzed using a grounded theory approach. As noted by Charmaz (2006), grounded theory consists of two main approaches to collecting and analyzing data, which include constructivist and objectivist views (Holstein, & Gubrium, 2003). The constructivist view focuses on studied phenomena and analyses the data as emerging from the shared experiences of both the researcher and the participants as well the researcher's relationships with participants (Holstein et al., 2003) whereas the objectivist view places more emphasis on the objective facts and assumes that the data already "exist" in the world and are awaiting discovery (Holstein et al., 2003). In the objectivist approach to grounded theory, where "external reality is

awaiting discovery,” the researcher is not the creator of theoretical knowledge, but serves more as a catalyst who records the facts about phenomena and helps it to be discovered (Holstein et al., 2003). This study took a constructivist view as physicians“constructs of the RTW process were explored in-depth and various views were connected in the web of constructs (Charmaz, 2006). Analysis of data occurred in three phases: open coding, axial coding, and selective coding (Creswell, 2007). Initially, data were transcribed by a medical transcriptionist. Transcripts were then examined by the investigator and Dr. Soklaridis during the phase known as „open coding“. Open coding is the initial step in the process of analyzing data and involves reviewing interview transcripts and segmenting them into categories of information (Creswell, 2007). Eight transcripts were read and analyzed with a thesis committee member. Initially, 31 categories emerged from the transcripts. At this stage, we attempted to „saturate“ the categories that emerged by using the constant comparative approach (Creswell, 2007). This process was instrumental in reducing the text to a small combination of themes that describe the RTW process. The distinction was made between work-related and non-work related absenteeism. The RTW process and the stakeholders involved in the process vary when the employee“s disability does not result from work. The role of the treating physician during the RTW process was discussed extensively by participants during the interviews. In axial coding, data were reviewed in relation to the central phenomenon and how these help explain and support it. The themes that emerged were centred on the open coding category to help build a coding paradigm. The next step was to generate schema of a process based on the theoretical model of the RTW process obtained in phase two of the analysis. In this phase, themes were interrelated at a broader level.

It was imperative to account for my own biases while analysing the data. In grounded theory research, data must be generated and rooted in the responses from the participants who

have lived the experience (Creswell, 2007). This can be a challenge as a person conducting the interviews is never a “neutral tool,” but rather has his or her own biases (Creswell, 2007). As an Occupational Health Nurse, I have knowledge about the RTW process from an employer perspective and have worked with treating physicians while returning injured workers to work. Hence, I have my own understanding of the role of a treating physician in the RTW process.

However, prior to carrying out the study, I identified my role in the research process as an investigator who collects data and facilitates discussion during the interview process. When analyzing transcripts, Dr. Soklaridis who is a social scientist, read and reread the transcripts together with me. This was instrumental to ensure that data was interpreted in a less biased way, from a “grounded” stance. In qualitative research, it is essential to understand and learn the phenomena from the participants’ perspective, not allowing personal preconceived notions and biases to guide the knowledge acquisition. It is imperative for the qualitative researcher to be aware of his or her own biases in order to check them as the collected data are analyzed. This allows the participants to paint the picture through their own experiences and perceptions with the researcher serving as a conduit of participants’ ideas (Creswell, 2007).

QSR NVivo 8 software was used to analyze and code data. With this software, I was able to import, sort and store data in a more organized, structured way. Each transcript was coded and quotes from each transcript were transferred into corresponding theme folders in NVivo.

CHAPTER 3: FINDINGS

The total number of treating physicians interviewed was fourteen. Nine were family physicians, four specialists, and one physician with expertise in disability management. There were eight females and six males. The majority were 45 to 54 years of age (refer to Appendix 1, Physician Demographic Background Checklist: Summary). One physician received his medical education outside of Canada while all others studied at medical schools across Canada. Physicians' years of experience in their field varied widely from 2.5 years to 33 years in medicine. For all treating physicians, the primary location of practice was Thunder Bay.

Data collected from qualitative in-depth interviews with the treating physicians was analyzed and produced a number of themes relating to the return-to-work process. These themes were organized into three levels of systems. A conceptual model was developed and consisted of macro, meso, and micro levels (refer to Figure IV). The following three themes and related subthemes emerged from the data:

1. Macro level
 - WSIB process
 - Social environment of the workplace
 - Availability of health care services
2. Meso level
 - Frequency of communication
 - Broken-telephone syndrome
 - Facilitated RTW coordination
3. Micro level
 - Role of the physician

- The treating physician's view of an injured worker's motivation to RTW and perception of safe RTW

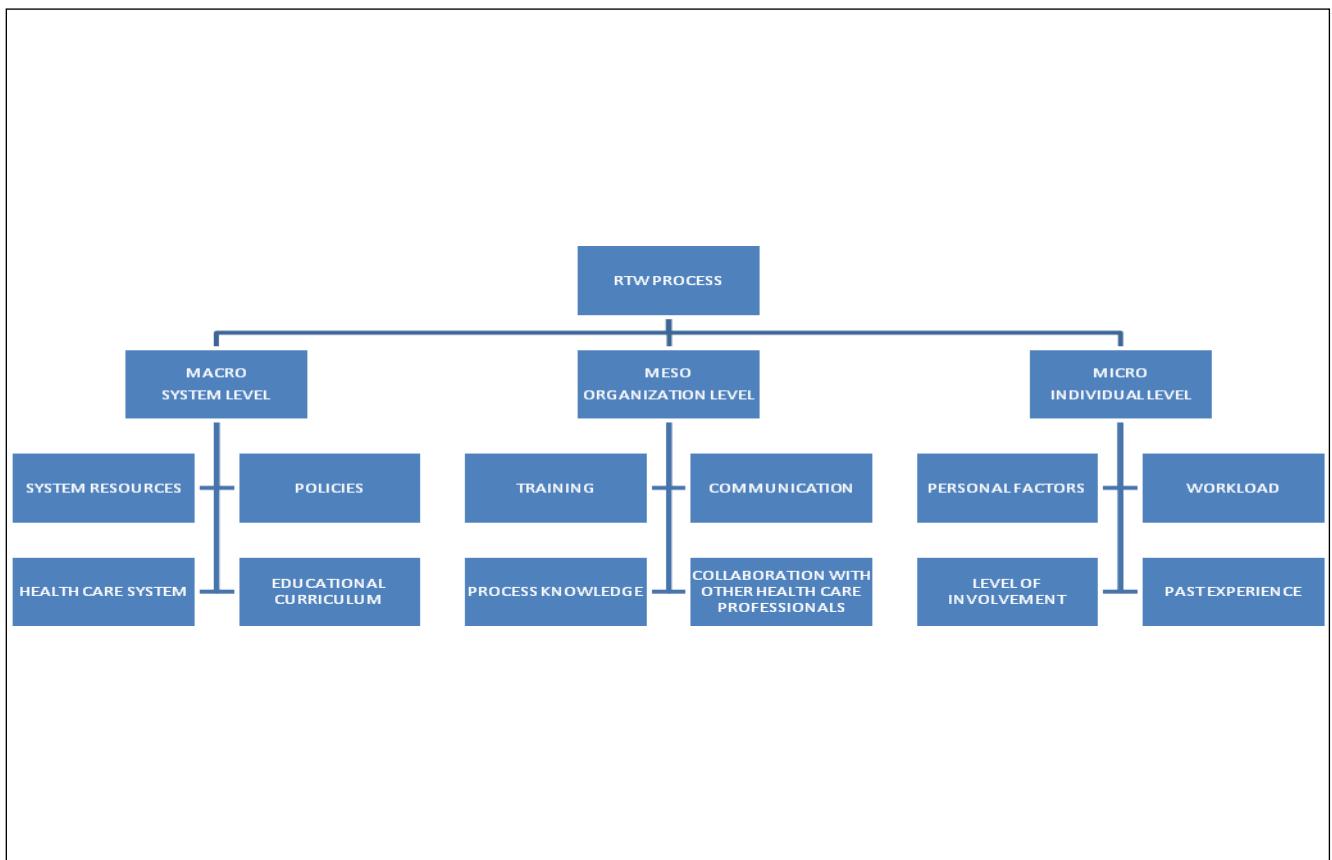


Figure IV: Levels within the RTW process

3.1 Macro Level

This section includes issues residing at the system level that were deemed influential in the RTW process by the treating physicians. There are three subthemes and they include the WSIB process, the social environment of the workplace, and the availability of health care services.

3.1.1 WSIB process

According to the treating physicians interviewed, they experience challenges in understanding and navigating through the WSIB claims process. They described feeling disconnected from the claims process, particularly when they filed a claim and the outcome of a claim was not in support of their recommendations. According to this treating physician it was difficult to understand why some claims were denied:

I filled out the forms, I mean my opinion that this is work related and stuff and so it is frustrating, you don't really know what more you can do for the patient because you don't even know why they decided that or how their physician is looking at it.

The treating physicians perceived that this frustration was partially a result of not understanding the WSIB claims process. They described how the compensation system was not always transparent with their decision-making process. This was particularly troubling to the treating physicians interviewed because they described following all the “right” steps to ensure the success of a claim:

So it is frustrating not really understanding how WSIB works because I don't know. I mean you fill out the forms and they get sent away and you just take for granted that everything is falling into place and they [patients] get what they need but when the patient comes back saying, „Well I'm getting cut off, you know from my physiotherapy in a couple of weeks and it got denied as a WSIB injury.“ . . . I don't really understand.

The treating physicians also described how their patients seemed to experience similar challenges understanding how the WSIB process works. The lack of transparency regarding the claims process suggested to them that their patients’ injury claims were not believed by the WSIB. This physician stated the following:

I feel like I'm not being heard and the patient is not being believed for their injury and then you know, it's really frustrating. I've had grown men cry in my office because of the treatment they've received through WSIB.

Many of the treating physicians described how even the WSIB did not seem to have the mechanisms in place to process complicated claims. According to this treating physician, patients who have chronic conditions have the most difficult time with the claims process:

I mean it's [WSIB] a business. They will accept the claims that are cut and dry and as I say usually it is that way and there's no problem but in some other complicated patients where maybe they've had some other injuries and had some other WSIB claims and they look for any reason to kind of [deny the claim].

