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EDITORIAL COMMENTS

With this overdue issue of the Newsletter, there are several changes to announce to our readers:

Our sincere thanks to Dr. Ken Fryatt who served as Editor from 2002 – 2004. Ken continues his occupational medicine practice in Calgary.

Dr. Jeremy Beach of the University of Alberta, and current president of the AMA Section of Occupational Medicine, has agreed to become co-editor of the Newsletter with Dr. Ken Corbet of the University of Calgary.

Michelle Sinotte, Instructional Librarian with the U of C Health Sciences Library is assisting with the planning and production of the Newsletter.

This issue's keynote article comes from the Institute for Work and Health in Ontario. Authors Dr. Joan Eakin and Judy Clarke describe from several perspectives the challenges that face an injured employee, his or her family, the small business owner, and workers' compensation boards. As treating physicians, our best medical efforts can be frustrated if there are larger issues of communication, trust, and job satisfaction. Primum non nocere, effective communications and timeliness are needed if we, as physicians, are to be part of a return to work solution, rather than part of the problem.

As a side note, Dr. Eakin began her social research of small businesses while at the University of Calgary. The paper she cites from 1992 was based on a study of health and safety attitudes of Calgary small business owners.

A shorter article (also reprinted from the Institute newsletter), reports on a study of how workers with arthritis cope in the work place.

Lastly, as always, we have listed several upcoming educational activities relating to occupational medicine.

We hope you enjoy this issue. Comments from readers are always welcomed at: *msinotte@ucalgary.ca*

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Co-Editors

THE EARLY AND SAFE APPROACH TO RETURN TO WORK: HOW IS IT WORKING IN SMALL BUSINESSES?

* Joan M. Eakin, MSc, PhD
** Ellen MacEachen, PhD and
*** Judy Clarke, BSc, MA

Unsuccessful return to work (RTW) after injury on the job has profound personal implications for workers, is disruptive and costly for employers, and represents a major financial liability for compensation agencies.

RTW is a complex, multi-dimensional process that depends as much on social, psychological and organizational factors as on the nature and severity of physical disability. Much policy and research effort is directed to the search for more effective strategies for managing RTW.

Early and Safe Return to Work (ESRTW) in Ontario

ESRTW is legislated in Ontario and underlies the approach of the Workplace Safety & Insurance Board (WSIB) and associated disability management sector. The approach

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aims to have injured workers return to work as "early" as possible after injury, before full recovery, and to have employers "accommodate" them by providing "modified" jobs that workers can manage without further injury. A core feature of ESRTW is "self-reliance": workplaces themselves are given primary responsibility for managing RTW, with the WSIB's role being limited to monitoring, facilitation and mediation. Workplace parties have a legislated "duty to co-operate" with the process. From a policy perspective, the challenge is to get workplace parties to be self-regulating in the intended way. Incentives for employers include financial rebates and penalties; for workers they include access to compensation and other supports.

An early return strategy is facilitated and legitimated by a shift in therapeutic opinion away from rest and pain avoidance as remedies for many musculoskeletal injuries (for example, Waddell, Feder, & Lewis, 1998; Waddell & Main, 1998), and by the growing belief that early return is health promoting (for example, AHCPR 1994). Workplace self-management of RTW is also guided by professional practices, including counsel in "best practices," such as the need for documentation and constant communication. Formal institutional mechanisms for managing compliance and fraud in the system are also part of the control apparatus of ESRTW.

A study of ESRTW in small workplaces

Existing research suggests that there are significant barriers to rehabilitation and disability management in small firms (Drury, 1991) and that RTW rates are inversely related to organizational size (Cheadle et al., 1994; Clarke et al., 1999). A recent University of Toronto/Institute for Work & Health study has explored ESRTW in small workplaces, particularly its sociological dimensions. The research used qualitative methods, including the analysis of textual materials (for example, policy documents) and interviews with injured workers and employers in a variety of independent small businesses (with less than 50 employees), and with disability and compensation professionals. Interviews were conducted using methods specifically designed to allow participants to speak freely, in their own terms, about the general nature of their work lives and about matters of injury, compensation and RTW.

This study identifies elements of ESRTW that can have problematic implications in small workplaces. It is important to note that the study was designed not to describe the prevalence of such elements, but to describe and account for their character.

