

**The Role Of The Physician In Disability Management:  
Assessing Family Physicians' View Of Discrepancies Between  
Practice And Canadian Medical Association Guidelines**

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## Abstract

This research project aimed to explore the views and perspectives of family physicians in British Columbia in regards to fulfilling their role in Disability Management. Specifically, seven physicians were interviewed in order to examine the discrepancies between physicians' practice in DM and their professional guidelines, with special attention to physicians' experience in collaborating with key stakeholders. Content analysis of the interview data revealed, that in accordance with previous literature, physicians' practice does not typically emulate the Canadian Medical Association policy and physicians describe several barriers as reason for this discrepancy. This study also revealed a multitude of frustrations encountered by physicians when interacting with other parties in Disability Management. This qualitative analysis of the physicians' point of view yields valuable insight into barriers, and potentially facilitating factors, for physicians to optimally perform their role in DM, while indicating specific areas worthy of further research.

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## Foreword

This is to acknowledge that the Literature Review section of this thesis (pages 2–23) is a large portion of an article titled ‘Physician-stakeholder collaboration in Disability Management: A Canadian perspective on guidelines and expectations’ by Christine A. Reynolds, Dr. Shannon L. Wagner and Dr. Henry G. Harder. This article has recently been accepted for publication and is forthcoming in the journal *Disability and Rehabilitation*, Vol. 28. As such, this document remains under copyright of the publisher Taylor & Francis Group (<http://www.tandf.co.uk>). This section of text has been included here with “entirely free permission” from the copyright holder.

The article was researched and written primarily by Christine A. Reynolds with guidance, feedback and edits from Dr. Shannon L. Wagner and under supervision of Dr. Henry G. Harder. These co-authors acknowledge the majority of this article was created by Christine A. Reynolds and that it is therefore appropriate for inclusion in this thesis. The senior author, other than the Master's degree candidate, has signed below in agreement that the contributions of the thesis author to this in-press article, are as stated.

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The Role of the Physician in Disability Management:  
Assessing family physicians' view of discrepancies between  
Practice and Canadian Medical Association guidelines

Introduction

The specific aims of this research were to examine discrepancies that may exist between the physician's role in Disability Management and return to work, as proposed by the Canadian Medical Association, and physicians' actual practice - with special attention to collaboration with key stakeholders. The literature identifies a distinct gap between the ideal function for the physician in Disability Management (DM) and the realization of these ideals (Edlund & Dahlgren, 2002; Guzman, 2002). For the Canadian Medical Association guidelines in particular, it is unclear to what degree the recommendations for the physician's role have been incorporated into physician practice. Further, few studies examine this issue from the perspective of the physician, and none to this writer's knowledge have employed a qualitative research methodology to explore the viewpoint of family physicians in British Columbia in regards to their role in Disability Management. The research herein included a series of interviews with family physicians to discover their view on the role of the physician in DM. These semi-structured interviews were conducted based on a series of evidenced-based questions addressing several domains that may highlight any inconsistency between the ideal function of the physician in DM and reality. The intent of this project was to gain insight into the physicians' perspective of their role as a DM stakeholder, including their frustrations, preferences and recommendations for improvement. Additionally, this research indicates directions for future study on this topic.

## Literature Review

Effective DM requires input and participation from a variety of stakeholders. Specifically, to assist in the recovery and return to work of an injured or ill employee, physician cooperation and collaboration with stakeholders is crucial. Together, with the role of the employer, the employee and the insurer, the physician is a critical component in DM – most notably, the family physician is in a unique position to offer objective clinical expertise regarding disability, while being detached from a particular workplace environment. The challenge for physicians is to avoid having to act as a gatekeeper to benefits or as the sole authority on return to work issues. In essence, the key to successful DM is for employers to offer early return to work options, for other stakeholders to identify and address concerns, and for the physician to treat and guide their patient while communicating information necessary for return to work planning.

The interaction between the physician and other DM stakeholders, especially the employer, is constantly evolving. Previously, the physician's word on return to work was viewed as absolute (Pransky, Shaw & Clarke, 2004). Currently, according to policy from medical associations across Canada, the physician's opinion should serve as a recommendation to be considered in conjunction with other factors when resolving return to work concerns (Canadian Medical Association [CMA], 2001). In particular, formal position statements from the Canadian Medical Association (CMA, 2001), the Alberta Medical Association (*Early return to work after illness or injury: The role of the physician in RTW planning*, 1994), the Manitoba Medical Association (Manitoba Medical Association [MMA], n.d.) and the Ontario Medical Association (*Ontario Medical Association position in support of timely return to work programs and the role of the primary care physician*, 1994) describe

the employer/employee relationship as the core of DM and stipulate that the appropriateness of returning to work is ultimately decided between these two parties, using restrictions or functional information provided by the physician for guidance.

Despite efforts by medical associations to clarify the physician's role in DM, the message contained in policy documents has not translated into practice. DM stakeholders, most often employers, still rely heavily on physicians' initiative when it comes to return to work decision-making and the physician continues to assume the majority of responsibility for resolving these issues. To effectively address disability in the workplace, this discrepancy between policy and practice must be remedied. That is, the physician must strive to emulate more closely the guidelines presented by their professional associations, while other DM stakeholders must work to educate and enable physicians in this function by fostering open communication and collaboration between parties.

In relation to DM, this review presents the physician's role in a historical context, various stakeholders' expectations of physicians, the position papers from several medical associations, and other relative guidelines. The discrepancy between the prescribed role for the physician and actual practice is highlighted as the basis for this research project.

#### *History of the Physician's Role in Disability Management*

Determination of disability and return to work capabilities of the injured or ill worker has historically been the responsibility of the physician, often based on medical assessment alone. Traditionally, employee absenteeism has been defined by a physician's assessment (Ontario Medical Association [OMA] Committee on Medical Care and Practice, 1994). Unfortunately, exclusively medical-based decisions regarding the appropriateness of return of work may be arbitrary (Douglas, 2000) and are frequently made with no knowledge of

particular job demands, other than as may be described by the worker. Due to this lack of information, the physician may base his/her decision on the worker's own opinion of ability to work rather than on a comparison of known work demands versus the patient's individual limitations. Furthermore, this type of decision-making by physicians is not always supported with objective medical criteria (Scheer, 1995). Regardless of whether objective medical evidence is part of the equation, the workplace typically remains distant from physicians and this often leads the physician to err on the side of caution when making return to work recommendations for their patients. For instance, if a physician is unsure of the work environment and its demands, she/he will often suggest time off of work until full recovery, rather than risk an unsafe return to work (Rankin, 2001). Unfortunately this protective, 'silo' type decision making is viewed by many DM stakeholders, employers in particular, as counterproductive to early return to work initiatives and to an employee's overall recovery. Conversely, physicians themselves are also frustrated with bearing the burden of dictating the final word on return to work. Thus, both physicians and employers are dissatisfied with the tradition of the physician making decisions in isolation (MacBride & Delvin, 1994). Some of the factors exacerbating this issue for physicians include time constraints, insufficient educational opportunities regarding occupational health issues, possible conflicts with their advocacy role, confidentiality, and the nature of the physician-patient relationship (Beaumont, 2003).

Fortunately, the trend today is away from physician certified absence, and towards a collaborative approach to return to work planning centered on the employee/employer relationship, hopefully relieving some of the onus placed upon physicians (*Ontario Medical Association*, 1994; OMA Committee on Medical Care and Practice, 1994). While in the past

employers sought physician approval before considering returning an employee to the workplace, today the employer may take a more active role in the decision making process, using the physician's recommendations as a guide. This cooperative approach allows each party to contribute to the DM process while working toward the dual goals of appropriate medical care and timely job re-entry ("Physician's must be patients' advocates", 2002).

#### *Stakeholder Expectations*

The expectations DM stakeholders have of physicians are sometimes diverse and may contribute to the complexity of the physician's role. Although certain parties may share mutual goals, the worker, the employer, the union, the insurer and the medical community all have different priorities. Accordingly, each of these groups has their own unique perspectives and beliefs regarding what the physician's role and responsibility should entail. For example, while most stakeholders recognize return to work as integral to a worker's recovery, differences in opinion arise over who should make return to work decisions (MacBride & Delvin, 1994). It is therefore helpful to examine the variable nature of the expectations specific to the key DM stakeholders who interact with physicians.

#### *Patient/Worker Expectations*

Of all the parties involved in DM, the worker/patient has the highest expectations of the physician. A patient expects their physician to provide appropriate medical treatment and prevent re-injury, while safeguarding their well-being and advocating for their health needs. Of these requirements, it is the personal care and attention from the physician that is foremost in importance to the worker. In fact, a physician's understanding and guidance appears to be more of a priority to patients than the physician's technical competence (Boland, 1995). Clearly then, patients value the interpersonal aspects of the physician's role. Boland (1995)

found that patients want a physician who will listen, sort out problems and that can be seen on a regular basis. These interpersonal factors set the foundation for the physician-patient relationship, unfortunately however, it is also possible that difficulties may arise as a result of this relationship's intimate nature.

As stated above, the patient expects a physician to advocate for their concerns. Although advocacy is a part of a physician's role ("Physicians", 2002; Melhorn, 2000), it is not implicit that this advocacy be entirely congruent with the patient's perceived needs. In other words, advocacy does not necessarily mean the physician should respond to all of the worker's requests. The physician's support should be based on what is felt would best serve the worker's recovery, and as Melhorn (2000) describes, should encourage rehabilitation as opposed to disability. That said, cooperation between patient and medical doctor remains crucial, otherwise advocacy will be overall ineffective.

With respect to medical insurance, the physician's role relative to patient expectations is complicated further as the physician is frequently, albeit reluctantly, put in a 'gatekeeper' position. Too often a worker's insurance benefits are contingent upon receiving some type of absence certification from their physician. As such, medical absenteeism is frequently patient-initiated, with the individual seeking documentation from their physician validating their perceived disability (McGrail, Lohman, & Gorman, 2001). The worker may be naturally disillusioned if the physician denies such a request, and this type of conflict can erode physician/patient interaction. It is therefore vital that the physician engage the worker in decision-making whenever possible and openly communicate the reason for actions required. Boland (1995) describes this interaction in his statement that "it is this delicate balance between patient autonomy and the appropriate use of expertise which lies at the heart of our

relationship with patients” (p.222). To best serve the DM process and the worker's recovery, it is essential for physicians to address a patient's wishes but strive for this balance with regards to patient expectations.