To help injured workers navigate the WSIB system one treating physician suggested developing a program that will support and advocate for these workers:

[It] would be good if there was some sort of program that WSIB had that can assist in a nonjudgmental way like with the forms or with sort of navigating the system. I feel that some people for whatever reason, may not have the cognitive ability, may not be as organized to be advocates and they really are uncertain as to what to do or how the process works and if there was somebody dedicated, like social workers through the program that can assist them to make things easier, I think that would be really helpful and advocate on their behalf. I feel like it's sort of like us vs. them but really if they assisted the worker and to navigate that process would be really helpful.

3.1.2 The Social Environment of the Workplace

The majority of the treating physicians described how delays in the RTW process were often a result of a lack of consideration for the social environment of the workplace. The treating physicians emphasized the importance of understanding the psychosocial factors that may impede RTW at the workplace. For example, several treating physicians described the significance of social relationships in the RTW process. From the treating physician's perspective, a happy worker returned to work earlier than workers who lacked social relationships:

I mean as a physician [I know], when the social environment is positive, people are raring to get back to work and they want to get back to work. They get back to work. So if people perceive the workplace to be hostile they are much more reluctant to put themselves into that situation and then you know after they have been away for a long time and then they get frightened to go back.

The treating physicians described the impact that an „environment of hostility“ at the workplace can have to the RTW process. They explained that when employers are resistant or state that they are unable to provide modified work for injured employees, this created an environment where the injured worker feels unwelcome. One treating physician described how some employers expect employees back to work only after full recovery:

The other problem that has to be considered is some employers are rather reluctant to take a worker back unless the worker can guarantee that he has completely recovered which may not be the case.

The treating physicians believed that this negatively impacted on the worker’s willingness to RTW. According to several treating physicians, workers requiring modified duties were afraid to go back to work:

One of the problems with an individual returning to work may be that they perceive that everybody else on their work team is against them, you know... [Patients think], “I can’t do it [go back to work], they [supervisor and colleagues] are all going to turn on me and shoot me or they are going to turn on me and say that I’m a bad worker or that my supervisors are going to say that if I can’t go back 100% then don’t bother going back at all.” And that’s what you hear workers say frequently; I can’t go back to that workplace unless I’m 100% because it’s dog-eat-dog in there.

One treating physician believed that the WSIB does not account for and fails to recognize these workplace issues and their impact on RTW:

Workplaces that would be more able to help identify social problems in the work place that are barriers to return to work, you know, sort of if you feel that your colleagues are not supportive of your return to work or if there was a dysfunctional workplace, there is no mechanism within workmen’s compensation to really address that.

Overall, the majority of the treating physicians believed that the social environment was the single most important factor that influenced the RTW process, after an injury and/or illness:

No, like I say, the biggest thing is, if workers compensation is really trying to get people you know back to work, a big piece that gets left out completely in the workers compensation process is the social environment at work.

3.1.3 Availability of Health Care Services

The availability of health care services, particularly a lack of family physicians, was often cited by the treating physicians as a factor that may delay or impede the RTW process. Perhaps unique to more rural and remote areas, several of the treating physicians were concerned with the lack of family physicians in Thunder Bay. If injured workers were not able to see a physician in a timely manner, it impacted on RTW and recovery:

If you think that 30 or 40 percent of the people in Thunder Bay don't have a family doctor, what happens to those injured workers... that cannot get in to see a physician to submit documentation that they are off work and need treatment and be compensated for the period of time they are off?

Although not having initial access to a family physician, other health care services, such as physiotherapy seemed to be available, especially when claims were accepted. In terms of access, some treating physicians believed that WSIB claimants had quicker access to care than individuals accessing care through their private insurance. Several treating physicians stated that if the work-related injury was approved by the WSIB, there was quick access to physiotherapy and specialist care:

Delay in access of physiotherapy, delay in access to orthopaedic referrals, limitations around especially if patient's, if WSIB once they have accepted a claim, it is pretty good providing access aid to specialty clinics like hand and upper limb clinic and places like that but until they are accepted by WSIB there are economic barriers in being able to access you certain kinds of physiotherapy.

One treating physician expressed that the communication and the partnership between the treating physician and the physiotherapist have become stronger over the years in Thunder Bay:

"The physiotherapists are more proactive now so I do more often now get phone calls from physiotherapists locally that say family doctor doesn't want to investigate or the patient has been told that everything is okay. I think they have this, how do I go about pushing them through. So there are more of the allied services, you know, personnel that are a little bit more in tune with what they need to do and what the time urgencies are and that's really improved over the last 12 years."

3.2 Meso Level

Communication was the main theme that surfaced at the meso level. The subthemes emerging from discussions with physicians centred on the following: frequency of communication, broken-telephone syndrome, and facilitated RTW coordination.

3.2.1 Frequency of Communication

The treating physicians described how communication with the WSIB was very rare and only occurred in cases when the claim was deemed problematic, i.e. no easy resolution can be found. When the treating physicians were asked about the frequency of their communication with WSIB, one treating physician replied with the following statement: “The WSIB representatives [contact the physician] infrequently. Usually only if they perceive that it is taking too long or there is a problem.”

Another treating physician concurred that communicating with the WSIB was triggered only when there were discrepancies with the claim. According to this treating physician: “I phone them [WSIB] every once in a while. . . . If I find there is a great discrepancy in what’s actually happening and what should be happening, I will phone. And usually it gets straightened out.”

The treating physicians were specifically asked about the frequency of communication with the workplace, i.e., occupational health nurses, disability management professionals, human resources representatives, and supervisors. One treating physician gave a brief, but very concise answer when questioned about communicating with the workplace and replied, “Very rarely.”

The WSIB has a physician on staff who assesses the more “complex” claims; those requiring employees to remain off work longer than a predetermined number of days based on their disability. Most treating physicians interviewed stated that they have never had contact with

the local WSIB physician. One treating physician expressed the need to increase visibility of the WSIB physician in the medical community and engage in more direct communication:

“Having contact and knowledge of a local WSIB associated physician would be helpful. I understand that there is one but I have only heard of this from a WSIB presentation that I went to at summer school two years ago. But that [WSIB] physician was not present.”

3.2.2 Broken Telephone Syndrome

The lack of direct communication between the WSIB, the treating physician, and the employer can result in information being missed and misinterpreted. According to the majority of the treating physicians, indirect communication contributed to the “broken telephone syndrome.” They described situations whereby they would get updates regarding the WSIB process through their patients. The treating physicians identified that having the patient as the “messenger” was not an effective way of communicating. The majority of the treating physicians explained how patients had their own interpretations of events, which were often different than the WSIB’s interpretation. As this treating physician stated:

The patient ends up coming and telling me stuff. . . . I actually get the patient to come regularly when they are under WSIB just because I want to know what’s going on between WSIB and them because what’s going on between WSIB and them, that whole communication thing is often quite different than what I am receiving from WSIB and what actually is happening to the person is important to me.

Another treating physician expressed the difficulties in understanding the process when communicating with WSIB, particularly when the injured workers served as the “messengers” of information: “I have patients state bizarre things about what WSIB has told them. Like it is just nice to be on the same page with them [WSIB].”

Much like the communication with WSIB, communication with the employer was seen as an important element in the RTW process and was perceived as lacking in most of the interactions discussed by the treating physicians. Similar reports were made by the treating physicians noting that employers do not contact physicians for/with updates, but rather

communicate through the injured worker. Another treating physician expressed the frustration of having to communicate with the employer through the injured worker instead of communicating directly with the employer. In the absence of direct communication, the treating physicians felt that things were getting lost and misinterpreted.

It's just frustrating when the patient comes back, my employer told me this, and you don't hear anything from the employer. It's all passed on second party through the patient, so is that true, was that misinterpreted, what do they [workplace] want from me [physician]. Now I don't know what to do. So, I guess if there could be improved communication when the employer is not able to provide modified duties as per my request, instead of just passing it through the patient and putting the patient right in the middle of the whole communication. And that's like playing telephone. Things get messed up when you don't have direct communication.

Several treating physicians pointed out that the doctor-patient communication was vital to the RTW process. The treating physicians described having an interest in the RTW process, but they lacked the direct communication needed for taking on a more active role in returning injured workers to work. Despite their busy schedules, several treating physicians acknowledged the need to improve communication with the various stakeholders through more direct communication and by relieving the patient of the responsibility to serve as the "messenger." One treating physician explained: "But the reality is everyone is busy, running in 10 different directions, but if there was some more direct communication, that would be helpful from the employer to the WSIB, and the WSIB back to you [physician]."

3.2.3 Facilitated RTW Coordination

Although most treating physicians described how communication, albeit rare, usually resulted in clarity around the claim, they felt that from the patient perspective, a lack of communication contributed to anxiety in the injured worker.

You need to have continuity that comes with proper communication between all the parties involved. The patient will get more anxiety. Of all the relationships of him getting better between him and WSIB by far is the hugest source of anxiety for that person. That's my opinion based on what I've seen over many years of dealing with people.

The treating physicians, in general, expressed the need to be more involved in injured workers’ care and identified communication as one of the steps to becoming more engaged. The treating physicians wanted to be included in the communication circle along with the injured worker, the WSIB, and the employer. When asked to describe how to improve communication between stakeholders, one treating physician described the role of having a “third party” facilitator to meet with all parties and facilitate RTW with the physician and employee present in the same room:

Or whether instead of the patient going to see this WSIB advocate or whatever, that maybe the advocate could come and see me with the patient. That would be useful because then we would all be in the same room at the same time talking the same language.

This individual, perhaps a social worker, would advocate for the injured worker and help them navigate the system.

What would be good if there was some sort of program like that WSIB had that can assist in a nonjudgmental way like with the forms or with sort of navigating the system, I feel that some people for whatever reason, may not have the cognitive ability, may not be as organized to be advocates and they really are uncertain as to what to do or how the process works and if there was somebody dedicated, like social workers through the program that can assist them to make things easier, I think that would be really helpful and advocate on their behalf. I feel like it’s sort of like us vs. them but really if they assisted the worker and to navigate that process would be really helpful.

Another treating physician mentioned a similar service available through an insurance company when employees are off work on short/long term disability rather than on WSIB: “Sometimes with insurance companies they will have an intermediary kind of person who will actually come with the patient and agree to a treatment plan and follow through with it.”