The social ecology of small workplaces

ESRTW in small businesses cannot be understood without reference to the nature and social organization of working life (Eakin, 1992). Many small firms are economically marginal and financial concerns are often paramount. In addition to being a key point of labour market entry for youth and immigrants, small businesses are often family enterprises. In the smaller establishments, employers generally have little or no managerial support and fulfill most organizational functions themselves. Although there is great variation between small enterprises, working life is often characterized by informal and personal employment relations, and a high valuing of independence, reciprocity and mutual obligation. All of these characteristics have significant implications for many aspects of business operation, and form a critical context for understanding RTW.

Employer experience

Small business employers can find production seriously, even catastrophically, disrupted by the injury of a key worker. There is generally little slack in the organization for back-up possibilities, and substitution of workers can be impossible ("You can't put a mechanic at the front desk!"). The demands of ESRTW compound the already challenging task of running a small enterprise. ESRTW is viewed as a business problem, and employers find ways to self-rely within the regulations so as to maximize the interests of the business ("playing it smart"). For example, one employer in the study avoids an increase in lost time by placing workers in charity work until they have recovered; another routinely contests compensation claims because it is more cost efficient in the long run.

Employers are not supposed to get involved in the medical side of RTW. However, some employers find that the input of return to work professionals is not always timely or consistent or based on adequate knowledge of actual working conditions. They find themselves left to figure things out on their own, making decisions regarding injury severity, work readiness and timing of return. Some get drawn into mediating and coordinating therapeutic advice and even into "playing the doctor," as in the case of one employer who sent injured

4employees, at the company's expense, to a private physiotherapy clinic.

ESRTW can disrupt ongoing authority relations within the firm. Some employers report trying to manage the resentment of co-workers who see injured workers as being favoured with "cushy" jobs. Occasionally, the only suitable modified work involves promoting the injured worker to a higher position, which can destabilize work relations. Employers may be drawn into issues of compliance and abuse. Some become preoccupied with the possibility that injured workers are faking, exaggerating, or claiming for injuries incurred outside of work or at other workplaces. Employers sometimes get involved in monitoring the worker's compliance, gathering evidence from professional consultants, other workers, even sometimes the worker's family or neighbours. A few said they hire private investigators to uncover employee transgressions. In any case, employers take on, as it were, the function of "field monitors" for the system, a role some of them resent and resist ("I don't want to be the bad guy"). Employer involvement in compliance and surveillance typically precipitates a rupture of formerly intact relationships between employers and workers, or intensifies already existing strains, and invokes spiraling deterioration in employer-employee relations.

Injured worker experience

The worker's experience with injury and ESRTW is frequently characterized by profound personal distress and social disarray. Much of this experience revolves around or is intensified by injured workers' encounters with the discourse1 of abuse. Most injured workers feel that their entitlement to compensation and time off work is under scrutiny, and deeply resent representation of injured workers as cheating, as being unwilling to work, as out for a "free ride," and as "milking the system" ("They [boss, WSIB] gave me the impression that I was faking it and, I just wanted basically...somebody to pay me so I could, you know, sit at home and watch my soap operas.").

Such imputations erode injured workers' sense of themselves as trustworthy persons and make defense of their moral identity a central feature of their experience with ESRTW. Much of what they say and do is at least in part, consciously and otherwise, directed towards publicly demonstrating the veracity of their claims of disability. Some workers hesitate to avail themselves of certain legal provisions (for example, reimbursement for drug costs) for fear they would be seen as "taking advantage" of the system, or as ungrateful. Injured workers must actively "perform" their credibility and goodwill. For example, one worker defended himself against the suspicion of "scamming" by insisting upon going back to work against medical advice, a gesture that also symbolically expressed loyalty to his job and his employer. The search for credibility overflows into non-work life. Workers recount stories of being reluctant to carry out the garbage, for fear of being seen by neighbours and judged (or worse, being reported to the authorities) as too able-bodied to be legitimately off work.

The expectation of early return and co-operation creates additional problems of credibility and the need for justification and negotiation. How do you know and convince others that you are ready (or not) to resume work? What constitutes an acceptable reason for turning down an offer of modified work? The same behaviour can be seen as co-operative or unco-operative, depending on the social context in which it is being viewed. Any aspect of RTW may become a litmus test of "good" co-operation. The need to "perform" co-operation can drive moral wedges between injured workers and co-workers, or create conflicting demands (for example, if workers refuse modified work to avoid chafing other workers, they may be considered unco-operative and be put at risk for losing their institutional support).