### *Employer Expectations*

As with the worker, employers also have expectations of physicians and their role in DM. Until recently, employers have relied almost entirely on medical doctors for making return to work determinations. Often lacking medical expertise internally, the employer looks to the physician to discern appropriateness of work for the injured or ill employee. Employers' interaction with physicians can be very limited and the physician commonly makes return to work decisions in isolation, as outlined previously. As a result, many employers have traditionally assumed a passive position in relation to working with the physician (*Ontario Medical Association, 1994; Sperry, 1996*). However, given the significant human and financial impact of disability, employers would benefit from a more proactive approach to solving return to work and other disability issues (*Sperry, 1996*).

Dependence on physicians for resolution of DM concerns has been a source of misunderstanding for employers. For example, employers feel frustrated by how easily they perceive physicians' provide 'off-work' notes, and by physicians' apparent lack of awareness of the economic impact of disability on industry (*Makdessian, 2000*). At the centre of this frustration is a lack of communication between employers and physicians. Often a physician's statement about return to work is viewed as final and absolute, leaving the employee and employer little room to negotiate (*Pransky et al., 2004*). However, even those employers without formal return to work programs have valuable, specific information about the workplace that must be shared with the physician. Scheer (1995) writes, “the physician

cannot fully appreciate the nature of work-injury relationships and the return-to-work goal of a worker-patient without visualization of the workplace” (p. 187). Nonetheless, the employer often expects the physician to resolve medical absence without knowledge of job demands and work environment. As previously described, this leaves the physician in a position where she/he must settle return to work issues based on medical evidence alone. The resulting, often conservative, recommendation by the physician is bound to disappoint the employer. Rankin (2001) suggests some introspection on the part of employers that along with improved communication may assist employers and physicians in the DM process.

The medical physician, while a full stakeholder, is often viewed by employers as a threat to successfully returning employees to work. Ironically, employers do not assess or analyze what they are doing or are not doing to address this perceived lack of co-operation. Rather they focus on what they perceive the employee – or the employee and the physician – is doing to sabotage the employer's return-to-work initiatives. When all stakeholders fully understand the issues and solutions available to the disabled employee, employer frustration will be addressed and the physician will not be left in the dark about accommodation options (Rankin, 2001, p. 20).

Thus, in addition to attending to the patient, the physician must be aware that valuable input is available from the employer and should consider the employer's expectations in the DM process – collaborating with the workplace is at the core of the physician's role in the resolution of return to work issues.

#### *Insurer Expectations*

The expectations of third party insurers also affect the physician's function in DM. Disability Insurers and Worker's Compensation Boards have unique requirements of physicians. These parties primarily need information to assist in the adjudication of medical claims, and as such insurers' expectations of the physician's role can be quite different than those of other stakeholders (*Ontario Medical Association, 1994*). Generally, insurer groups are more sophisticated in terms of medical expertise than the employer or worker, and



therefore they expect to receive detailed, technical information from physicians to assist in entitlement decisions. Typically, an employer has access to workplace relevant restrictions provided by the physician and cannot obtain medical or personal information without a worker's consent. The insurer on the other hand, is usually privy to such clinical records because of legislative or contractual agreements. Moreover, insurers often have internal health professionals who are able to interpret technical medical information.

Each insurer has their own distinct set of policies and procedures that define the nature of their interaction with physicians and other stakeholders in DM. The variation and complexity of insurance systems however, can make it difficult for physicians to effectively meet the needs of these groups. While each public or private insurer has its own intricacies, some demands on physicians are common. For example, most insurers, including Worker's Compensation Boards, expect the physician to focus on a certain injury or illness adjudicated as part of a specific claim (*Worker's compensation act*, n.d.). Ironically, despite this request to contain treatment to a specified area, insurers will frequently expect physicians to answer broad questions such as whether a worker is capable of returning to work; in essence, expecting the physician to act as an adjudicator (Dorrell, 2002). This can be a source of friction for physicians, who without complete knowledge of an insurer's benefit system are asked to make a decision that may affect the status of a worker's claim and accompanying benefits (*Ontario Medical Association*, 1994). To resolve potential conflicts between insurers' expectations and physician cooperation, insurers' requests of physicians must be congruent with contractual and other agreements outlining appropriate interactions between these parties.

*Physician Expectations*

Physicians themselves also have an idea of what their role in DM should encompass, of primary importance to most physicians is their relationship with the patient. In the DM context, physicians' priorities are to focus on improving the health and well-being of the worker, and to provide appropriate treatment and guidance in a professional, courteous manner. McGrail et al. (2001) state that preventing disability depends on the success of this physician/patient relationship.

With regard to stakeholders other than patients, physicians' expectations of their own role can be affected by negative perceptions. When acting with employers for instance, physicians may be guarded or protective of their patients because while serving as patient advocates, some physicians view the employer as the 'bad guy' (Makdessian, 2000; Harder & Arnold Smith, 2004); the same can also be said for the physician's attitudes towards insurers. Naturally, the physician's role is to safeguard the health of the employee and for many physicians, insurer initiated early return to work may be perceived as a threat to their patient's recovery. As suggested previously, improved open communication between physicians and DM stakeholders is needed. In order to minimize negative perceptions and improve the physician's DM participation, all groups must consider various options and develop 'win-win' solutions in the best interest of the worker. For example, employers must make physicians and insurers aware of return to work programs and available modified work for injured or ill employees. This awareness will deter physicians from taking an unnecessarily protective stance for their patients, and encourage medical doctors to use the workplace proactively to enhance employee recovery and return to work success (*Ontario Medical Association, 1994*).

As has been discussed, physicians are continuously challenged in meeting the expectations of DM stakeholders. Regarding the optimal role for the physician, Edlund and Dahlgren (2002) describe that overall “physicians show that they experience a large and most likely growing discrepancy between ideal and reality. They want to be able to function as ‘team players’ but at the same time the demands on them have increased” (p 732).

Therefore, for DM to be effective, it is vital that the expectations and needs of stakeholders, and the challenges they present, be incorporated when defining the physician's role.

#### *Canadian Guidelines for the Physician's Role in Disability Management*

Appropriately, it is the medical community itself that has come forward in recent years with practice policies that outline the physician's involvement with return to work. In these guidelines, the medical community asserts that the focus of the physician's role should shift away from making work ability determinations in isolation and that return to work should ideally be negotiated between the employer and employee (McGrail et al., 2001). This new approach forms the foundation for policy statements by several Canadian medical associations. To date in Canada, official policies regarding the physician's role in return to work have been issued by the Canadian Medical Association (CMA, 2001), the Alberta Medical Association (*Early return*, 1994), the Manitoba Medical Association (MMA, n.d.) and the Ontario Medical Association (*Ontario Medical Association*, 1994).

#### *Alberta Medical Association Guidelines*

The first Canadian medical association to establish a formal policy addressing the physician's role in DM was the Alberta Medical Association (AMA). In February 1994, the AMA released a position statement entitled *Early Return to Work After Illness or Injury* and this document was designed to describe the attending physician's function in the return-to-

work process (*Early return*, 1994). The basis for the AMA policy is the notion that early return to work benefits a patient physically, socially, and financially, and that it preserves a stable workforce for the employer. In keeping with this viewpoint, the AMA describe the physician's role in facilitating workplace re-entry for employees, but stress that it is the employer that ultimately controls whether or not the employee can come back and, if so, when. The AMA position statement indicates that "it is the employer who determines the type of work available and whether a physician's recommendations can be accommodated" (*Early return*, 1994, p. 2). A summary of the physician's role in return to work planning, as detailed in the AMA statement is as follows,

- 1) Planning for return to work should begin early in the disability period
- 2) The physician should become familiar with the essential demands and health and safety hazards of the patient's work
- 3) The physician has a responsibility to both the patient and society and may be required to put the public interest before that of the individual patient
- 4) When the physician believes the patient has sufficiently recovered and can safely participate in a trial return to work period, the patient should be clearly informed. When providing a written note to the employer, the physician should consider: task limitations, schedule modifications, environmental restrictions and medical aids or personal protective equipment
- 5) In all cases, the physician must state whether these restrictions are permanent or temporary and, if temporary, give an estimate of their duration
- 6) Medical information may only be divulged when requested and authorized by the patient and physicians must consider who will be interpreting the return-to-work note (*Early return*, 1994, p 1-2).

What is clear from the AMA position statement is that the physician is instructed to consider job demands and potential modifications to tasks, schedule or environment, when reflecting on a patient's suitability to return to work. These guidelines also emphasize that the physician's responsibility lies in providing the employer with appropriate permanent or temporary restrictions, in regards to the patient's abilities. Accordingly, the AMA policy

proposes that it is then the supervisor, safety officer or nurse who will actually be determining if work within the physician's restrictions is available (*Early return*, 1994).

#### *Manitoba Medical Association Guidelines*

Following the AMA's document on the physician's role, the MMA (MMA, n.d.) released a position statement called *Early Return to Work After Illness or Injury: Role of the Physician in Return to Work Planning*. This document is similar to the AMA policy and outlines essentially the same key points highlighted in the AMA recommendations. Some additional information included in the MMA document is worth noting. Mainly, the MMA stipulates in their introduction that a worker need not be '100%' before attempting work in some capacity, and that inappropriate delays in returning to work may predispose a worker to chronic pain and disability. Overall, the central theme of the MMA policy statement reiterates the theme of the AMA document – that is, the physician's role is to provide restrictions and it is the employer's responsibility to assess whether there is work available that meets these restrictions. As per the words of the AMA, the MMA statement also reads "it is the employer who determines the type of work available and whether a physician's recommendations can be accommodated" (MMA, n.d., p. 2).

#### *Ontario Medical Association Guidelines*

The OMA has also released a position paper addressing the physician's role in return to work. This document was published in March 1994, after the Alberta policy, and is entitled *OMA Position in Support of Timely Return to Work Programs and the Role of the Primary Care Physician*. The OMA policy is considerably more comprehensive than those produced by the AMA and MMA. In addition to focusing in more detail on the philosophy found in the previous two documents, the OMA statement includes guidelines for timely

return to work programs and for physicians' interaction with disability insurers. In their paper, the OMA defines the role of the physician in helping employers and employees achieve return to work objectives, highlight the value of work in rehabilitation and treatment, and identify early return to work as an intervention (*Ontario Medical Association, 1994*).