Some treating physicians felt that they mainly are responsible for advocating for their patients and that their patients rely on them to a large extent when navigating through the WSIB system. Hence, it would be beneficial to have that additional person who has the knowledge,

expertise and most importantly the time to help injured workers get back to work after a workplace injury.

Well somebody that would be another additional advocate for the patient because I feel like I only can do so much for them, like I expect them to bring the form, or I expect certain things, like I feel a lot of patients rely on me for that, but the reality is they need to have discussed things with their employer or what-not so you know, I don't think they understand the process. I think it can be confusing, so if there is somebody that can help sort of facilitate that, like some social worker. Again with some of the skills on you know other employment opportunities, financial, other sort of avenues they can go with the system through the process, I think that's a big thing and then maybe advocate for them for you know, speeding along some of the process.

One treating physician stated that the person involved in RTW would need to have some medical knowledge to review medical documentation and assist with RTW:

I need to be able to have people who are receiving my notes actually have medical training instead of clerical training. So that when I have the case worker who has perhaps minimal to no medical training asking me questions, I don't have to spend the time explaining the medical facts to them.

3.3 Micro Level

At the micro level, two central themes were identified. The first theme is the role of the treating physician in the RTW process and in the treatment of injured workers. The second theme is the treating physician's view of an injured worker's motivation to RTW and perception of safe RTW. The micro level is concerned with personal beliefs and attitudes, more specifically how the treating physicians perceive their role in the RTW process, and how the treating physicians view an injured worker's motivation to RTW and the perception of safe RTW as a factor in the RTW.

3.3.1 Role of the Treating Physician

The treating physicians felt that their role in the medical management of injured workers was to diagnose and prescribe appropriate treatment. When asked to describe their role in the

RTW process, one treating physician gave a very concise answer, stating: “Basically my job is to help the patient get better, that’s my job.”

The treating physicians believed that early RTW occurred only after diagnosis and treatment have been established to allow the injured worker to start appropriate work given their fitness to RTW. This treating physician described the role in the following way:

To make the diagnosis early and provide appropriate treatment early, so that I can get them back to work as early as possible. On the other hand, I kind of consider myself a little bit of a barrier, a protection from their employers and even workmen’s comp because they are often told or forced to go back to work to [in]appropriate work or work too early or work too often, and so I kind of consider myself more of a patient advocate than a work advocate.

Most treating physicians perceived their role as an advocate, where they “protect” the injured worker from the WSIB and their employer, especially if they felt that RTW was too quick and functional abilities have not been restored to the required level. The role of patient advocate was frequently mentioned by the majority of the treating physicians. According to this treating physician: “Well my role is I think I would advocate largely for the patient in terms of restoring them to their previous medical condition before the injury. That would be my ideal goal.”

The treating physicians discussed the importance of focusing on the patient, but also moving beyond the injury to consider the abilities of injured workers who may need additional supports, such as extra training, to be functional at work: “To get them better and get them back to work and if they can’t get back to work, to advocate for retraining.”

Most treating physicians alluded to the fact that treatment of injured workers and RTW are time-sensitive and stated their goal was to advocate in a timely manner: “My role is diagnosis of the injury and treatment of the injury and you know being a facilitator in trying to get them back to work as soon as possible.”

One treating physician identified that a physician's role is also to identify the workplace-related nature of injury. Depending on the nature, the process and subsequent steps will vary.

This specialist stated:

I would see it certainly involving initial diagnosis of any condition that may have resulted from a workplace injuries, and along with that assessment and part of the diagnosis, trying to identify whether or not the workplace actually played a role. For example, some patients will sometimes come to me with an overuse type injury and will maybe not identify that it is related to their workplace necessarily so I think part of that role in diagnosis is also identifying whether or not the workplace may be contributing or responsible for an injury. And then following through from that you know, ordering appropriate investigations and studies to deal with the issue and recommending treatment that hopefully will be supported by workplace insurers and that sort of thing.

3.3.2 The Treating Physician's View of an Injured Worker's Motivation to RTW and Perception of Safe RTW

Several treating physicians felt that the duration of time off work and the RTW process were related to injured workers' motivation to RTW. Motivation to RTW was perceived as dependent on factors such as enjoying one's work and getting paid well to do their job. This treating physician felt that these are important elements in the motivation to RTW:

It [RTW process] depends on the patient's motivation so you know, some of them get paid well, they do very well and it works well and they get back to work and they like to go into work so those people do well.

However, other factors such as the perception of their injury can play a role in injured workers' readiness to RTW. One treating physician felt that injured workers needed to be reassured that it was safe for them to RTW: "[I need] to reassure the injured employee that there is nothing serious and that they can go back to work."

Another treating physician felt that employees can successfully return to their job only after they have recovered from their injury to a degree where they feel safe to RTW and feel that they will not sustain this or similar injury again: "For the patient, I think that the patient is

satisfied that they have recovered to the ability that they can do their job again without fear of reinjury.”

Macro, meso, and micro level themes come together to shape the RTW process. The treating physicians identified that at the macro or system level, the WSIB process, the social environment of the workplace and the availability of health care services influence the RTW process. The WSIB process refers to the practices in place where the treating physicians, injured workers, the workplace and the WSIB work on returning an injured worker back to work. The treating physicians concluded that many gray areas exist in the WSIB process, which creates greater challenges when treating injured workers. Another influential factor in the RTW process was the social environment of the workplace. The treating physicians emphasized the importance of considering the psychosocial aspect of returning to work and identified the gaps that exist in the current system in addressing these issues. In addition, an overwhelming proportion of the population in Thunder Bay does not have a family physician. This means that an injured worker who does not have a family physician will delay seeing a physician for assessment, diagnosis, and treatment. Having timely access to appropriate health care services is critical with RTW.

The treating physicians described various elements that they perceive as influential in their medical treatment of injured workers. These elements, seen as either challenges or facilitators, in the RTW process and the medical treatment of injured workers fell into one of the three levels of influence- micro, meso or macro. At the meso level, the treating physicians reported that infrequent communication among stakeholders, which often led to misinterpretation of information, was a major drawback in the RTW process. A suggested solution to this problem was having an individual who would facilitate and coordinate the RTW process. At the micro level, the treating physicians discussed their role in the RTW process and their view of an injured

worker's motivation and perception of safe RTW. The majority of the treating physicians saw their role as a patient advocate, in addition to being diagnosticians. Furthermore, injured workers' perception of their injury and motivation to resume work were seen as the determining factors in RTW. The treating physicians reported that workers who enjoyed their work and believed that it was safe to return to the workplace were more motivated to RTW.

CHAPTER 4: DISCUSSION

The treating physicians in this study discussed what they considered to be influential factors in the medical management of injured workers following an occupational injury. I grouped these factors into three main categories that further shaped my theoretical framework of treating physicians’ experience of the RTW process following an occupational injury: macro, meso, and micro. These three levels (see Figure IV) collectively influence the process of RTW and the medical management of injured workers, as described by their treating physicians.

In my study, the treating physicians emphasized that medically managing injured workers and assisting them in their RTW was a complex and dynamic process that went beyond the simple physician/worker relationship. Numerous stakeholders are involved in the process, and each has their own roles and agendas that at times can seem misaligned with those of the treating physician. Although the treating physicians were clear on their role specific to addressing the injury (i.e., diagnosis and treatment), they struggled to understand where they fit within the RTW stakeholder circle. They described the various challenges in defining their role in the overall RTW process.

Established organizational and systemic structures exist to guide the care that treating physicians provide to injured workers. For example, their role in the RTW process has been defined by sources such as the Canadian Medical Association (CMA) and the Ontario Medical Association (OMA). However, the treating physicians identified several gaps between their role as prescribed by their professional associations and the role that they actually practise when treating and managing occupational injuries. The in-depth interviews provided a forum for them to express insightful and meaningful views of the challenges they encountered when providing care to injured workers and assisting with RTW.

4.1 Theoretical Framework

The collaborative mental health framework (Mulvale & Bourgeault, 2007) assisted me in understanding how factors at different levels of influence interacted and to see the gaps in the current administration of the RTW process in northern Ontario. In this framework, the authors discussed a network of agents, at various levels, that can mesh to form collaborative mental health teams. They emphasized the need for collaboration to exist among mental health service providers. Although these individuals may come from different disciplines, they work together on a common case to achieve a certain goal. This interdisciplinary collaboration results in a network of service providers whose goal is to provide mental health services to clients in need.

The RTW process can be seen in a similar fashion. As in Cartmill et al.'s (2011) example, the RTW process examined in my thesis also involved stakeholders from diverse disciplines and professional backgrounds who could be brought together, forming a transdisciplinary team, with the common goal of assisting the injured worker return to work. By definition, a transdisciplinary team shares expertise among its members and is thus instrumental in providing a more holistic approach to care (Cartmill et al., 2011). Key elements of such sharing would include identification of common, client-centred goals, and engaging in free-flowing communication about the case at hand (Cartmill et al., 2011). The treating physicians in my study agreed that stakeholder interactions were fundamental to the RTW process; to facilitate a successful RTW, stakeholders needed to engage in continuous dialogue and ongoing collaboration.

In the RTW process, the injured worker is at the centre of the process (see Figure V), and other stakeholders, including the treating physician, play a role in assisting the injured worker in

returning to work. The elements of the network are present, but the pathways between them are not well enough established. The findings from my thesis show that interconnections between key stakeholders were not strong. Although these stakeholders were present in the process, they did not collaborate with one another, and they did not take a transdisciplinary, teamwork approach to returning injured workers back to work.