Implications for policy and practice

This study prompts reflection on some of the underlying assumptions of the ESRTW approach. First, although this study cannot determine if the approach reduces compensation costs, it does point to some ways in which costs are being transferred (for example, to employers, injured workers and their families, other institutions) or may be of a new sort (for example, self regulation in small workplaces loses the economies of scale of administrative knowledge and experience in managing RTW that exists in larger workplaces).

Second, the notion of "safe" in ESRTW needs to be expanded to incorporate notions of social and psychological safety in addition to conceptions of physical security. In contrast to the belief that early return to work is of psychological benefit to workers and hastens recovery, these findings reveal negative social experiences that have been found elsewhere to contribute to the development of chronic disability (Reid, Ewan, & Lowy, 1991; Tarasuk & Eakin, 1994; Tarasuk, Shannon & Ferrier, 1998).

Third, the findings raise issues about the notion of early return. With ESRTW, workers may get limited time out and find themselves back at work while they are still in a fragile and vulnerable physical and emotional state. They have incomplete access to the "sick role" (Parsons, 1975) and to socially legitimated relief from normal responsibilities. Their status is ambiguous – they are not "normal," but they are at work; they are injured, but expected not to act so; they get some of the rights of the sick role, but not all. Their vulnerability at this time clearly saps their capacity to meet the demanding requirements of ESRTW and to negotiate their way through a social minefield of contingencies that have the potential to profoundly influence their lives.

Fourth, the study flags some challenges in the application of self-reliance in small workplaces. Self managed RTW can be problematic because it assumes a level playing field among workplace parties in negotiating RTW. Without such in-house structures as unions or health and safety committees, small workplaces are generally poorly positioned to manage the inherent difference in standpoints and interests between employers and injured workers. RTW is politically charged terrain and can easily become adversarial. Although the ESRTW approach allows for a WSIB role in conflict resolution, by the time mediators get involved, some problems can be intractable and the damage irreversible.

Fifth, although psychosocial challenges of RTW have been reported in workplaces of all sizes (Harlan & Robert, 1998; Niemeyer, 1991; Strunin & Boden, 2000; Williams, 1991), many ESRTW problems are linked to workplace size. The ESRTW model appears to be primarily designed with the large, unionized workplace in mind. It is likely that one size does not fit all, and that alternative strategies are needed that are tailored to the structural conditions of work and social relations of small enterprises.

Finally, the study suggests that some issues – particularly the discourse of abuse and its impact on workers and the system – transcend size and the particulars of RTW. The politics of entitlement and blame are central to occupational health and social welfare systems more generally, and deserve serious reflection in tackling the challenges of RTW.

Based on the report: *Return to Work in Small Workplaces: Sociological Perspectives On Workplace Experience with Ontario's "Early and Safe" Strategy*, November 2002, by Joan M. Eakin, Judy Clarke and Ellen MacEachen. This study was funded by the Ontario Workplace Safety & Insurance board's Research Advisory Council.

*Dr. Joan Eakin is a sociologist with a research interest in work and health. Her focus is on the relationship between health and the social relations of work.

**Dr. Ellen MacEachen received the 2003 Mustard Fellowship in Work Environment and Health at the Institute for Work & Health.

***Judy Clarke is a Research Associate for the Institute for Work & Health

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Footnote: 1. A set of interrelated concepts, ideas, and practices (including talk, actions), manifested in both everyday behavior and in institutional texts, materials and objects (for example, policies, bureaucratic forms).

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STUDY LOOKS AT HOW WORKERS WITH ARTHRITIS COPE

Reprinted with permission from At Work: Information on Workplace Research from the Institute for Work and Health issue 37 Summer 2004.

How do people with chronic, sometimes disabling health problems cope in the workplace? Dr. Monique Gignac, who recently joined the Institute as an Adjunct Scientist, thinks it's important to find out.

"There's a definite lack of research about work and chronic illness–even though studies show chronically ill workers are more likely to leave the workforce than those without such problems," says Gignac, a social psychologist with an interest in stress and coping.

The goal of her four-year study, funded by the Canadian Arthritis Network and the Canadian Institutes of Health Research, is to learn how people adapt to work limitations caused by arthritis.