From the start, the OMA position statement explains that they intend to take an evidence-based approach to the issues surrounding the physician's involvement in DM. The introduction reads,

The primary purpose of this paper is to make it clear that medicine is open for dialogue with employers and employees. We recommend that future initiatives to reduce absenteeism due to injury or illness be based on data and data analysis regarding the pattern and course of such absenteeism over and above the clinical diagnosis (*Ontario Medical Association, 1994, p. 2*).

Therefore, at the outset, this paper stresses an impetus for changing the medical community's current practice in return to work and rehabilitation. In terms of DM, the OMA position statement suggests that we eliminate the gatekeeper/adjudicator role of the patient's family physician, and preserve the physician's responsibility to address prevention issues. The OMA policy also encourages physicians to help the patient focus on their capabilities and to utilize timely return to work programs where available. In keeping with the other two provincial policies, the OMA paper leaves the decision on return to work up to the employer and employee, while the physician provides prompt treatment, medical restrictions and "proactive support for the employee's disease-specific capabilities" (*Ontario Medical Association, 1994, p. 7*).

*Canadian Medical Association Guidelines*

Subsequent to the three provincial policies establishing the physician's role in DM, the CMA (CMA, 2001) published a policy statement on the same topic. The document is

entitled *The Physician's Role in Helping Patients Return to Work After an Illness or Injury* and the CMA cites the AMA, MMA and OMA statements as the basis for this policy. The introduction in the CMA paper summarizes the physician's role in a DM context as follows,

The physician's role is to diagnose and treat the illness or injury, to advise and support the patient and communicate appropriate information to the patient and the employer and to work closely with other involved health care professionals to facilitate the patient's safe and timely return to the most productive employment possible (CMA, 2001, p. 1).

The CMA document expands on the recommendations listed previously in the AMA policy. As per the provincial medical associations' positions, the CMA supports the concept of the employer/employee relationship as the key element in return to work determination. In particular, the CMA policy states that "successful return to work primarily involves the employee and his or her employer and requires the assistance of the attending physician" (CMA, 2001, p.2).

It is both fortunate and timely that several provincial medical associations and the CMA have taken the initiative to address the physician's role in DM, as this is an area that is often a great challenge to other stakeholders. Specifically, the theme in the three provincial policies has been endorsed and validated by the CMA's position paper. What is critical here is that the four formal policies share a common message - that is, the physician's role is to provide medical treatment and guidance, and to provide information outlining a patient's restrictions. These documents all consistently express that it is the employer and employee who have the responsibility of facilitating return to work in cooperation with each other and the workplace environment. Thus, the consensus within the Canadian medical community is that return to work decision-making should not be the sole responsibility of the physician.

*'Physician Education Project in Workplace Health' Guidelines*

In addition to the medical association documents, a practical guide for physicians called *Injury/Illness and Return to Work/Function* was developed in June 2000 by the Physician Education Project in Workplace Health (PEPWH), and funded by the Workplace Safety and Insurance Board of Ontario (WSIB). As with the medical association documents, this publication outlines the physician's role in returning patients to work and/or function. The PEPWH guidelines describe physicians' responsibilities under the following headings: Assess, Diagnose, Treat, Develop Return to Work/Function Plan, Monitor, Report, Communicate and Prevent (Physician Education Project in Workplace Health [PEPWH], 2000). This document provides the background and theory for the physician's role in an attempt to act as a resource for medical professionals. The PEPWH philosophy mirrors those of the medical communities' position statements, underscoring their emphasis on communication, early return to work and the importance of the employee/employer relationship in determining return to work readiness. Also of interest, this document lists for physician's consideration, factors that have a positive or negative affect on patients' return to work.

The overall scope of the medical association policies and that of the PEPWH publication reflects the complex nature of the return to work process, the necessity of communication between concerned parties and the inappropriateness of the physician being placed in a policing role. It is clear from these documents that their writers have seriously considered best practices for physicians in terms of meeting the needs of the worker and other DM stakeholders. What is not evident in any of the policies is a strategy for implementation of these new guidelines. Therefore it is unclear to what degree the



recommendations have been incorporated into physician practice and/or awareness, nor how close the medical community is to achieving the ideals presented. Part of the challenge to implementing the current guidelines is the fact that so many other stakeholders contribute to the success of the physician in their role of assisting the patient in return to work.

Fortunately, other policies, legislation, contractual agreements and “best practice” protocols provide further guidance for physicians and their interactions with different groups.

#### *Insurer Guidelines*

For insurers, such as the Worker's Compensation Board (WCB) and private disability insurers, the physician's role can vary from treatment provider to clinical consultant to medical witness (Schoor, 1991). This range of expertise is utilized by insurers to solve a variety of claim related problems such as determining functional ability and work readiness, achieving diagnostic consensus or prescribing a treatment program. The more specific a request the insurer makes, the more effectively a physician can work to meet the insurer's needs. That said, insurers need guidance in both working with physicians and appropriately employing physicians' expertise.

The OMA's position statement on the physician and their involvement with return to work includes several points directly addressing the physician's responsibilities when working with insurers. Of primary importance is the concept that the physician is in no way required to make entitlement decisions, such as whether or not a patient qualifies for long term disability (*Ontario Medical Association, 1994*) as this function is the duty of the insurers and their internal policies and systems. In relation to the insurer, the OMA document reads,

The company claims adjudicator is responsible for the decision that the insured is, or is not, entitled to contractual benefits. However, the clinical role of the patient's personal family physician is still patient centered and remains:

1. To activate medical treatment, medical restrictions, and rehabilitation
  2. To co-operate with the patient's efforts to obtain third party benefits by providing timely objective information as requested
  3. To accept overall responsibility for the patient's medical care
  4. To request and help coordinate appropriate auxiliary treatment and rehabilitation services
  5. To advocate for the patient in ways described in this paper
- (*Ontario Medical Association, 1994, p. 5*)

Understandably, these are very general guidelines and every insurance policy or contract will have a unique framework. Working within an insurance system, whether it is WCB or a private disability insurer means that depending on the specific policy, actions by the physician will have certain consequences for the patient. Therefore, in making treatment and rehabilitation decisions, physicians must keep the intricacies and functions of a particular insurer in mind, without compromising their professional integrity and while striving to adhere to the above guidelines (Scheer, 1995).

In addition to general guidelines for insurer and physician collaboration, Worker Compensation (WC) has specific legislated requirements of physicians. The Worker's Compensation Act in British Columbia for example, details reporting timelines, reporting content, and physician billing as well as describing WC's control over treatment provided, treatment restrictions and potential physician punishment for offenses committed against the Worker's Compensation Act (*Worker's Compensation, n.d.*). As with private disability insurance systems, it is the physician's responsibility to remain abreast of their duty under Worker Compensation Acts in a given jurisdiction, and to be aware of the consequences of their actions on the Worker's Compensation patient.

Whether a worker's claim is covered by WC or by a private insurer, the physician's role is primarily to assess and treat impairment. As described, it is not the decision of the physician whether a patient is eligible for a disability benefit. This determination is a contractual one comparing insurer contract provisions against characteristics of the worker (Dyck, 2000). Ideally, Dorrell (2002) suggests that insurers should ask physicians about a patient's abilities, in addition to their symptoms, treatments and limitations when seeking input for claims management. Although most insurers are cognizant of what they can reasonably expect from physicians in terms of assistance with DM, due to the increasingly complex and litigious nature of medical insurance claims the interaction is rarely as simple as these guidelines suggest. Thus, as with the medical community guidelines for physicians, insurer policies and even contractual agreements, do not always translate into actual practice.

#### *Employer Guidelines*

When compared to the formal policies outlining physician-insurer relations, guidelines for employer-physician interaction can be much less clear. Employers are frequently uncertain of what they can expect from physicians and how the workplace should best approach physicians to resolve return to work issues. Furthermore, many small to medium-sized employers may not have formalized return to work programs, making it more difficult for the physician to safely encourage early return to work. In general terms, for employers, the physician's role should be limited to quantifying physical abilities, organizing medical treatment and monitoring and evaluating treatment plans to ensure employees are progressing towards return to work objectives (Rankin, 2001). For some time, employers have also relied on the physician to make return to work decisions. However, as the Canadian medical association policies now state, deciding return to work issues should essentially be

an outcome of the employee-employer relationship, with the physician contributing information to assist in the decision making process (CMA, 2001; *Early return*, 1994; MMA, n.d.; *Ontario Medical Association*, 1994).

Previously, an employer expected a worker to be '100%' before returning to the workplace and physicians were often reluctant to recommend an early work re-entry. Though gradually, with increased awareness of the significant benefits of early activation, both employers and physicians are working to bring employees back to work before they have completely recovered. Medical association guidelines now recommend,

a shift away from the 'full-recovery' model of disability management to a proactive model where employees and employers work together using objective medical input from workers' personal physicians. In effect, the disabled worker and management would have primary responsibility for initiating a return to work program that incorporates input from the physician (MacBride & Delvin, 1994, p. 32).

Many workplaces are incorporating these principles and developing return to work programs for injured or ill employees. The availability of appropriate modified work for the returning employee means that physician's medical restrictions can often be accommodated and timely return to work achieved.

The OMA position statement goes as far as to suggest for employers, certain core values for timely return to work programs, including specific guidelines for the physician. In relation to return to work programs, the OMA suggests the employee's physician offer current concepts in treatment and rehabilitation, advocate for a quality employee-employer relationship, and provide timely, well-founded, functional limitations (*Ontario Medical Association*, 1994). Ideally, employers should keep these parameters in mind when making requests of physicians in order that they may fulfill their role accordingly.

Despite the fact that medical associations and other sources clarify the physician's role with employers to some degree, in reality many physician-stakeholder relationships are marred by struggle and misunderstanding. As such, physicians would benefit from improved interactions with key DM parties. Fortunately, medical association policy, in combination with insurer and employer guidelines as described herein, can serve as a basis for 'best practice' ideals in this regard.

### *Challenges for the Physician*

Moving forward, the role of the physician in DM will continue to evolve and some particular challenges exist for the physician as we look to the future and their continued contribution to managing disability. Specifically, the suggested scope of the physician's role, the need for physician education in DM, and the availability of workplace return to work programs are key issues of concern. Although timely and relevant, the position statements of the medical associations offer a broad and theoretical definition of the physician's role in return to work. Responsibilities described in these documents are as diverse as recognizing health and safety hazards of the workplace to considering psychosocial barriers to recovery. The CMA position statement for example, includes phrases such as "the physician should identify and address potential obstacles to the recovery of function and return to work as soon as possible" (CMA, 2001, p. 3) and "the physician should be familiar with the family and community support systems" (*Early return*, 1994, p. 2). Although it may be well-founded to expect these duties to be part of a physician's role, the reality is that physicians are hard pressed to achieve these ideals, on top of providing primary medical treatment and guidance.