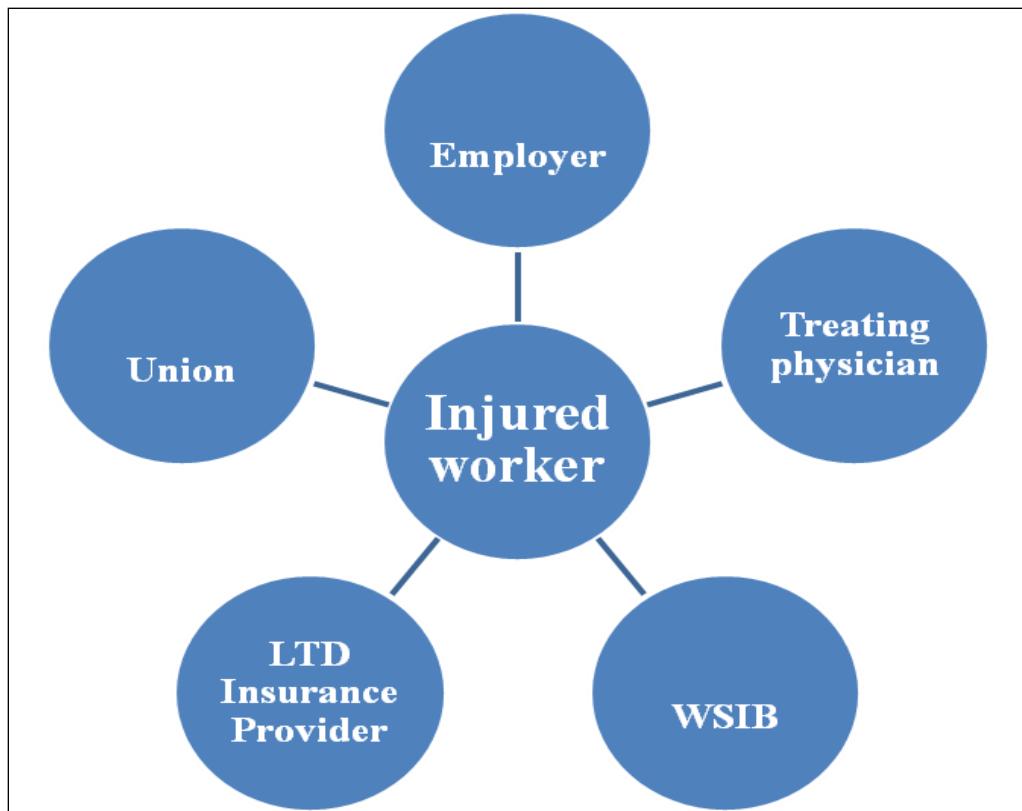


Figure V: Organization of the RTW stakeholders

One of the main objectives of my study was to explore the elements that facilitated (facilitators) and elements that inhibited (barriers) the RTW process, from the perspective of the treating physicians. Mulvale et al. (2007) examined facilitators and barriers within the mental health care delivery system and identified three major categories: global, local, and within-team categories. Similarly, the RTW process examined in my study uncovered factors that can be

categorized at three distinct levels—macro, meso, and micro—which interact and influence the treating physician’s overall experience of treating injured workers and the process of RTW.

The macro-level factors in my study corresponded to the Mulvale et al.’s (2007) global factors. Macro-level factors are constituted by elements such as the social environment of the workplace and the availability of the health care services and as such are generally considered to be beyond the influence of the individual treating physician. They exert their influence on a systemic level. The meso-level factors in my study corresponded to Mulvale et al.’s local factors. They exerted their influence on both organizational and interpersonal levels. Communication among stakeholders as a group, in general, and between the treating physician and the rest of the team, in particular, were central to understanding the barriers and facilitators at the meso level. Lastly, the micro-level factors in my study corresponded to Mulvale et al.’s within-team category. These were directly driven by the individual’s knowledge, skills, and attitudes regarding the RTW process. In my study, three main micro-level themes were extracted from the interviews with the treating physicians. These were the treating physicians’ perceptions of their role in the RTW process, their view of an injured worker’s motivation to RTW, and their view of the injured worker’s perception of safe RTW. These factors varied depending on the treating physician.

4.1.1 Macro Level

The treating physicians described macro-level, systemic factors that affected the RTW process and their medical management of injured workers. These included the WSIB process, the availability of services health care system, and the social environment of the workplace. Friesen et al. (2001) identified the workplace system as a meso-level theme influencing timely and safe RTW. In my study, however, I placed the social environment of the workplace at the macro

level, because elements at this level are influenced by factors extending beyond the organization (e.g., worker shortages, workload issues, and funding constraints).

4.1.1.1 *The WSIB Process*

The WSIB is an insurance company that determines the eligibility for benefits after workplace injury, and thus plays a key role in adjudicating claims. Once an occupational injury occurs, it is reported to the WSIB if the injured worker seeks medical help other than first aid and/or is absent from work as a result of the injury. At this point, the treating physicians become involved in the process to first medically assess the injured worker. Following the assessment of an injured worker, the treating physician has to complete and submit standardized forms to the WSIB for the claim to be processed.

According to my findings, the treating physicians felt unable to understand and follow the WSIB's claims process. In studies with similar findings, family physicians perceived the WSIB process was too complicated and even viewed the WSIB as an "adversary" (Russell et al., 2005; Schweigert et al., 2004). The WSIB's claims process appears unclear to the treating physicians; it was described as "not transparent" and outcomes were often unpredictable even when all the required paperwork was completed properly by the treating physician. As a result, several of the treating physicians expressed frustration about their inability to influence decisions in individual cases. They described situations where they did not understand the WSIB adjudication process. Also, they reported that their patients did not fully understand this process either. They further expressed concerns that their patients might perceive the WSIB as trying to find any reason to deny their claim. Overall, the treating physicians identified a certain level of mistrust and a lack of perceived support from the WSIB for themselves and their patients.

A more transparent decision-making process would allow stakeholders to feel more engaged with the process, and power relations among them to become less visible (Frame & Brown, 2007). Exchange of knowledge in a more interactive manner can help to open the communication channels among stakeholders (Frame & Brown, 2007). In an open dialogue, stakeholders are more likely to share their values and interests, which in turn has the potential for facilitating more collaborative networking within the decision-making process.

However, Russell et al. (2005) reported that family physicians perceived that other stakeholders (including insurers, employers, and unions) wished to influence them in a way that met their own organizational financial needs when managing occupational injuries. My research illustrates how this perception has created an environment in which physicians and injured workers have come to believe that the WSIB undermines their interpretations of the healing and the RTW processes. For example, the treating physicians in my study were concerned with the WSIB's management of complex claims, where diagnoses and prognoses were not as clearly defined as other claims. In these physicians' opinion, the WSIB was not able to manage these "grey area" cases adequately. Commonly, they believed that the WSIB system needed to be restructured to address these gaps.

In order to improve the process, the treating physicians in my study recommended facilitating RTW coordination through using an advocate to help the injured workers navigate through the intricate WSIB claims process. These physicians felt that many injured workers might not have the cognitive ability to work within the complex WSIB system. The advocate could help fill out WSIB forms, interpreting what was required from the injured worker and bridging any gaps in understanding the process. Further, these physicians expressed the concern that learning the complex WSIB claims process would impose additional stress on injured

workers already suffering some type of loss of functioning (whether physical or psychological). Facilitating RTW coordination could be the responsibility of a designated individual, who could assist injured workers, bring the stakeholders together, and address any obstacles to RTW.

The WSIB launched a service delivery model (SDM) in 2008 focused on improving the RTW process. As part of this model, specialists such as case managers and nurse consultants were to be introduced into the RTW process, to assist all parties with timely decision making, collaboration, and better communication (WSIB, 2011). This model could help address many of the barriers identified by the treating physicians in my study and create the facilitated RTW coordination that the treating physicians recommended. However, it appears that treating physicians have failed to become engaged in the SDM. It is possible that the treating physicians interviewed were not aware of this new program and its availability to physicians participating in RTW. One of the key components in this new SDM is the introduction of a Return to Work Specialist whose focus would be to facilitate RTW and case resolution at the workplace. This could help address the current gap in practice discussed by the treating physicians in my study.

A more in-depth discussion about facilitated RTW coordination follows.

4.1.1.2 The Social Environment of the Workplace

For purposes of my study, I have defined the social environment of the workplace as elements contained in the workplace, including organizational climate, which have the potential to affect the RTW process. Such elements include the availability of modified duties, organizational climate, perceived support for RTW from supervisors and coworkers, control over one's job demands, the presence of positive relationships with the employer, and the overall internal dynamics of the workplace (Friesen et al., 2001; MacEachen, 2006). Organizational structures at work, trust and credibility of all stakeholders, communication and positive

relationships, and workplace initiatives are just a few of the multiple workplace factors that can determine RTW (Friesen et al., 2001).

Organizations are often driven by the need to reduce their WSIB costs and other primary and secondary costs associated with disability, so that developing and implementing RTW programs becomes less of a priority (Frache et al., 2005). The literature indicates that employers who communicated more positively around occupational injury and initiated returning an injured worker back to work (e.g., by providing modified duties) were able to reduce their costs associated with occupational injuries (Friesen et al., 2001). These employers tended to treat all workers fairly, engage in regular communication, and promote collaboration among all stakeholders. However, upholding such a supportive role was often described by employers as a challenge, given the need to maintain their productivity and minimize economic loss (Frache et al., 2005).

The ability of employers to accommodate injured workers as soon after their injury as possible can make the employers appear more supportive, in addition to helping reduce lost time from work. As noted by MacEachen et al. (2010), employers can appear insensitive to injured workers' needs when, in an attempt to reduce workers' compensation premium surcharges, they request an immediate RTW following an occupational injury. There seems to be a fine line between offering modified duties to the injured worker and not appearing to be forceful with RTW.

Research has shown that assigning modified duties to injured workers is key in RTW (Friesen et al., 2000; Westmorland et al., 2005). Many employers recognize the need to provide modified duties as early as possible following an occupational injury, but at the same time some are still very cautious about returning individuals back to work after an occupational injury

(Frache et al., 2005). The majority of treating physicians in my study described employers as hesitant to return injured workers to work until they were “100 percent recovered,” despite the treating physicians’ recommendations. Sometimes this was because modified duties were not available, and sometimes because supervisors were not supportive of the injured workers (Guzman et al., 2002). Several of the treating physicians in my study described the growth of an environment of hostility if employers, for whatever reason, were unable to accommodate the worker by offering modified duties. In their view, an absence of modified duties prolonged a worker’s absence and contributed to a perceived lack of support. Clearly, the lack of available modified duties created a barrier for RTW.

The issue is not only to provide modified duties, but also to provide the right *kind* of modified duties. Problems can arise when injured workers’ functional abilities are misaligned with the modified duties offered by the employer (MacEachen, Kosny, Ferrier, & Chambers, 2010). Misalignments can have negative effects on the social relations between injured workers and their employers (MacEachen et al., 2010).