The study involves 492 people with a diagnosis of osteoarthritis and/or rheumatoid arthritis. They were all employed at the time of the first interview and worked in various fields including business, health services and transportation.

"Each person was interviewed three times at 18-month intervals," explains Gignac, who is also a Scientist with the Toronto Western Research Institute and an Assistant Professor at the University of Toronto. "We asked a wide range of questions about their health and how they were doing at work."

According to preliminary data, 40 per cent of workers said their arthritis had caused occasional work absences. One in five had switched from full- to part-time employment or had changed jobs. For example, one nurse became a community care access centre case manager and a construction worker became a truck driver.

Many workers reported making physical changes to their environment while others changed what they did (i.e. moving files from bottom to top drawers; carrying boxes on a trolley). Some gave up "extra" leisure activities to preserve their energy for work. Others reported asking for help from co-workers.

Disclosure to managers and co-workers is another troublesome issue, she adds. About one-third of those surveyed had not told people at work about their arthritis, fearing it might affect their employment or how others saw them.

Gignac believes the current "greying" of the Canadian workplace has major implications for workers, employers, policy-makers and others. According to a recent Health Canada report, arthritis and related conditions are the leading cause of long-term disability in Canadian adults. By the year 2026, it's estimated that six million Canadians will have arthritis, many of them will still be in their prime earning years.

"We want to share our findings about successful coping strategies with workers and also let employers know that making certain efforts–ergonomic changes, greater job flexibility–may reduce time and productivity losses caused by worker absence and turnover," says Gignac.

UPCOMING CONFERENCES

CANADA:

- **Occupational & Environmental Medical Association of Canada (OEMAC)**
  Annual Scientific Conference and AGM
  June 12 - 14, 2005: St-John's, Newfoundland, Canada.
  http://www.oemac.org/oemac/en/index.html

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- **School of Occupational & Environmental and Hygiene**
  University of British Columbia
  Comprehensive Industrial Hygiene Review Course
  June 13 - 17, 2005 UBC, Vancouver.
  http://www.soeh.ubc.ca/Continuing_Education/default.stm

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- **Alberta Chapter of the American Industrial Higiene Association**
  The 4th Annual Health & Safety Conference
  November 7 - 9, 2005: Calgary
  http://www.aiha.ab.ca/aiha_ab/library/05hsconf.pdf

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- **Canadian Centre for Occupational Health and Safety (CCOHS)**
  Continuing educational listings
  http://www.ccohs.ca/events/cont_ed.html

INTERNATIONAL

- **International Commission on Occupational Health (ICOH)**
  28TH International Congress on Occupational Health ICOH 2006
  June 11-16 2006: Milan, Italy
  http://www.icoh2006.it/

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- **Australia & New Zealand Society of Occupational Medicine (ANZSOM)**
  2005 Annual Scientific Meeting: Maritime Occupational Medicine
  August 9-13 2005: Fremantle, Western Australia
  http://www.anzsom.org.au/

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- **International Academy of Indoor Air Sciences**
  Indoor Air 2005
  September 4 to 9, 2005: Beijing, China
  http://www.indoorair2005.org.cn/

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- **Asia Pacific Occupational Safety and Health Organization (APOSHO)**
  Annual Meeting and Symposium
  Sept 5-8 Bali, Indonesia
  http://www.aposho.org/

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- **The Scientific Committee on Epidemiology in Occupational Health (EPICOH)**
  18th International Symposium on Epidemiology in Occupational Health
  11-14th September 2005: Bergen Norway
  http://melding.uib.no/doc/Konferanser/1101297970.html

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- **Northwest Center for Occupational Health & Safety (U of Washington)**
  A Small Dose of Toxicology - Steven G. Gilbert, PhD, DABT
  September 11-18, 2005 (Alaska Cruise)
  http://depts.washington.edu/ehce/OSHA/course/AKCruise.html

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- **XVIIth World Congress on Safety and Health at Work**
  September 18 - 22, 2005: Orlando, Florida
  http://www.appcluster05.com/App/homepage.cfm?moduleid=16&appname=343

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- **American College of Occupational & Environmental Medicine (ACOEM)**
  State-of-the-Art Conference (SOTAC 2005)
  October 26-30, 2005: Chicago, Illinois
  http://www.acoem.org/education/conference.asp?EVENT_ID=4