Some of the difficulty in implementing these guidelines is likely due to physicians' time constraints, high workload and a lack of DM-specific educational opportunities (Pransky et al., 2004). In particular, Dorrell (2002) suggests that physicians being overworked and having minimal training in DM as the reasons the CMA document message is, in many cases, not being realized. Further, the OMA acknowledges that having clarified and described the ideal contribution of the attending physician, another step is still needed – that is, financial incentives reinforcing physicians' adoption of the proposed role definition (*Ontario Medical Association, 1994*). As for education in DM, physicians receive minimal formal instruction in this area (Pransky, Katz, Benjamin & Himmelstein, 2002) and many family physicians lack training in Occupational Medicine prior to establishing a practice (*Ontario Medical Association, 1994*). This educational void in the field of DM must be addressed in order for physicians to successfully implement their newly outlined professional guidelines.

Finally, even with increased awareness and training, the success of the physician performing this role hinges to a great extent on the presence or absence of return to work programs in the workplace. Without a return to work program or availability of modified work, the physician is left with very little choice in terms of safely encouraging and facilitating early work re-entry for their patients. The more commonplace these programs become, the more options will be available for the physician to consider when defining worker limitations and capabilities. Krauser (1994) states that “there appears to be a general agreement among key stakeholders that timely return-to-work programs represent a win-win-win situation for employees, employers and primary-care physicians” (p. 31), but until return

to work programs become the norm, physicians will be significantly limited as to the effectiveness of their DM efforts.

### *The Physician's Perspective*

Despite an apparent lack of awareness about DM, the broad nature of the suggested scope of practice and the presence or absence of employer return to work programs, ideally physicians will aspire to perform as close to their professional guidelines, and stakeholder expectations, as possible. Adhering to the recommendations of the medical associations and other best practice policies is critical to the success of the DM process and will enhance the efforts of other stakeholders. Most significantly, physicians will hopefully support the employer-employee relationship as central to resolving return to work issues, and to this end, communicate with these parties as needed.

Unfortunately, few studies have assessed the gap between these proposed ideals and physician's own practice; in particular, the discrepancy that exists between physician approaches and Canadian medical association guidelines. In order to optimize stakeholder collaboration and in turn overall DM effectiveness, the perspective of the physician must be understood. Two studies, each employing a survey format, provide some insight as to the physician's view on DM issues and their role therein; however, these studies do not encompass family physicians in British Columbia. Pransky et al. (2002) found that although primary care physicians acknowledge a key role in DM, their practices in managing patients' time absent from work, providing patient restrictions/limitations and communicating with employers may lead to poor return to work outcomes. Similarly, Guzman, Yassi, Cooper and Khoklar (2002) conclude that for family physicians in Manitoba, most appear aware of their role in DM and their effects, but that their actions differ from professional guidelines.

Guzman et al. (2002) specifically suggest that qualitative research methods may provide valuable insight to the physicians' perspective, but in particular may serve as a vehicle to better assess the influence of 'desirability' (discussed under *Potential Limitations*) in physicians' reporting of their practices.

### Research Aims

The research conducted here aimed to better understand dilemmas facing physicians in their efforts towards performing the ideal role in DM as outlined in Canadian guidelines. Further, physicians' own suggestions for optimizing their function in DM were also elicited. It is by asking physicians themselves, what their thoughts, views and experiences are in relation to their role in DM, that recommendations for improving future practice can be developed. The results of this research also indicate directions for further research through revelation of critical elements and issues in DM, from the physicians' point of view. Perhaps more importantly, this research provides a glimpse into the physicians' perspective of their DM role which may facilitate greater understanding of the challenges they face, and perhaps contribute to improve physician collaboration with stakeholders, leading to more effective DM.

### *Research Questions*

What are the views, perspectives and experiences of BC family physicians with respect to their role in Disability Management, specifically in collaboration with key stakeholders? How does their practice compare to their ideal role in DM as proposed by the CMA? What do BC family physicians suggest as solutions or recommendations to enable fulfilling this 'ideal' role?



## Methods

Taylor and Bogdan (1998) state that, “the important reality is what people perceive it to be” (p.3) - the value then, of the information gained from examining the physicians’ viewpoint on DM issues is evident. The research conducted here, which aimed to assess family physicians’ perspective of their role in DM, was exploratory in nature and as such was best suited to qualitative research design (Morse & Field, 1995). A qualitative methodology was most appropriate because very little literature exists regarding the subject of inquiry - comparing the physicians practice and perceptions to their professional guidelines for DM – and, the research objective was to gain insight into this relatively novel issue through descriptive input from physicians (Creswell, 2003). With respect to learning about the physician’s role in DM from the perspective of the family physician, in the context of their unique practice, the appropriateness of utilizing qualitative research methodology is supported in the following comment from Morse and Field (1995), “qualitative methods are particularly useful when describing a phenomenon from the *emic* perspective, that is, the perspective of the problem from the ‘native’s point of view’” (p.10). In addition, the proposed research was entered into without a concrete and specific hypothesis or preconception of the physicians’ opinions and views in terms of the DM component of their job - in fact, it is this lack of understanding of the physician’s perspective that inspired this research initiative.

A content analysis was the core of the research analysis; any ‘theorizing’ was based on the data themselves (physicians’ responses and comments) as opposed to pre-established theories or themes (Taylor & Bogdan, 1998). It is this researcher’s view that in order to fully appreciate any discrepancies between physicians’ practice and their proposed function in

DM, along with other related issues, physicians' insights must be explored in depth; to date, to this writer's knowledge, this has not been done in a qualitative fashion for physicians in BC.

### *Participant Selection*

Study participants were family physicians from several private practice locations in British Columbia; seven physicians in total were selected from both the Lower Mainland and Northern British Columbia. Implementing theoretical sampling – the identification and use of participants whom the researcher feels may best inform the research based on the theoretical foundation for the project (Morse & Field, 1995) – a diverse sampling of family physicians, in terms of geographic, demographic and professional characteristics was attempted. Theoretical sampling for this research insured that in determining participants, as many variables as possible that influence responses/opinions, and in turn the results of the research, were included in the sample group (Mays & Pope, 2000). Incorporating a range of viewpoints also decreases the likelihood that a particular perspective was presented as the 'sole truth' on the topic and improved the validity of these research findings (Mays & Pope, 2000).

Physicians were identified, for the most part, through previous contact with the researcher or program supervisor, while other family physicians were selected from the British Columbia College of Physicians and Surgeons' (BCCPS) online physician directory. All physicians approached regarding involvement with this research project were registered with the BCCPS. Potential participants were contacted initially by phone at which time the proposed research intent was summarized briefly and a request for permission to send more information about the project was communicated (see *Appendix 1* for phone script). In

support of the principal that the nature and consequences of any research must be fully and openly disclosed prior to agreement to participate (Christians, 2000), a copy of the Research Information Sheet (see *Appendix 2*) was sent via fax to potential participants for their review. If interested, an interview date was determined at a place and time of convenience to the participants – most often the office of their professional practice. After participants had reviewed the information sheet, a signed consent (see *Appendix 3*) was requested of and received from all participants prior to commencing interviews. Participation in this research study was voluntary and subjects for inclusion in this research were not compensated, but each received a nominal gift (a UNBC mug) in appreciation of their contribution. To assure confidentiality as the “primary safeguard against unwanted exposure” (Christians, 2000, p.139) a numbering system to replace individual physician names (e.g. ‘Interview 1’ in place of ‘Dr. J. Smith’) was employed to anonymously identify recorded audio files and interview transcripts. Participants were permitted to withdraw from the research at anytime without consequence, and any information already collected would have been securely disposed of; to date, no participants have withdrawn from the study.

### *Ethical Considerations*

This research project was approved by the University of Northern British Columbia Research Ethics Board. Although qualitative research is considered to be low risk, the issue of confidentiality in conducting one on one interviews with family physicians could be an ethical concern. Confidentiality was formally addressed in this research to avoid two avenues of sabotage – the physician's own privacy must be respected and maintained, as must that of patients. To this end, the researcher explained in the pre-interview conversation with the physician participant, the use and nature of the research, the use of the data and the lack of

risk inherent in the project. Prior to data collection, informed consent was then obtained for each physician participating in the study. Also of concern, in relation to several questions in the semi-structured interview, a physician may conceivably have responded by describing a particular patient along with their characteristics, conditions and/or DM implications. In this type of situation, the physician was requested to keep the identity of their 'example' anonymous and if needed, was instructed to replace the person's name with a fictitious name. The protection of confidentiality extended beyond the interviews themselves; throughout the transcription, data analysis and reporting phases, confidentiality was maintained by changing physicians' names to numbers for the transcription, data analysis and labeling of audio and text files.

### *Procedures*

#### *Semi-structured Interview*

Despite the potential ambiguity of the written or spoken word, interviewing is a powerful method of facilitating understanding of human beings (Fontana & Frey, 2000). For the purpose of this research, interviewing was the most appropriate method of obtaining the desired data. In this project, clarity of the research interest and types of questions pursued further combined to make interviewing the most effective and efficient data collection design for this project (Taylor & Bogdan, 1998). Specifically, the 'semi-structured interview' format was selected because the nature of the research demanded that the participants (physicians) describe particular aspects of their practice and their DM experience, as guided by specific questions, while at the same time, elaborate or expand on issues of concern to them; the ability to bring up comments that may not be directly posed in the series of research questions, was also a requirement. This openness was facilitated by the semi-structured

interview (open-ended questions) which unlike a structured interview, intends to elicit views and opinions of participants (Creswell, 2003) and most importantly “provides the participant the freedom to explain a situation in his or her own words” (Morse & Field, 2002, p.94).

Conducting a semi-structured interview enabled the revelation of both rational and emotional aspects of participants' responses as compared to a completely structured interview where the emotional dimension can be overlooked (Fontana & Frey, 2000). This more holistic impression, not just a rationalized response, is what was sought in this research in order to better understand the physicians' unique views and perspectives of their DM role.

The 'structured' component of the interview consisted of specific, evidence-based questions that serve to guide the interview, and by virtue of being in a list format ensured that no topics or points were missed (See *Appendix 4*). As described earlier, interviews were conducted in a setting agreeable to the participant - this included the family physician's office, their home, or a designated meeting room. While respecting participants' time restraints, these one-time interviews ranged from 35 to 60 minutes in duration, the objective having been to progress through and complete the series of questions in a timely manner while allowing for open dialogue with participants. With participant consent, interviews were recorded by handheld digital audio recorder.