An overwhelming majority of the treating physicians in my study reported that happy workers, who had positive social relationships at work, were more likely to return to work sooner. Clearly, the psychosocial environment of the workplace determines successful and timely RTW (Frache et al., 2005; Russell et al., 2005; Schweigert et al., 2004). The literature shows that injured workers need to feel supported and given adequate assistance by both their supervisors and coworkers during the RTW process (Westmorland et al., 2005). Friesen et al. (2000) said that, in particular, an organization’s people-oriented work culture and a worker’s positive attitude were important facilitators for successful RTW outcomes. In my thesis, a people-oriented work culture was defined as a workplace environment where employers focused

on the employees, were committed to supporting injured workers in their return to work, engaged in positive communication with injured workers while they were away from work recovering, and ensured safety when the workers returned.

According to the treating physicians in my study, RTW was facilitated when injured workers felt welcomed and productive in their workplace. These physicians felt that the WSIB does not currently have a mechanism in place to identify workplaces with poor psychosocial environments. The lack of such assessment tools could further contribute to barriers for RTW.

4.1.1.3 Availability of Health Care Services

The treating physicians in my study described the availability of health care services as an important factor in the RTW process. I have defined availability of health care services as including access to a treating physician following an injury and any rehabilitative health services recommended by the treating physician. The treating physicians reported that the shortage of physicians in Thunder Bay could delay the medical assessment and treatment of workers following an occupational injury. This delay could further negatively affect RTW.

Most of the physicians in my study did not cite access to other specialized services (such as physiotherapy) as problematic in Thunder Bay. This was especially true for injured workers whose claims had been approved by the WSIB. In fact, treating physicians described consistent and improving communication with physiotherapists, and they viewed physiotherapists' expertise as a required service in the RTW process.

Overall, my study found that workers who were absent from work due to an occupational injury and whose claim had been approved by the WSIB had better access to health care than those with a nonoccupational injury. Workers with no insurance coverage who sustained a nonoccupational injury, or whose WSIB claim was denied, experienced delays in accessing

publicly funded physiotherapy services, for example. The physicians in my study attributed this discrepancy in access mainly to the change in entitlements for physiotherapy services by the Ontario Health Insurance Plan (OHIP). After April 1, 2005, OHIP no longer covered physiotherapy services for Ontarians aged 20 to 64 years (MOHLTC, 2005). Passalent et al. (2009) reported that, in Ontario, an imbalance exists between the demand and supply of publicly funded physiotherapy services. One possible reason for the increased demand for physiotherapy services was the increasing prevalence of individuals living with chronic illness (Passalent, Landry, & Cott, 2009).

My study revealed that once a claim was approved by the WSIB, the quality of care received by the injured worker was usually good. This may be the result of the WSIB's proactive approach to timely and effective RTW. The WSIB is focused on ensuring early and safe RTW and, hence, has invested funding to provide the necessary rehabilitative services as early as possible.

There is evidence in the literature that geography can play a part in health inequalities. Individuals in different geographical areas have varying health experiences, and those who are deprived of services because of where they live are at higher risk for health disadvantage (Curtis & Jones, 1998). My study found that people in Thunder Bay are geographically isolated from some necessary rehabilitative health services. However, whenever a required treatment is not available in Thunder Bay, the WSIB frequently will send injured workers to a centre in southern Ontario for treatment. Having to relocate temporarily to receive treatment can be emotionally and physically difficult for injured workers, the treating physicians said, as familiar environments would be left behind.

Timely access to other health care service providers is particularly important in instances when injured workers require specialized assessment that is beyond the scope of practice of the treating physician. For example, physicians are often asked to complete the paperwork from the WSIB regarding the functional abilities of an injured worker. However, family physicians are not trained in occupational health and generally have little experience in assessing the functional abilities requested by the WSIB. As a result they are frustrated with the process; often, they question the usefulness of this functional assessment form (Soklaridis et al., 2011) and may prefer to delegate this task to a physiotherapist.

4.1.2 Meso Level

Meso-level factors were those that originated at organizational and interpersonal levels, and mainly involved communication. They included such elements as established collaboration and communication practices, training of stakeholders as it pertains to disability management and RTW, and any other factors that can be modified at the organizational level. Communication (the exchange of information that can take on different forms) is the central concept at this level (Charlot & Duranton, 2006). The most common way of communicating has been face-to-face, or direct, communication, but, arguably, this form is becoming obsolete due to the emergence of new and innovative forms of communicating (Charlot & Duranton, 2006). Technological advances and forms of virtual communication have allowed for less human face-to-face interaction.

Three subcategories of communication were identified for the purposes of this thesis: the frequency of communication, the broken-telephone syndrome, and facilitated RTW coordination.

4.1.2.1 The Frequency of Communication

The treating physicians in my study reported minimal, irregular contact with the WSIB. Communication occurred only when the claim became problematic. As a result, decisions were made in “silos,” without clarification of outstanding issues or attempts to find alternative ways to improve outcomes. From the perspective of the treating physicians, isolated decision making affected the accuracy and robustness of the decisions made both by treating physicians and the WSIB.

The WSIB employs physicians who are assigned to a certain geographical area. These physicians are usually called upon to assist with complex WSIB claims, or in cases where there is no evidence of improvement in an injured worker’s functional abilities even after all recommended treatment options have been followed. For example, a typical fracture usually requires 4 to 6 weeks of recovery time, so the WSIB physician would be consulted when an injured worker continued to remain off work with no improvement beyond that normal recovery time.

Among the treating physicians interviewed, the majority were not aware of the existence of the WSIB physician in their geographical area. They expressed a strong desire to increase the visibility of WSIB physicians and making these individuals more accessible to them for complex cases and other consultations, and reported wanting to work more closely with these WSIB physicians in trying to assist injured workers in returning to work.

My study revealed that treating physicians had very poor communications not only with WSIB physicians, but with employers as well. Most often, they were not aware of the level of support available from employers (Schweigert et al., 2004) and had little or no contact with employers, which meant that they were unaware when modified duties were available and had

been offered to the injured worker. They believed that there was a tendency to miss information, thereby delaying workers' return to work, because no one had been designated as a facilitator to liaison between the treating physician, the WSIB physician, the employer, and other stakeholders.

4.1.2.2 Broken-Telephone Syndrome

The intricate network of stakeholders involved in the WSIB RTW process contributed to the challenges in the communication patterns. "Broken-telephone syndrome" refers to the effects of a lack of direct communication between the treating physician, the WSIB, and the employer. Miscommunication or poor communication between these groups is a barrier to RTW (Friesen et al., 2000). Just as good communication has a positive effect and helps to ensure successful RTW, poor communication can have the opposite effect.

Work absence can be prolonged by miscommunication or noncommunication of information related to the functional abilities of an injured worker, and/or a lack of the availability of modified duties in the workplace. Miscommunication refers to the communication of inaccurate information. By noncommunication I mean a complete lack of communication or an untimely exchange of information between the stakeholders. Miscommunication in health care, especially between the health care provider and other parties, has been documented to affect health outcomes negatively (Kagawa-Singer & Kassim-Lakha, 2003). Miscommunication can lead to information being misinterpreted and even missed.

Communication, both formal and informal, is essential to supporting a cohesive teamwork environment (Cartmill et al., 2011). Formal communication among stakeholders consists of records of clinical rounds and meetings, and chart and report writing; informal communication takes place during unscheduled interactions among team members. Both types of

communication are critical to maintaining a connection among the stakeholders involved in the RTW process. Treating physicians in my study described feeling reluctant to make decisions regarding RTW when information about the workplace was not communicated to them in a timely manner, or at all.

In an ideal situation, the RTW stakeholders should sit at the same table and discuss the RTW plan. However, the physicians in my study were mindful of the challenges involved in accommodating every stakeholder's busy schedule and to get everyone together at the same time. They felt that a useful alternative to meeting in person could be teleconferencing; even writing a letter detailing concerns about the RTW plan would be useful. But although communicating in this way would work, the physicians indicated that it seldom happened.

Forms of miscommunication and noncommunication can affect a treating physician's decisions on, and participation in, an RTW plan. For example, although modified duties might be available to the injured worker immediately after the onset of injury, no mechanisms existed to ensure that this information got passed on to the physicians. Due to this lack of information and uncertainty about the duties available to the injured worker, physicians were often concerned about the safety of RTW and injured workers performing duties outside of their functional abilities.

Obviously, injured workers' injury should not be aggravated by the duties they are assigned at work. But when physicians were not certain about the duties available to the injured worker, they were more reluctant to clear them to return to work (Guzman, 2002). One has to wonder why such a gap exists between the possible availability of modified duties at work and physicians' recommendation to return to work with modified duties. Lack of direct communication between employers and treating physicians is one possible explanation. Another

might be the lack of reimbursement for time allocated to RTW-related matters (Schweigert et al., 2004). Treating physicians might get more involved in RTW if they were adequately paid for their efforts. Guzman et al., (2002), for example, found that 11.8 percent of the physicians interviewed reported that they needed more time and better reimbursement to encourage them to participate in RTW planning.

In addition, there appears to be much fragmentation in the way information is communicated to stakeholders. In fact, information related to RTW is often funnelled to physicians through the injured worker, and that in pieces only. This further contributes to the barriers observed at the meso level.

Overall, communication was described by the treating physicians as infrequent and sporadic, with no known indicators or triggers to initiate contact.

These communication obstacles have contributed to further inefficiencies in the medical management of injured workers and RTW. Information can be lost or misinterpreted. Injured workers, the conduits of information about their medical status, can interpret their situation differently from the physicians who have treated them. They can also hold different views from their employers on important RTW issues. Stakeholders need to be able to exchange information in a timely manner and engage in continuous dialogue as the injured worker progresses through the RTW. The treating physicians in my study were eager to take on a more active role in the RTW process, but they believed that this was not possible without the collaboration of the other stakeholders (namely, employers, the WSIB, and the injured worker). They reiterated the great need for an RTW coordinator.

4.1.2.3 *Facilitated RTW Coordination*

A central finding of my study is the need for facilitated RTW coordination, to address the lack of direct communication among stakeholders. I define *facilitated RTW coordination* as a process wherein a designated individual would be responsible for planning, implementing, evaluating, collaborating with other stakeholders, and following up on the RTW plan for an injured worker. RTW coordinators would be essential, vital players in the RTW process and could work in a variety of settings (Gardner et al., 2010). In fact, several RTW coordinator characteristics and competencies have already been identified in the literature as critical to successful RTW. Specific professional designations have been shown to be less essential than knowledge, skills, and attitudes towards achieving positive results (Gardner et al., 2010). Often, the information requested by the employers and the WSIB is medical in nature, such as nature of illness, restrictions, and length of absence required for recovery. Therefore the treating physicians in my study suggested that the individual fulfilling this role would need to possess some medical training and knowledge so as to communicate effectively with the medical professionals. In addition, the physicians expressed the need to have meaningful discussions with a RTW coordinator who is knowledgeable about limitations, safe work duties, and needed recovery times for injured workers, based on their injury. An RTW coordinator could focus on developing a safe and timely RTW plan for the injured worker, serve as a facilitator for RTW, and assist the injured worker in navigating through the complex WSIB system.

However, the physicians did not discuss the disadvantages of introducing a RTW coordinator into the process, one of which would be the cost of training and the salary for the coordinator. Another difficulty would be in ensuring that each injured worker had access to an RTW coordinator. The treating physicians in my study did not discuss any experiences with the

WSIB RTW coordinator assigned to assist with claim management. As mentioned above, one possible explanation for this was their lack of knowledge of the existence of this official.

4.1.3 Micro Level

Micro-level factors are individual factors that the treating physicians perceived as being influential in the RTW process. Two main themes emerged at this level: the perceived role of the treating physician, and the treating physician's view of an injured worker's motivation to return to work and their perception of safe RTW.

4.1.3.1 The Role of the Treating Physician

RTW has biomedical and psychosocial aspects; injuries do not happen in a vacuum. In the biomedical model of care, treatment for an illness focuses strictly on the biological and somatic variables of an individual, and does not take into consideration the social, psychological, and behavioural effects of the illness on that individual (Engel et al., 1977). My findings concur with the current evidence in this regard (Russell et al., 2005). However, the overall RTW process includes workplace psychosocial factors encompassing more than the individual. In fact, the RTW process goes beyond health care, crossing various professional, organizational, and systemic boundaries.

The role of treating physicians in the RTW process was a major focus of discussion in my study. In general, the physicians felt that patient diagnosis, medical treatment, and referral were their main responsibilities. In this it was evident that their view of their role centred on the individual patient. For instance, if a worker suffered a fracture, it was easy for them to adopt the role of medical doctor and follow a prescribed course of medical management for that injured worker. Likewise, RTW meant a commitment to restoring their patient's functioning so that the patient could go back to work.

The physicians tended to be more comfortable with how to diagnose and treat a patient's injury, and less comfortable with how to manage the psychosocial aspects of RTW (Soklaridis et al., 2011). It was easier to be objective, they said, when the injury was clearly medical in nature (such as a fracture) and had a clearly laid-out treatment plan. However, when the psychosocial issues of an injury were prominent, they might need to adopt the role of advocate. They acknowledged the importance of psychosocial factors, but they struggled with the role of advocate. My research indicated that the role perceptions the physicians held could, in themselves, serve as a barrier to RTW.

In their role as patient advocate, treating physicians tended to rely on injured workers' subjective accounts of their injury, and often neglected to consider all aspects of RTW (Russell et al., 2005). For example, they often felt that they were not able to influence or help injured workers with the internal dynamics of their workplace, such as the injured workers' relationships with their supervisors. They also expressed feeling inadequate to help injured workers effectively navigate the WSIB process. Part of their feelings of inadequacy arose from having little control over meso- and macro-level factors affecting the psychosocial aspects of the RTW process. They mentioned facing several challenges, such as how to influence communication among the stakeholders, obtain pertinent information from employers, or expedite access to health care services for the injured workers. Further, the treating physicians felt that they did not have sufficient time to be able to fully address injured workers' concerns, which typically extended beyond the medical needs. Particularly challenging were injured workers with comorbid, ill-defined or mental health conditions that required additional time to address the RTW process and plan of treatment. The treating physicians felt that the extensive paperwork was consuming much of their precious time that could be spent on providing patient care.

In the physician/injured worker relationship, physicians experienced greater control of the situation. Nevertheless, their perceived inability to influence the elements external to even this relationship was surprising, given their status within the health care system. Physicians continue to be dominant in the health care environment, a fact that has been well documented in the literature. Friedson (1970), for example, talked about the high prestige physicians enjoy in the industrial world, compared to other occupations. Coburn et al. (1983), moving on from Friedson's work, noted that in fact medical dominance had been declining over the years. Reasons for this included the involvement of governments in health insurance; increased focus on other health occupations, such as nursing; heightened elite scepticism; and, possibly, internal fragmentations within the medical profession itself (Coburn et al., 1983). Nevertheless, physicians today continue to have a higher degree of power over their patients than other health care providers—such as nurses, occupational therapists, and physiotherapists—and they continue to be described in the literature as superior symbols of healing (Gair & Hartery, 2001).

Physicians' level of professional autonomy is also evidence of their dominance.

The phenomenon of medical dominance could have influenced the treating physician/RTW team relationship. Perhaps the physicians saw their role as unique and somehow apart from the RTW process. They found it difficult to reach out to other parties involved in the RTW process for assistance, guidance, and help, perhaps because they still perceived themselves as dominant in the stakeholder circle. This isolation in the RTW process became problematic when a need arose for specialized expertise that went beyond their scope of practice. For example, the treating physicians felt that their self-identified lack of training in occupational medicine affected their ability proactively to recognize health and safety issues for individual injured workers based on their occupation and injury type, and to decide when it was safe for

them to return to work. This certainly could be a possible barrier when medically managing injured workers.

My study suggests that the treating physicians' focus on the medical side of RTW to the exclusion of the psychosocial side may be due to their lack of knowledge about such other areas of RTW as job duties, offer of modified duties, and WSIB follow-up. For a successful RTW process, physicians need to be better informed about injured workers' workplaces in general and workplace availability of modified duties in particular.

My study showed that physicians were more inclined to recommend RTW when they had knowledge that an injured worker's functional limitations would be closely followed at the workplace. Employers could easily communicate these sorts of details (including the availability of modified duties) to treating physicians in a letter, email, fax, or telephone call.

4.1.3.2 Treating Physicians' View of Injured Workers' Motivation to RTW and Perception of Safe RTW

Employee motivation is an important factor in RTW (Schweigert et al., 2004). Some motivating factors include a sense of financial security, physical integrity and dignity, attachment to career, and maintenance of valued workplace (Frache et al., 2005). My findings concur with the literature. The treating physicians also described an injured worker's motivation to return to work as a determining factor for RTW. They said that it was easier to facilitate RTW when an injured worker was already positive and open to considering an early RTW. Several of them also posited that injured workers who were well paid and enjoyed their work were more likely to return to work than workers who felt that they were not adequately compensated and did not enjoy their work.

Another critical element that emerged from my findings was the effect of injured workers' fear of reinjury on their perception of a safe return to work. If they were afraid of reinjury, they were less likely to return to work in a timely manner (Frache et al., 2005). Workers who sustained acute occupational injuries to their lower backs often displayed varying degrees of fear of movement, and avoided repeating certain work activities in order to prevent reinjury. These workers required individualized interventions—such as education and counselling on physical abilities and safety at work—to support them with RTW. One study showed that fear-avoidance beliefs were one of the predictors of chronic disability for patients with acute low-back pain (Godges et al., 2008).

The treating physicians reported that, in their experience, the RTW process was hindered when an injured worker perceived the RTW to be unsafe, or displayed a fear of reinjury. Injured workers appeared to rely on physician feedback about the injury, and would base decisions about their future safety at work on their physicians' advice. The treating physicians thus felt that they had a certain influence over how injured workers perceived their injury. They also felt that injured workers needed to be reassured about the level of the severity of their injury.

The treating physicians in my study identified a myriad of concerns about the medical management of injured workers. They categorized barriers and facilitators into micro, meso, and macro levels of influence. Meso and macro factors were perceived by the treating physicians as beyond their control, and they recommended addressing these at a higher, system or organization level. At the micro level, the physicians appeared to feel some confusion about their role in the RTW process. They felt more comfortable with the medical practitioner and advocate roles in cases where psychosocial aspects of the RTW were not prominent. However, in cases that featured numerous psychosocial issues, particularly when work possibly contributed to an

aggravation of the initial injury, the effects of medical injuries, the treating physicians felt less clear about their role. For instance, when a worker was ready and able to RTW on a gradual basis, but no modified duties were available, the physician cannot control the situation. The issues identified by the treating physicians in Thunder Bay do not appear to be unique to a northern community. Rather, these are common issues faced by physicians in rural areas of southern Ontario as well. Although Thunder Bay is considered an urban community in Ontario's northwest, challenges experienced by the treating physicians interviewed appear to be more magnified than in the urban communities in the south.

4.2 Strengths and Limitations of the Study

4.2.1 Strengths

This study was the first to explore the experiences of treating physicians in northern Ontario; most other studies have focused on the experiences of physicians in southern Ontario. This group's participation in my research will help readers gain a better understanding of the issues, and fill in gaps when looking at RTW practices in Ontario overall.

Another strength of my study was that I was able to capture in-depth perspectives of a group of treating physicians that consisted of family physicians, orthopaedic surgeons, and a physician with expertise in disability management. All were volunteers who had a special interest in the topic of RTW and were very forthcoming about sharing their experiences about RTW, and all were key points of contact for medical treatment by workers hurt in an occupational injury.

4.2.2 Limitations

My study has two major limitations. First, the treating physicians I interviewed had varying demographic backgrounds, specializations in medicine, and levels of experience in treating injured workers. Their views and perspectives may have been dependent on their individual experiences with treating injured workers, and their level of knowledge of disability management practices and occupational medicine. The more knowledgeable and experienced in medical management of injured workers they were, potentially the more able they were to paint a more comprehensive and insightful picture of the RTW process in Thunder Bay. Systemic factors faced by the treating physicians who were orthopaedic surgeons as opposed to family physicians might also have varied.