#### *Interview Questions*

The individual interviews involved the researcher presenting participants with eight questions and two case examples. The questions addressed several aspects of the physicians' role in DM, with special attention to their perspectives on collaborating with stakeholders and emulating professional guidelines (See *Appendix 4*). The purpose of the two case examples at the conclusion of the interview was to provide physicians with an opportunity to

respond to practical scenarios and describe their approach to resolving return to work dilemmas.

#### *The Researcher's Role*

The researcher's role in this project was to consistently, professionally and as impartially as possible, collect qualitative data from one on one interviews with participants. During the interviews with participants, the researcher progressed through the series of questions in the same manner, dialogue and format with each participant. Every effort was made by the researcher to remain objective during questioning and when listening to responses. Despite the researcher's own relative knowledge, experience and personal perspective, this bias was not deliberately introduced into the interview proceedings and/or the interpretation or analysis of data. "Although qualitative researchers cannot eliminate their effects on the people they study" (Taylor & Bogdan, 1998, p.8), for this study, the views and insights of the researcher were not purposefully or collaboratively incorporated, as may be the case with various other qualitative research approaches.

#### *Transcription and Data Storage*

Recorded interviews with participants were immediately stored on the researcher's person, and transported to the secure UNBC lab. At the lab, a duplicate digital audio file was made as 'back-up' and was securely stored in locked file cabinet; original audio recordings were then stored in an alternate locked file cabinet. Recordings and subsequent transcripts of interviews were labeled using a numeric system to replace physician names – as described previously. Recorded interviews were transcribed from audio to written form utilizing a transcription service (Teletouch Services Inc.). The confidential nature of the data was reviewed with the transcriber to ensure it was not discussed with or accessed by anyone but

the researcher and project supervisor (see *Appendix 5* for transcriber confidentiality agreement). Also, to enhance validity of the audio data, the transcriber was instructed to type word for word and not to summarize the dialogue (Morse & Field, 1995). Then, when the interview had been transcribed, the researcher verified each written document for accuracy by comparing it to the audio recording; the written version was then copied and securely filed, also in locked file cabinet in the UNBC lab (Morse & Field, 1995). Data and copies collected will be stored for a period of seven years or longer, after which time they will be securely destroyed. Throughout the data collection, transcription and data analysis processes, access to data (audio files, back-up copies thereof and transcribed copies) was limited to the researcher (Christine Reynolds), the project supervisor (Dr. Shannon Wagner) and the transcriber.

#### *Data Analysis*

Data analysis was performed on two levels – a content analysis of the individual question or category level, as well as a thematic assessment of the interview responses overall. Following data collection and transcription of the seven physician interviews, the initial sorting of data was – as suggested by Morse & Field (1995) for semi-structured interviews – to divide responses according to each question asked (e.g. Question 2, Question 3 and so on). These were then analyzed as separate units of analysis (Ryan & Bernard, 2000). The researcher read all responses for one question and conducted a content analysis (or ‘topic analysis’) of these data (Morse & Field, 2000). The content analysis consisted of applying pre-established codes of interest – ‘a priori’ coding – to the qualitative interview data (see *Appendix 6* Codebook) (Neuendorf, 2006; Ryan & Bernard, 2000; Stemler, 2001). To minimize ambiguity in analysis of text data (participant responses) the codes utilized were

developed to be as mutually exclusive and exhaustive as possible (Neuendorf, 2006; Stemler, 2001) without compromising the evidence-based rationale for each. Also, in keeping with a classical content analysis, the units of analysis – each interview question and its associated response – were for the most part non-overlapping (Ryan & Bernard, 2000). In addition to the coding and content analysis performed for each interview question, broader themes were identified via analyzing participants' responses on the whole and these were then interpreted in the context of the research questions and with a view to identify emerging themes.

To address the validity of interview data collected, transcribed copies of interviews were sent to the participants for their review, requesting that the physician verify that the written form of the interview accurately represented their dialogue/responses/views as expressed at time of interview (Creswell, 2003); all participants have been given the opportunity to review the transcription of their interview and all seven participants have responded confirming the accuracy of the transcriptions. Also suggested by Creswell (2003), a detailed and rich description of data has been attempted in the results section to further enhance the validity of these research findings. As a reliability measure, inter-rater reliability was measured by having a naive colleague code all questions (units of analysis) for at least 20% of participant interviews. The rater was trained by the researcher (approx. 1 hour) on the coding scheme for this research project (see *Appendix 6* Codebook and *Appendix 7* Coding Score Sheet). Due to the small sample size and the nature of data collected (dialogue in text form) 'percent agreement' was the measure chosen to assess the degree of congruency between the alternate rater's coding and that of the researcher; eighty percent was the minimum percent agreement sought for inter-rater reliability. The decision to accept 80% percent agreement (as opposed to 90% for example), was based on the appropriateness of



accepting lower reliability coefficients in exploratory studies, such as are the research aims and design of this project (Lombard, Snyder Duch, & Campanella Bracken, 2005). The researcher and naive coder rated an initial sample of 2 interview transcriptions (28% of participant sample) and on this initial trial, percent agreement was sub-par. Therefore, further rater training (approx. 1 hour) was conducted along with a refinement of coding category definitions until 81% agreement (for each whole interview) was obtained when inter-rater reliability was assessed on a final sample of interviews. The interview transcriptions analyzed in the initial coding trial and those in the final reliability assessment were all included in the final data analysis by the researcher (7 interviews total). Further inter-rater reliability measures were not performed for this study (for example Cohen's Kappa) due to the relatively small number of participants and associated question responses (units of analysis), as well as the lack of completely mutually exclusive and exhaustive categories for certain sub-units of analysis (segments of interview responses such as Question 3.c) (Stemler, 2001).

## Results

### *Participants*

As described above, seven family physicians, currently registered with the British Columbia College of Physicians and Surgeons, were interviewed - three physicians from a rural area, two physicians from an intermediate region and two physicians from an urban setting (Canadian Rural Information Service, 2005). The average age was 46 (range 34-72); three were female and four were male. Six participants were Caucasian, one participant was Chinese-Canadian. Participants had been practicing medicine for an average of 18 years (range 5 – 30).

*Disability Management Training/Education*

Three out of seven participants reported receiving no training in disability management as part of medical school. Four participants reported receiving some training in disability management or occupational medicine as part of their medical school curriculum however, three of these remark that it was “very little” or “extremely limited”; for example, a “one hour didactic lecture”. Post-grad, five participants describe taking some form of disability management or return to work related courses or seminars - these ranged from one day insurer-sponsored educational sessions to three month full-time university coursework. Two physicians reported receiving no disability management training post-grad. For recent educational opportunities in Disability Management – the last two years – one participant reported attending a WCB session designed for physicians while six participants reported no educational training in disability management in the last two years.

*CMA Guidelines: Physician Practice, Discrepancies and Recommendations*

Out of seven physicians interviewed, six were in agreement with the physician's role in DM as proposed by the CMA – to provide guidance (e.g. physical restrictions information) while leaving the return to work decision ultimately up to the employer and employee.

Statements such as:

“I agree absolutely”

“My role is to define what the patient is capable of doing and incapable of doing. And I think it is then up to the employer to determine whether or not they are willing to work within those parameters”

“I prefer to stay out of the decision making role as much as possible. You know unfortunately we are often placed in that position without adequate training to make those decisions and often with significant pressure from your patient to decide favourably in their direction. So the more I can be removed from it the happier I am”

One physician response however, was in direct opposition to the CMA proposed function for the physician in DM - the participant stated:

“I think the decision should be up to the employee and the physician, not the employer. I think the employer should provide information as what duties are available and what job description is and how that can be modified, but in my experience if you left that decision to the employer, the employee would not get the best management”

When family physicians were asked to report on how their practice compares the CMA guidelines, the answers were not as consistent and as their ‘agreements’ with the CMA guidelines, in theory and ideology, would suggest. Three of the seven participants reported their practice emulated the CMA proposed guidelines, three others reported their practice did not and one physician described her/his practice as close to the CMA ideal, but not exactly that. Those participants who described their practice as in line with the CMA proposed guidelines for the physicians role in DM, outlined their practice as described in the quotations above. Those that suggested their practice did not match the CMA ideal commented:

“The employer is supposed to supply information about the work...this almost never happens, so that ideal is not met”

“I would say I can see some progress towards that goal but we are not there yet”

Physicians offered a variety of recommendations to address the discrepancy between actual practice and the physician's role in DM as outlined by the CMA. Six of the seven participants suggested solutions addressing role conflicts, such as conflict with the physician's advocacy role or conflicts between roles of various DM stakeholders. No physicians provided recommendations addressing physician time constraints or DM educational opportunities, but two had other recommendations; one participant did not offer

any specific solutions. See Table 1 for a detailed summary of participant recommendations that may help better align physicians practice with their professional associations' ideals.

Table 1 Physician recommendations for reducing the discrepancies between the ideal function of the physician in DM and reality – their actual practice

Physicians Recommendations That Address Role Conflict include:

Disability Management Services

“disability management, recovery management, however you want to phrase them...objective third parties”

“an impartial middle person...they can mediate between all the different parties”

“third party that is there to act as the liaison between employee and employer I think that would make it a more realistic possibility, because right now I think there is way too much you know in the way of complexities between personalities”

Forms that Avoid Requests for Return to Work or Disability Decisions from Physicians

“time loss forms and return to work certificates and so on...focused on descriptions of what people of what their capacity is, what they can do rather than making a sort of blanket subjective judgement as to whether they are disabled or not”

Improved Family Physician Access to Independent Medical Examinations

“some way that the physician can recommend that in some way that doesn't get him into trouble with the patient...a family physician is not in a position to force the issue or at least encourage the issue is a better way to put it. Whereas an independent medical examiner can, he can make a very straight objective, write a report, whatever”

Physicians Recommendations That Address Other Issues include:

Appropriateness/ Convenience of Forms

“ a check off that canvasses various activities...the central activity is determining what things the person can or can't do”

“a form that outlined the physical limitations that the patient has and in a very easy to do method...appropriate forms would solve a lot of the problems”

Access to Job Demands Information

“it may be of some assistance for the companies to put their job description on the website or on their form if they send out a form they should send along a one-pager about the requirements of their work”

Confidentiality

“ a disability manager works in a personnel department and understands the necessity for confidentiality which many organizations don't”

When queried about frustrations in working together with *employers* towards return to work for the worker/patient, physicians offered a variety of examples. Six out of seven physicians identified workplace issues, such as lack of available appropriate work and interpersonal conflict, as a source of frustration. Three out of seven reported communication concerns as frustrating, none specified education or confidentiality as source of frustration and three physicians mentioned other sources of frustration in collaborating with employers. See Table 2 for a detailed summary of employer related frustrations for physicians.