Secondly, interviews with the physicians took place between October 2008 and May 2009, shortly after the WSIB had implemented its new service delivery model (SDM) in 2008. The SDM could potentially affect the RTW process. It is possible that the treating physicians might not have had sufficient time to learn and familiarize themselves with the SDM, but were still learning about this major change, and might not have been knowledgeable enough to comment on the model in the interviews.

In addition, it is important to note that the convenience sampling strategy used to recruit physicians does not necessarily allow for generalizability of the findings. Physicians were not randomly selected and my findings may not be representative of other physicians in Thunder Bay or other geographic areas.

CHAPTER 5: CONCLUSION

In my study, the treating physicians identified several factors that they perceived to have an impact on the RTW process. I organized these into three levels: macro (system), meso (organization), and micro (individual). All factors interact in a complex network of stakeholders.

At the macro level, there is a lack of transparency in the WSIB adjudication process. Often, the WSIB was not seen as a partner in the RTW process, but rather as a barrier to it. Also, the social environment of the workplace, especially if employees do not feel welcomed back to work, plays an important role in creating more challenges for RTW.

Injured workers require health care services in order to be rehabilitated. Issues arise depending on whether a WSIB claim has been approved as work-related or not. In Thunder Bay, services such as physiotherapy seem to be more readily available for people who access them through the WSIB system than through the public system (i.e., through private physiotherapy clinics). For example, injured workers whose occupational injuries have been approved and are being compensated by the WSIB are typically able to access services in a more timely manner, even if that means arranging for the injured worker to get treatment in another city, for instance in southern Ontario. Although this situation may not be unique to Thunder Bay, the treating physicians noted the important differences for injured workers who were seeking physiotherapy through private sources and those who relied on publicly funded physiotherapy services.

Communication was identified as one of the fundamental areas required for safe and early RTW. Therefore, it is important to investigate ways to improve communication—and thereby enhance collaboration—among stakeholders in the RTW process. Potential policy changes could involve improving physician remuneration for the medical management of WSIB cases, introduction of mandatory basic occupational medicine training for all physicians, and

various organizational policies pertaining to disability management (e.g., mandatory offer of modified duties). Further research into the experiences of other stakeholders and health care professionals, such as physiotherapists and chiropractors, could help inform the RTW process.

It would certainly be interesting to see the role that geography plays in RTW. Thus, focusing the research on the north, and not just on the more urban central and southern Ontario regions, would deepen our understanding of the RTW practices as a whole. In addition, a comparison of how undergoing the RTW in an urban centre in Ontario was different from experiencing the process in a remote area of Ontario would be important in assisting the development of interventions to improve the process, based on the needs of different communities and stakeholders.

Although the RTW process is influenced by various systemic and organizational barriers and facilitators, factors at the individual level also affect the process. Micro-level elements such as treating physicians' perception of their role in the process, their view of an injured worker's perception of motivation to RTW, and whether it is safe for them to return to work, are important when focusing on the injured worker/treating physician relationship. The treating physicians saw their role mainly as advocates for injured workers, and they practice a biomedical approach where they assess, diagnose, prescribe, and treat the medical aspects of the injury. Insufficient time to address the complex needs of injured workers and to include psychological support, preventive advice and guidance was seen as a major barrier to quality care. The shortage of family physicians and extensive paperwork required by the WSIB were identified as some of the factors contributing to the lack of time experienced by the treating physicians.

Treating physicians share a special relationship with injured workers. In many instances, when injured, workers turn to treating physicians first for their expertise and support. In addition,

the treating physicians felt that they could influence how injured workers perceived their injury and whether it was safe for them to RTW. From their experience, the physicians found the RTW process easier to facilitate when injured workers were positive about RTW, felt they were adequately compensated for their work, and enjoyed their job.

Although many of my findings could be relevant in all jurisdictions, treating physicians in this northern urban community experience challenges to a greater degree than their southern counterparts. It appears that even the urban communities in the north face similar challenges as the rural communities in the south. In the north, similar to the rural communities in the south, a major barrier to timely RTW identified by the treating physicians was the inability of injured workers to be medically assessed in a timely manner. Improved wait times would help ensure access to appropriate health care services in people's own communities. It has been easy to use a one-size-fits-all approach to RTW, in which no consideration is given to differences based on geographic variability. But access to health care services may be different in a remote community as compared to an urban centre. This, in turn, can potentially affect wait times and prolong the RTW process. Clearly, policy needs to focus on continuing to improve wait times for injured workers in communities outside the southern urban centres.

It is well established in the literature that the psychosocial environment of the workplace plays an essential role in RTW, and researchers need to focus on finding innovative ways to influence and create a more a positive workplace environment. One of the gaps identified by my study is that WSIB currently has no system in place to assess the psychosocial environment of the workplace. Findings from my study point to the benefit of having an RTW coordinator, which could help in the assessment of the workplace psychosocial environment, but further studies are needed to evaluate the cost effectiveness of this intervention.

Further research needs to examine the psychosocial barriers to RTW and how to overcome them. There is a need to transfer knowledge into practice with practical, implementable tools that stakeholders at various levels can use in their practice. In particular, this would help the treating physicians ensure that their practice is aligned with best practice guidelines. Developing more practical tools for practitioners to use is important since many physicians are not able to stay current with the occupational health research due to lack of time, knowledge, or interest in the field.

Lastly, my thesis raises issues around disability management in northern Ontario that are likely important in other jurisdictions. I explored the challenges that the treating physicians face at the systemic, organization, and individual levels when medically managing injured workers who have sustained an occupational injury. Much of the research in disability management is relatively recent, and ongoing examination of this very diverse field may lead to improvements at many levels, benefiting individuals as well as our society as a whole.

References

- Ammendolia, C., Cassidy, D., Steenstra, I., Soklaridis, S., Boyle, E., Eng, S., . . . Côté, P. (2009). Designing a workplace return-to-work program for occupational low back pain: an interview mapping approach. *BMC Musculoskeletal Disorders*, 10(65), 1-10.
- Baril, R. (2003). Early return to work of injured workers: multidimensional patterns of individual and organizational factors. *Safety Science*, 41, 277-300.
- Bennion, S. K. (2008). Overcoming barriers for a successful return to work. *Professional Case Management*, 13(4), 241-243.
- Black, C., Cheung, L., Curson-Prue, S., Douple, L., Guirguis, S., & Haines, T., . . . Wills, M. (2000). Injury/illness and return to work/function: a practical guide for physicians. *Physician Education Project in Workplace Health*.
- Brotchie, K. & Casey, B. (2008). Poverty in motion, the rippling effects. Retrieved from <http://www.injuredworkersonline.org/Documents/PovertyMotionReport.pdf>
- Brown, S. E. (2008, February 15). Survey finds poverty among injured workers. *Chronicle Journal*.
- Cartmill, C., Soklaridis, S. & Cassidy, J. D. (2011). Transdisciplinary teamwork: the experience of clinicians at a Functional Restoration Program. *Journal of Occupational Rehabilitation*, 21, 1-8.
- Charlot, S. & Duranton, G. (2006). Cities and workplace communication: some quantitative French evidence. *Urban Studies*, 43(8), 1365-1394.
- Charmaz, K. (2006). *Constructing grounded theory: a practical guide through qualitative analysis*. Sage Publications.
- City Profile, City of Thunder Bay. Retrieved from http://www.thunderbay.ca/Living/About_Thunder_Bay/city_profile.htm
- Creswell, J., W. (2007). *Qualitative inquiry and research design, choosing among the five approaches* (2nd ed.). Thousand Oaks, CA: Sage.
- Curtis, S. & Jones, I. R. (1998). Is there a place for geography in the analysis of health inequality? *Sociology of Health & Illness*, 20(5), 645-672.
- Denzin, N., K., & Lincoln, Y., S. (2005). *The Sage handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.
- Disability Resource Network of BC. Retrieved from http://www.drnbc.org/child.cfm?DPAR_PARENT_ID=2&DCHD_CHILD_ID=248

- Eakin, J., MacEachen, E., & Clarke, J. (2003). "Playing it smart" with return-to-work: Small workplace experience under Ontario's system of self-reliance and early return. *Journal of Policy and Practice in Health and Safety*, 1(2), 19-42.
- Edlund, C., & Dahlgren, L. (2002). The physician's role in the vocational rehabilitation process. *Disability and Rehabilitation*, 24(14), 727-733.
- Frame, B., & Brown, J. (2008). Developing post-normal technologies for sustainability. *Ecological Economics* 65, 225-241.
- Frache, R. L., Severin, C. N., Hogg-Johnson, S., Cote, P., Vidmar, M., & Lee, H. (2007). The impact of early workplace-based return-to-work strategies on work absence duration: a 6-month longitudinal study following an occupational musculoskeletal injury. *Journal of Occupational and Environmental Medicine*, 49(9), 960-974.
- Frache, R. L., Baril, R., Shaw, W., Nicholas, M., & Loisel, P. (2005). Workplace-based return-to-work interventions: optimizing the role of stakeholders in implementation and research. *Journal of Occupational Rehabilitation*, 15(4), 525-542.
- Frache, R. L., Cullen, K., Clarke, J., Irvin, E., Sinclair, S., & Frank, J. (2005). Workplace-based return to work interventions: a systematic review of the quantitative literature. *Journal of Occupational Rehabilitation*, 15(4), 607-631.
- Frache, R. L., Cullen, K., Clarke, J., MacEachen, E., Frank, J., & Sinclair, S. (2004). Workplace-based return-to-work interventions: a systematic review of the quantitative and qualitative literature. *Institute for Work and Health*, 1-15.
- Friesen, M. N., Yassi, A., & Cooper, J. (2001). Return-to-work: the importance of human interactions and organizational structures. *Work*, 17, 11-22.
- Gair, G. & Hartery, T. (2001). Medical dominance in multidisciplinary teamwork: a case study of discharge decision-making in a geriatric assessment unit. *Journal of Nursing Management*, 9, 3-11.
- Gardner, B. T., Pransky, G., Shaw, W. S., Hong, Q. N., & Loisel, P. (2010). Researcher perspectives on competencies of return-to-work coordinators. *Disability and Rehabilitation*, 32(1), 72-78.
- Guzman, J., Yassi, A., Cooper, J. E., & Khokhar, J. (2002). Return to work after occupational injury: family physicians' perspectives on soft-tissue injuries. *Canadian Family Physician*, 48, 1912-1919.
- Guzman, J., Yassi, A., Baril, R., & Loisel, P. (2008). Decreasing occupational injury and disability: the convergence of systems theory, knowledge transfer and action research. *Work*, 30, 229-239.
- Health Council of Canada. (2009, April). *Teams in actions: primary health care teams for Canadians*. Retrieved from <http://www.healthcouncilcanada.ca/teamsinaction.pdf>