In working with *private insurers* (e.g. Manulife, Great West Life), all seven physicians reported process or policy issues of the insurer as a significant source of frustration. Additionally, one physician mentioned communication frustrations, three pointed to lack of education (on the part of the insurer or their representatives) as frustrating, two participants described role conflict (as described above) frustrations and no physicians detailed other frustrations in regards to involvement with private insurers in a DM context. See Table 2 for a more detail of physicians' frustrations with private insurers.

Physicians alluded to similar frustrations in collaborating with *Worker's Compensation Board (WCB)* towards return to work, as they did for private insurers. Six physicians referred to process or policy frustrations with WCB, one physician cited communication related frustrations, one physician reported lack of education as a frustration, three identified role conflict issues as frustrating and two physicians described other frustrations in working together with WCB. See Table 2 for more information on physicians' frustrations with WCB.

Lastly, when participants were asked to reflect on potential frustrations with the *patient/worker*, as another key stakeholder in the DM arena, physicians often commented that

the patient was the least problematic in terms of frustrating experiences. Nonetheless, physicians report some challenging points in working with the patient/worker. For the patient, two physicians reported workplace issues as a source of frustration, two mentioned entitlement mentality (the worker/patient feels they are 'owed' time off, compensation, etc.) as frustrating, two participants described patient psychological and/or psychosocial variables as frustrating and two physicians cited other sources of frustration in working with the employee/patient towards return to work. See Table 2 for detailed summary of patient/worker related frustrations for physicians.

#### *Physician Proposed Solutions to Frustrations*

When asked for solutions to identified frustrations in collaborating with *employers* in DM, two of seven physicians suggested strategies addressing communication, three participants recommended solutions to education issues, none brought up any confidentiality focused solutions, two described remedies targeting workplace related frustrations (as outlined above) and two detailed other recommendations. See Table 2 for a summary of solutions to employer associated frustrations.

To resolve frustrations with *private insurers*, five physicians described solutions that target process or policy issues, two participants mentioned remedies to communication, one physician suggested educational solutions, three outlined strategies that address role conflict, and one participant recommended other solutions. See Table 2 for a description of solutions to frustrations physicians experience with private insurers.

For frustrations relating to physician-*WCB* involvement in DM, one participant suggested solutions aimed at communication, one physician described education oriented remedies, three physicians outlined strategies that address process or policy frustrations, one

physician mentioned solutions targeting role conflicts, two participants offered other solutions, while two physicians provided no solutions. See Table 2 for a detailed presentation of solutions to physicians' frustrations with WCB.

With respect to the *patient/worker*, physicians offered few solutions. One physician suggested communication improvements, one recommended education strategies, one emphasized solutions that address workplace issues, two participants mentioned other solutions and two physicians did not present any solutions to frustrations with the patient/worker within the DM context. See Table 2 for details on physician solutions to frustration in collaborating with the patient/worker.



Table 2 - Physician Frustrations and Proposed Solutions for Collaborating with DM Stakeholders

Stakeholder	Physician Frustrations	Proposed Solutions
<b>EMPLOYERS</b>		
	Communication	
	“not providing a job description”	“craft the communications and information gathering process in a way that you know is suited to the way that medical care is provided”
	“the few times I have contacted employers directly they have not been grateful”	“pay for the forms, pay for the information...”
	“when you ask an employer for a detailed description of what the job responsibilities are: one it's generally not forthcoming or...not relevant”	
	Education	
	none mentioned	“employers need to be open to, I think it's an awareness of health and how things work”
		“a standardized document that defines the role of the employer, the role of the physician, and defines the role of the patient.”
		“education”
	Workplace Issues	
	“the foreman for instance he just wants a very fit worker on the job, he does not care about the sick leave policy...”	“they still have to work on their ability to accommodate”
	“smaller firms have fewer resources”	“take their duty to accommodate seriously”
	“the pressure that they often put on the employee”	“to have an actual arms length disability disability management”
	“threat of loss of employment, but I have found that less (now)”	
	“me sort of saying here are the limitations and they say ‘well, we don't have any work for him’. That has often been the case”	
	“inconsistency (accommodation)”	
	Other	
	“they sort of expect a lot of free service”	“be realistic about you know how primary medical services work”
	“bias that everybody is a scammer”	
	“the inability of the employer to recognize what their role is and what my role is”	“...pay for the physicians time. That's all and they would get a lot more cooperation.”

Table 2. Continued.

	<p>“to pay me (physician) more credit than they appear to do”</p>
<p><b>PRIVATE INSURERS</b></p>	
<p>Communication</p>	
<p>“where there is either no communication or the communication that is required is in the form of huge narrative reports</p>	<p>“ask for the pertinent, to the point information”</p> <p>“it’s only fair to put questions to them (physicians) that they are realistically qualified to answer”</p>
<p>Education</p>	
<p>“they are inadequately trained”</p> <p>“Absolutely” (lack of case manager expertise)</p> <p>“I find them a combination of malice and incompetence”</p>	<p>“better training for the disability managers, medical training”</p>
<p>Process/Policy</p>	
<p>“there is a sort of list of how long conditions should take for people to get better...insurers go by this list cut and dry”</p> <p>“repeated reports they ask for asking for a lot of the same information...it’s a really inefficient use of everybody’s time”</p> <p>“unrealistic expectations in terms of documentation”</p> <p>“the volume of paper work...and they always require monthly updates”</p> <p>“it’s the forms...private insurers that require the patient to pay are kind of frustrating”</p> <p>“the time it takes for the patient to actually get payment”</p> <p>“agenda to pay out their claim at all cost”</p> <p>“perceive everything to be measured objectively...if they are unable to directly prove an obvious pathology with an investigation they denounce and they claim the patient is malingering”</p>	<p>“make (forms) more streamlined...they should have a medical advisor who has been recently in clinical practice to go through these forms”</p> <p>“limit the background information that is required...ask for a paragraph summary”</p> <p>“stop sending this endless supply of forms on a monthly basis, that costs the patients”</p> <p>“craft the communications and information gathering process in a way that...is suited to the way that medical care is provided”</p> <p>“look beyond the algorithm and the paper work”</p>

Table 2. Continued.

	<p><b>Role Conflict</b>                  "they wouldn't take the physician's word for the condition"                   "to ask a professional 'is person disabled or not' and then without making it clear that someone else is making that decision"                   "questioning my judgement as to whether this person really does need to apply for it"</p>	<p>"it would be far more conducive if there was a less adversarial role"                   "people being asked to give information that is appropriate to their role"                   "to respect that opinion (physician's) and listen to it rather than simply assume that I am an unthinking universal patient advocate"</p>
	<p><b>Other</b>                  "bias that everybody is a scammer"</p>	<p>"be realistic about you know how primary medical services work"</p>
<p>WCB</p>		
	<p><b>Communication</b>                  "you provide the objective information but you're still getting communication that suggests that they haven't accounted for it"</p>	<p>"needs to be efficient...hotline phone numbers"</p>
	<p><b>Education</b>                  "it's frustrating if you're dealing with someone who doesn't have a background in this area"</p>	<p>"disability management people should have a better understanding of soft tissue injuries"</p>
	<p><b>Process/Policy</b>                  "they want people to return to work and don't take the physician's word that this patient is not meeting the normal standard for return to work in time"                   (WCB) "very much algorithmically dictated"                   "delays that often occur in them deciding to accept a claim, which leaves the patient in limbo..."                   "when a request is made for a specialist assessment or CT scan, it is very slow..."                   "the recommendations of weekly follow up, which means a weekly form...the number of forms with WCB"</p>	<p>"(address) the number of forms and timing to get the back"                   "Absolutely." (one consistent case manager)                   "more use of hotline phone numbers and better use of sharing those"</p>

Table 2. Continued.

	<p>“generally an incredible combination of institutional disorganization combined with some amount of...an agenda as to not pay out and a suspicion of almost every patient”</p> <p>“the case manager often switches”</p> <p>“often I will request referral to visiting specialist clinic, doesn't happen...we have to keep hounding them”</p>	
Role Conflict	<p>“they are not understanding or not accepting the physician's word...this causes unnecessary referrals to specialists”</p> <p>“it's very nebulous and very political”</p> <p>“the fact that they put such little respect or consideration towards my opinion”</p>	<p>“there should be a system of accepting the physician's opinion and more emphasis on accepting the general practitioner's opinion”</p>
Other	<p>“there's another bias that you know all clamaints are scammers and that all doctors are superficial or you know not thorough”</p> <p>“the case manager is coming up with the most selective reasoning, most private logic in trying to determine a diagnosis and prognosis for the patient</p>	<p>“...there should be guidance to physicians to strictly try and be objective...irrespective of who's paying for the form” (re: WCB specialists)</p> <p>“they just need to realize that these people are people and not numbers. They need more humanity...”</p>
PATIENT/ WORKER		
Communication		<p>“they (patient) could do a little bit more in terms of documentation”</p>
Education		<p>“public service announcements about participation, physical fitness stuff like that. The general attitudes towards physical, mental preparedness for work, the responsibility we all have to go to work healthy and so on”</p>

Table 2. Continued.