- Holstein, J. A., & Gubrium, J. F. (2003). *Inside interviewing: new lenses, new concepts*. Thousand Oaks, CA: Sage.
- Institute for Work and Health, the Ontario Society of Occupational Therapists, the College of Occupational Therapists of Ontario. (2008). *Working together: Successful strategies for return to work*.
- Jin, R. L., Shah, C. P., & Svoboda, T. J. (1995). The impact of unemployment on health: a review of the evidence. *Canadian Medical Association Journal*, 153(5), 529-540.
- Kagawa-Singer, M. & Kassim-Lakha, S. (2003). A strategy to reduce cross-cultural miscommunication and increase the likelihood of improving health outcomes. *Academic Medicine* 78(6), 577-587.
- Kelley, M. L., & Kuluski, K. (2008). Physician satisfaction and practice intentions in Northwestern Ontario. *Canadian Journal of Rural Medicine*, 13(3), 129-135.
- Krause, N., Dasinger, L. K., & Neuhauser, F. (1998). Modified work and return to work: a review of the literature. *Journal of Occupational Rehabilitation* 8(2), 113-139.
- Krause, N., Frank, J. W., Dasinger, L. K., Sullivan, T. J., & Sinclair, S. J. (2001). Determinants of duration of disability and return-to-work after work-related injury and illness: challenges for future research. *American Journal of Industrial Medicine*, 40, 464-484.
- Krause, N., Dasinger, L. K., & Neuhauser, F. (1998). Modified work and return to work: a review of the literature. *Journal of Occupational Rehabilitation*, 8(2), 113-139.
- Kvale, S. (1996). *InterViews—An Introduction to Qualitative Research Interviewing*. Thousand Oaks: Sage.
- Leipert, B. D., & George, J. A. (2008). Determinants of rural women's health: a qualitative study in Southwest Ontario. *The Journal of Rural Health*, 24(2), 210-217.
- Local Health Integration Network. Retrieved from
http://www.northwestlin.on.ca/uploadedFiles/Home_Page/Report_and_Publications/Nor th%20West%20LHIN%20Population%20Health%20Profile%202009%20v.2.pdf
- Loisel, P., Buchbinder, R., Hazard, R., Keller, R., Scheel, I., & van Tulder, M. (2005). Prevention of work disability due to musculoskeletal disorders: the challenge of implementing evidence. *Journal of Occupational Rehabilitation*, 15(4), 507-524.
- MacEachen, E. (2006). Systematic review of the qualitative literature on return to work after injury. *Scandinavian Journal of Work, Environment & Health*, 32(4), 257-269.
- Ministry of Health and Long-Term Care. Family Health Teams. Retrieved from
http://www.health.gov.on.ca/transformation/fht/fht_mn.html on March 1, 2011.

Mulvale, G. & Bourgeault, I. V. (2007). Finding the right mix: how do contextual factors affect collaborative mental health care in Ontario? *Canadian Public Policy* 33, s49-s64.

Murphy, D. R., & Rosenblum, A. (2006). Return to work after two years of total disability: a case report. *Journal of Occupational Rehabilitation*, 16, 253-260.

North West Local Health Integration Network. Moving forward 2009-2010 annual report.

Retrieved from

http://www.northwestlhin.on.ca/uploadedFiles/Home_Page/Report_and_Publications/annual%20report%202009%20-%202010%20Eng.pdf

Ontario Medical Association. (1994). *OMA position in support of timely return to work programs and the role of the primary care physician*. Retrieved from <http://www.oma.org/phealth/trtw.htm>

Ontario Medical Association. (2008). *OMA position paper on the role of the primary care physician in timely return to work*. Toronto, ON: Ontario Medical Association.

Ontario Medical Association Section on Occupational Health. (1991). Supporting family physicians in the practice of occupational medicine. *Ontario Medical Review*, 58, 20-23.

Passalent, L., Landry, M. & Cott, C. (2009). Wait times for publicly funded outpatient and community physiotherapy and occupational health services: implications for the increasing number of persons with chronic conditions in Ontario, Canada. *Physiotherapy Canada* 61, 5-14.

Post, M., Krol, B., & Groothoff, J. W. (2005). Work-related determinants of return to work of employees on long-term sickness absence. *Disability and Rehabilitation*, 27(9), 481-488.

Quinn, P. R. (2002). Returning to work after disability. *Employee Benefits Journal*, 27(2), 13-17.

Romanow, R. J. (2002). Building on values: the future of health care in Canada- final report. Commission on the Future of Health Care in Canada. Retrieved from <http://dsp-psd.pwgsc.gc.ca/Collection/CP32-85-2002E.pdf>

Rourke, J. T., Incitti, F., Rourke, L. L., & Kennard, M. (2005). Relationship between practice location of Ontario family physicians and their rural background or amount of rural medical education experience. *Canadian Journal of Rural Medicine*, 10(4), 231-240.

Russell, G., Brown, J. B., & Stewart, M. (2005). Managing injured workers: family physicians' experiences. *Canadian Family Physician*, 51, 78-85.

Schweigert, M. K., McNeil, D., & Double, L. (2004). Treating physicians' perceptions of barriers to return to work of their patients in Southern Ontario. *Occupational Medicine*, 54, 425-429.

Service Ontario. *Workplace Safety and Insurance Act, 1997*. Retrieved from http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_97w16_e.htm

Soklaridis, S., Tang, G., Cartmill, C., Cassidy, J. D. & Andersen, J. (2011). "Can you go back to work?": Family physicians' experiences with assessing patients' functional ability to return to work. *Canadian Family Physician*, 57, 202-209.

Thunder Bay Community Economic Development Commission. Major employer list: Thunder Bay 2011. Retrieved
<http://www.thunderbay.ca/Assets/CEDC/docs/Major+Employers+List+2011.pdf>

Thunder Bay Community Economic Development Commission. Thunder Bay Labour Force 2011. Retrieved
<http://www.thunderbay.ca/Assets/CEDC/docs/Labour+Force+Characteristic+History+-+opens+a+new+window.pdf>

Van Oostrom, S. H., Driessen, M. T., de Vet H. C. W., Franche, R. L., Schonstein, E., & Loisel, P. (2009). Workplace interventions for preventing work disability. *The Cochrane Library* 1, 1-10.

Waehler, G. M., Dong, X. S., Miller, T., Haile, E., & Men, Y. (2007). Costs of occupational injuries in the construction in the United States. *Accident Analysis & Prevention*, 39, 1258-1266.

Westmorland, M. G., Williams, R. M., Amick, B. C., Shannon, H. S., & Rasheed, F. (2005). Disability management practices in Ontario workplaces: employees' perceptions. *Disability & Rehabilitation*, 27(14), 825-835.

Wilkins, K., & Mackenzie S. G. (2007). Work injuries. *Health Reports*, 18(3), 1-18.

Williams, R., Westmorland, M. G., Shannon, H. S., & Amick, B. C. (2007). Disability management practices in Ontario health care workplaces. *Journal of Occupational Rehabilitation*, 17, 153-165.

Workers' Compensation Board of Nova Scotia. (1999). *Return-to-work programs: a workplace development manual*.

Workplace Safety and Insurance Board. Statistical supplement to the 2009 annual report. Retrieved from
<http://www.wsib.on.ca/files/Content/AnnualReports2009StatisticalSupplement/StatSupp09.pdf>

Young, A. E. (2009). Return-to-work experiences: prior to receiving vocational services. *Disability and Rehabilitation*, 1-10.

Young, A. E., Wasiak, R., Roessler, R. T., McPherson, K. M., Anema J. R., & van Poppel, M. (2005). Return-to-work outcomes following work disability: stakeholder motivations, interests and concerns. *Journal of Occupational Rehabilitation* 15(4), 543-556.

Yuen, D. (2009). The Role of primary care physicians in return to work after occupational injury or disease: a systematic review of guidelines and literature. Master's thesis, Lakehead University, Thunder Bay, Ontario.

APPENDIX 1

Table I: Claims registered by year of registration (2005 to 2009)

	2005	2006	2007	2008	2009
Injuries and illnesses in current year	339,733	322,254	314,313	296,774	237,404
Injuries and Illnesses in prior years	13,263	14,597	14,848	15,541	12,073
Total registrations	352,996	336,851	329,161	312,315	249,477

Source: Workplace Safety and Insurance Board, Statistical Supplement to the 2009 Annual Report

<http://www.wsib.on.ca/files/Content/AnnualReports2009StatisticalSupplement/StatSupp09.pdf>

Appendix 1 Cont'd

Physician Demographic Background Checklist: Summary

Please circle all that apply and complete the following:

1. Sex: Male 6 Female 8
2. Age group: 25-34 3 35-44 4 45-54 5 55+ 2
3. Year graduated: **Ranged from 1961 to 2005**
4. Medical school attended:

Dalhousie University, Manitoba University, McMaster University, University of Ottawa, University of Toronto, International, Queens University

5. Focus of practice: Family Medicine 9 Specialty (specify) 4 Disability Management 1
6. Experience in family medicine/your speciality (years): **2.5 years to 33 years**
7. Practice characteristics: academic 6 nonacademic 4 urban 6 rural 3 group 4 solo 4
8. Primary location of practice: Thunder Bay 14 other 0
9. How many injured workers have you treated in the last year (approximately):

100, >200 (surgeon), all (WSIB), 10-20, 60% (surgeon), 60% of practice (surgeon), 200-300, 50, 20, >100 per year, 3/day- 5 d/week, 2%, 250-400 (surgeon)

10. Familiarity with Occupational Medicine, i.e. training or conferences:

minimal, little, 2 days in residency focused on this- no other conferences, CCFP training.