<p><b>Workplace Issues</b>          "some worker's who don't want to go back to work...they will amplify their problem or reject the physician's attempt to get them to go back to work"           "where that person's unhappiness with the job is you know is the largest part of the claim. So it isn't an injury or health concern primarily"</p>	<p>"with the patient worker it's a systemic problem and requires a systemic solution. Both sick leave and the long term disability management systems need revision and the union management contracts need revision".</p>
<p><b>Entitlement Mentality</b>          "there is a sense out there that there is some entitlement to you know, if the work is stressful I'm going on stress leave"           "some have a entitlement attitude and ...they end up sabotaging the treatment program before it's completed"</p>	
<p><b>Psychological or Psychosocial Issues</b>          "the stress of being off work or the stress of being physically injured... sometimes it can make it more complex to try and get them (patient) back into work because they are completely off track and it's not just a matter of healing tendons and strained muscle"           "very few of them have an agenda to 'milk the system', those do exist...and it's fear based in terms of worsening an injury or making it worse by using it before it's fully recovered and second it's fear based because they have heard horror stories involving their insurer, their WCB ...there are all kinds of anxieties, unfortunately most of them based in reality."</p>	
<p><b>Other</b>          "the biggest difficulty that I have is the possibility of doing the appropriate assessment in the office, you know with regards to how much weight they can lift, what their endurance is"           "the length of time and number of hoops they (patient) have to jump through"</p>	<p>"date of injury have this application process that would provide interim funding "           "a lot of stuff needs to be accessible" (treatments)</p>

### *Communication Preferences*

When physicians were asked about their preference for communication methods with DM stakeholders, six of seven physicians stated fax was their mode of choice. Four of these also reported the phone as a preferred source of communication. Some physicians further distinguished between communication preferences depending on the specific stakeholder involved - for instance, one participant responded by saying:

“if it's coming from the insurance company or from WCB I want it in writing, a fax perfect okay. If it's a case manager who's wanting to know something about a patient I've got no problem with them picking up the phone and phoning me”

Although no physicians specified email as a preferred source of communication, two of the seven physicians attested to the convenience and expedience of electronically formulating and sending reports where possible, such as with the WCB Medical Office information System (MOIS). One physician described that communication mode preference is also dependent on the focus of the request or contact, as well as the expectations for physician response, and that to avoid “asynchronistic communication” (such as not being able to return a phone call within office hours) “it works best to have several options”.

### *Physician Experience with Employer Return to Work Programs*

When asked about their experience in working with patients participating in employer-based return to work programs, all seven physicians reported they had worked with patients who had been involved with such programs. Six out these seven physicians articulated that their experience was positive, using descriptors such as “worked fairly smoothly”, “they are good”, and “I'm happy to find those programs” in reference to experiences with these programs. Meanwhile, one participant described involvement with employer return to work programs as typically negative. This physician remarked:

“the one where it works really well, I don't see them, right, they get back to work and so the problem is I see the ones when it's not working and where it's dysfunctional, there the patient feels they are not being heard, patient feels they are being pushed...and I think that it's placing a lot of inordinate power on the employer's side”

Despite one physician reporting negative experiences with return to work programs for patients, all seven physicians agreed that these programs ultimately contribute positively to patient outcomes. Responses such as:

“far less patient anxiety...and probably faster return to regular duties”

“it gives more of a cooperative kind of flexible impression to employees”

“allows a patient to gain confidence”

“I think it is really important. At the other end of the spectrum the sort of brute force method somebody who works for an employer that has no resources at all and the individual has a choice between going to work with the impairment or having no income”

illustrate some of the benefits to patient outcomes physicians feel result from participation in return to work programs. Although all participants felt employer return to work programs positively influence patient outcomes overall, some physicians provided qualifiers to this sentiment as these comments demonstrate:

“where the unions aren't blocking it I think they have very good outcomes”

“I think it probably helps to get them back to work quicker. I think they can be structured far more friendlier way for the patient and a far less intimidating way for the patient”

#### *Proportion of Physician Work Load Spent on DM Issues*

Participants were prompted to estimate the proportion of their day that is typically allotted to DM concerns. Physicians were asked to suggest a percentage of patient load that involves DM issues and/or the proportion of their work day that consisted of DM related work. In assessing the percentage of patient load involved with DM, two physicians

estimated < 5%, two physicians estimated 5-10%, no participants estimated 10-15%, one physician estimated 15-20%, and one physician estimated 20-25%. Not all physicians were able to discern the proportion for their work day that was typically spent on DM issues due to the varying nature of their particular practices. Four participants did describe their DM work in relation to the time spent in an average work day – two physicians estimated 10-15% of their work day is involved with DM concerns and two others reported 20-25% of their work day is DM related. Of note, the four physicians who were able to estimate the proportion of their work day allotted to DM described a higher proportion (percentage) than that of their patient load. This point is highlighted in one physician's response:

“I mean 5 percent (proportion of patient load). Proportion of my day however, would be 20 or 30 percent because these patients create a great deal of work”

### *Case Studies*

#### *1) Patient/Worker Does Not Feel Ready to Return to Work*

In Case Study Number 1, physicians were asked how they would handle a scenario where a rehabilitation specialist had deemed a patient fit to perform a gradual return to work, a schedule had been arranged but the worker communicates to the physician that the worker does not feel ready to return to work (see *Appendix 4, Question 9* for complete case study). To deal with these circumstances, six out of seven physicians described that they would seek more information and clarification from the patient:

“find out why they are not ready to return. Find out what their expectations are once they return to work...find out what other issues the patient is having...often what they need is reassurance”

“ask them (patient) why they don't feel that they are ready to return to work and find out where the discrepancy is”



“there is a physical fitness to return to work but there is a psychological fitness to return to work and there's also the rest of the patient's life...so I think I would have the patient back to my office, again ask them what's going on and what it is and then see if we can work with it”

“to explore with the patient as to why they don't feel ready to return to work and what return to work means to them. It maybe the light work in the gradual return to work schedule hasn't been sufficiently explained to the patient, or it may be that they generally have anxieties about what might happen if they fail...they may mistrust the employer”

“the return to work form...we'll just take it out and we'll canvas those things”

Three of the six physicians who attested that they would discuss things with the patient also reported that they would communicate with other stakeholders as these comments articulate:

“go back to the rehab program and say these are the issues identified that we are working with, what do you think, you know try to work as a team to get them back”

“just try to make sure there is good communication between all parties and then formulate a plan”

“I can phone physio”

One physician responded to this case study by describing that under certain, common circumstances, the physician may end up simply supporting the patient's request:

“if the patient should be going back to work and the treating therapist and rehabilitation program are correct and the employer has the proper paperwork then we (physicians) are faced with a tremendous conundrum because what the patient is really telling me is that ‘they don't want to go back to work and doctor, you're my doctor, you should side with me’...and in that situation we are faced with often agreeing with the patient because we have no other way of getting around it”

## *2) Patient Worker Keen to Return to Work But Not Fully Recovered*

The patient/worker in Case Study 2 presents an alternate dilemma for the physician as compared to Case Study 1. In Case Study 2, the patient requests a return to work note from the physician despite not being fully recovered (see *Appendix 4 Question 10* for complete

case study). All seven participants outlined that they would seek more information and clarification from the patient to address this scenario. Participants responded to this Case Study with:

“What I want to do is know what does the patient actually do?”

“I question the patient about the nature of his work

“it’s a negotiating point. It’s something I need to assess what’s going on with them that drives them when their not quite 100% to get back to work and see if he can work with any of those identified issues”

“kind of strike a balance of not discouraging this keenness but minimizing the risk

“I am going to try and just sort out and make sure he really is fine to go to work”

One of the seven physicians also indicated they would seek more information and clarification from other stakeholders, specifically the employer, by saying:

“I might negotiate with him (patient) to be offer a certain period of time while I can clarify with the employer what the duties are”

### *Other Themes*

Outside of participant responses to specific questions, the physician interviews revealed a wide range of experiences, insights and points to consider. When the units of analysis (transcribed interview) were reviewed in their entirety and in a holistic fashion, several prevalent themes emerged. The most significant of these include: 1) employee / employer issues were described as compromising the fulfillment of the CMA proposed role for the physician in DM, 2) despite the CMA ideal, physicians continued to be asked (by stakeholders) to make return to work decisions, 3) participant physicians felt their medical opinion warrants greater respect from DM stakeholders, 4) participants explained that appropriate employer RTW forms would be of assistance in enabling physicians to perform their DM role effectively, and 5) Disability Management or Case Management services were

cited as a desired solution for physicians dealing with DM concerns. For the first point – the impact of the employer-employee interface on the optimal function of the physician in DM – many physicians outlined the difficulty in fulfilling their DM role as proposed by the CMA when the employee-employer relationship was in conflict or adversarial in nature. The following comment illustrates this point, “there ends up being a bit of an adversarial dynamic between employer/ employee so then I end up having to take more of an advocate kind of role versus the employer...”. Participants described that the CMA guidelines rest on the assumption that the employee/employer relationship is a functional, communicative and supportive one. For instance “the personality issues on the part of the worker and the supervisor come into play...the employee will circle back and say ‘you know I presented your form to my supervisor and he said he didn’t want me there until I am 100%’”. This comment is reflective of what physicians reported as a common situation that inhibits the physician’s ability to merely supply restrictions/limitations and capabilities information, as suggested by the CMA, and leave the return to work decision up to the employee-employer. Furthermore, physicians’ responses suggested the CMA guidelines also rest on a second assumption, that employers have the resources to accommodate and appropriately manage their employees from a disability standpoint. “All of it (CMA guidelines) assumes that the, it’s a firm that has the resources...the reality is that a lot of small firms don’t have those resources.” Another theme in the data was that DM stakeholders continue to approach physicians as if they are the sole authority on work-readiness despite medical associations’ guidelines that stipulate return to work decision-making should not be the isolated responsibility of the physician. Several physicians attest to the inappropriateness of various stakeholders, be it insurers or employers, putting the physician in a position where they are

asked to make the final decision regarding an employees ability to return to work. Numerous participant views explain the prevalence of this practice:

“You know unfortunately we are often placed in that position without adequate training to make those decisions and often with significant pressure from your patient”

“it's a huge responsibility to give that and no one appreciates the responsibility that the physician has in saying this patient is read to go to work”

“I think a lot of times it's still tempting for employers and insurers to sort of reach and put the question point blank to the doctor ‘Can Joe work yes or no?’”

Physicians interviewed also frequently mentioned that they felt their medical opinion should be given greater respect and consideration by DM stakeholders. This theme was echoed by several participants. For example:

“but other times they wouldn't take the physician's word for the condition”

“it is frustrating when your have done a thorough assessment when you think you have a track record of doing thorough assessment you provided tons of documentation and that's still not acknowledged”

“I had made some recommendations earlier in the course, like for instance to have this person off for a 2 week period...and that never happened”

Several physicians described the appeal of an efficient and appropriate return to work form and the role such a form could play in more effective communication with stakeholders. Specifically, physicians attested that many return to work forms request either too little or inappropriate information, such as with some employer forms. Participants outlined some characteristics they would like to see in a return to work type form in these words:

“it is objective, it breaks down their job into duties that you (physician) can clarify and you're not always asked to say what components they (patient) can or can't do in terms of job description. You can just say what components they can do and the employer can then use that to find work”

“a blank page and a request for a narrative handwritten is not very realistic so to

the extent that we are looking at short answers and check lists for specifics that's very helpful"

"a medical certificate does not give enough information when it says 'off work, can't go back to work'"

"if they (employer) send out a form then send along a one-pager about the requirements of their work"

Lastly, physicians' desire for assistance in their DM work, through improved utilization of DM professionals was a consistent theme for participants. Different physicians used different terms for these 'third party', objective facilitators, such as:

"disability management, recovery management, however you want to call them"

"the disability management person...would assure that the information doesn't sort of float around the work site because that's always the worry, people's private information"

"if you had an impartial middle person...they can mediate between all the different parties"

#### Discussion

This research project qualitatively examined the views, perspectives and experiences of family physicians in BC regarding their role in DM. Through analysis of participant responses to the evidence-based, semi-structured interview questions, experiences, concerns and recommendations were revealed, illuminating the unique DM position of the family physician. Some of the participant physician views were consistent with previous research while other insights reflected a contrast to existing DM literature. Beaumont (2003), Pransky (2004) and Dorrell (2002) have established that for family physicians, formal Disability Management or occupational medicine training is minimal to none, specifically as part of medical school curriculum. This finding was supported by the present research with the majority of participants reporting having had "very little" training. This finding suggests that

providing family physicians with greater DM educational opportunities should be a consideration. As for the ideal role of the physician, in terms of emulating the CMA guidelines, the participants in this project for the most part, agreed with the CMA in theory, but reported that physician practices do not necessarily reflect this ideal. This finding is in keeping with previous findings such as Guzman, Yassi, Cooper and Khoklar (2002). Interestingly, participants described issues relating to role conflict as barriers to fulfilling their role in DM as outlined by the CMA, but did not mention physician time constraints or lack of educational opportunities, factors cited by Beaumont (2003), as contributors to the apparent discrepancy between physician practice in DM and their professional guidelines. In fact, participant physician recommendations that address factors affecting the performance of their DM function, indicate that role conflict may be the most significant issue for physicians.

Naturally, and as expected, the family physicians in this research project expressed a host of frustrations with various stakeholders in DM. In working with employers, the participants felt that workplace issues such as interpersonal conflict or lack of accommodation options were a source of great frustration. This is in accordance with Pransky et al. (2002) who discerned that patient/employer conflicts and job dissatisfaction were endorsed by physicians as serious impediments to facilitating return to work. Participants also expressed that communication with employers was another source of difficulty. Conversely however, the literature suggests the same can be said for the employer's perspective of the physician. Scheer (1995) acknowledges that employers feel the physician does not appreciate the workplace-injury relationship without being familiar with the nature of the job. Clearly, improved exchange of information and ideas is needed between physicians and employers, and the specific means by which to achieve this improved

communication should be explored. As for workplace issues (e.g. lack of supervisor support for return to work), the physician has a very limited capacity to directly influence these concerns. However, participant comments on this problem indicate that development of multi-party, DM collaboration strategies aimed at reducing workplace issues that negatively impact a patient's return to work, would be well warranted.

With respect to private insurers and the WCB, process or policy related concerns emerged as the greatest frustration for family physicians. Participants also identified role conflicts as a concern with both private insurers and WCB. Physician complaints of being placed in inappropriate decision-making positions as reported in the present study are echoed by Dorrell (2002) who found that insurers often ask a physician to make a return to work decision or, in essence, 'adjudicate' a claim. The range of physician frustrations with these two stakeholders that relate to procedural and systematic orientation, and those relating to role conflicts, are seemingly complex and perhaps overwhelming to physicians. As a result, further research regarding optimizing the physician-insurer interface in a DM context should ideally be conducted in conjunction with insurer representatives, in an effort to develop comprehensive solutions that adequately serve both parties. That said, participant responses in this project revealed that the scope and inherently problematic nature of physician-insurer interaction are perceived by some physicians as insurmountable obstacles to fulfilling their ideal DM role.

Considering the patient/worker as a key DM stakeholder, participants reported psychological and psychosocial issues, entitlement mentality and workplace issues as the greatest challenges in collaborating towards return to work. For psychological and psychosocial factors the importance of identifying these non-physical concerns that affect

patients' recovery and work re-entry are critical and often within the family physician's domain. Unfortunately, both workplace issues and a patient's entitlement attitude remain difficult and perhaps inappropriate areas for the physician to address. It is understandable then, that physicians in the current sample were hard-pressed to offer any remedies to these two frustrating, non-medical patient/worker variables.

Most physicians in the present study reported fax transmission as their preferred mode of communicating with DM stakeholders, but due to the small sample size it cannot be assumed that this necessarily reflects the communication preferences of family physicians in general. Given the qualifiers included by several physicians when specifying fax as the communication vehicle of choice, and the fact that some participants mentioned the phone and other means as effective communication, it is reasonable to conclude that physicians' preferred means of communication may be unpredictable and dependent on the particular characteristics of a physician's individual practice. Therefore, to this end, DM stakeholders should establish early on in their interactions with physicians what their most preferred mode of communication is for any required correspondence. This is critical to the DM process because as Pransky et al. (2004) have found, establishing effective communication is a powerful but under-utilized strategy that may help reduce adversarial interactions between DM stakeholders, while at the same time potentially enhance disability outcomes.

When asked to reflect on their experience with return to work programs, all of the physicians in this study reported experience with such workplace initiatives. Of these, all but one participant reported this experience as a positive one. Perhaps of more significance, is the result that all participants described return to work programs as having a positive effect on patient outcomes. This view mirrors the sentiment of the CMA policy which declares that "a



safe and timely return to work benefits the patient and his or her family by enhancing recovery and reducing disability (CMA, 2001, p.1). Viewed from a different standpoint, Shaw, Pransky and Fitzgerald (2001) attest that “policies that allow only a full return to work may result in prolonged disability” (p. 824). However, the problem is that there persists a lack of universally available return to work programs, or even modified or transitional work, for returning employees. Further research directions may consider exploring how family physicians may best collaborate with employers in an attempt to develop ‘safe and timely’ return to work plans in the absence of formal return to work programs per se. This is especially relevant in light of the finding that the physicians sampled herein cited access to modified or transitional work for patients as an enabling factor for the fulfillment of the physician’s DM role as outlined by the CMA.

In terms of patient load and percentage of work day allotted to DM issues, responses from the participant physicians were varied. Some estimated the proportion of patients that were involved with return to work or disability concerns was lower than 5% while others estimated it to be as high as 25%. Pransky, Katz, Benjamin, and Himmelstein (2002) determined disability or return to work issues arose in approximately 10% of physician/patient encounters and although this falls within the range suggested by our sample, a greater number of participants in this project would have yielded a more accurate measure of the DM work load for physicians. Future research would ideally survey a large number of physicians and derive a statistical average for the percentage of patient load that is DM related, while also comparing the proportion of physicians’ work day spent on DM to the proportion of patient load – the data in this project suggests that for some physicians, the

time spent on DM tasks per work day may be greater than the percentage of patient load suggests.

Physicians' approaches to dealing with the two case scenarios provided were surprisingly unanimous, in that, with one exception, all physicians detailed how they would typically seek more information and clarification from the patient, as well as other stakeholders, regarding the employee's abilities and the appropriateness of return to work; this was true for both the case example where the patient was reluctant to attempt work and where the patient was over-keen to return. This finding is particularly hopeful because it illustrates the sampled physicians' openness to dialogue with their patients with respect to resolving return to work issues. Furthermore, for many participant physicians, the data revealed they were not eschew to contacting other DM parties that may aid in the decision making process. The fact the only one participant, in one of the case examples, stated she/he would likely end up having to automatically 'side with the patient' lies in contrast to allegations commonly made against physicians by DM stakeholders such as, that physicians casually provide 'off-work' notes (Makdessian, 2000) and that the family physician can be a threat to successfully returning an employee to work (Rankin, 2001). Further research, comprehensively analyzing physicians' practice in dealing with return to work dilemmas, - such as those presented in the case examples - including data triangulation, (e.g. observational analysis, combined with document review) would more accurately illustrate the strategies employed by physicians in resolving DM issues with their patients and other stakeholders.

The more global themes revealed in the present study underscore the more categorical and question-directed findings – that physicians face a host of challenges with emulating the

DM role as outlined by Canadian medical associations; some of these barriers being within physicians' control and some clearly requiring better cooperation from key stakeholders. The fact that several physicians expressed openness to DM assistance in the form of an objective third party (e.g. return to work coordinator or DM professional) is promising. Such a solution may prove beneficial in facilitating collaboration amongst DM stakeholders who understandably have many shared, but also competing, interests and goals in regards to return to work (Young, Wasiak, Roessler, McPherson, Anema & Poppel, 2005).

Altogether, the research conducted in this project has shed light on the perspectives, views and experiences of family physicians with respect to their role in Disability Management. Unfortunately, the participants here only confirmed earlier findings that suggest an ongoing discrepancy exists between the ideal function for the physician in DM – those proposed by their professional associations - and actual practice. This may be due, in part, to the underlying assumptions upon which the essence of the CMA guidelines rest, such as the existence of a supportive and cooperative employee/employer relationship. It is when these assumptions are not upheld, that participant physicians reported deviating from their professional guidelines, commonly out of necessity, in order to preserve the integrity of the patient-physician relationship while safeguarding the patient's well-being. Thus, future research should aim to explore and identify mechanisms that may assist physicians in dilemmas where external variables conspire to compromise the performance of their DM role.

Barriers to physicians' successfully performing their DM role appear considerable, as the numerous and significant frustrations reported by participants indicate. Fortunately, physicians in this study were also able to offer a variety of interesting and perhaps plausible

remedies to these problems; the most applicable of these solutions include: implementing educational initiatives that aim to clarify roles and responsibilities of different DM stakeholders, improving communication strategies, promoting realistic expectations of physicians (including outlining for stakeholders, what is appropriate and inappropriate to request of physicians), and, utilizing third party, objective DM assistance for certain circumstances. The efficacy of such suggested DM interventions should be investigated in detail with a view to incorporate the interests of other stakeholders while enabling physicians to better perform their ideal function in the DM arena.

While this study revealed rich and descriptive data from the family physician's perspective, more research should be done to qualitatively assess the views and experiences of other key DM stakeholders regarding the physician's role in DM, ideally utilizing a larger sample size than in this project. Young et al. (2005) found that "embracing a comprehensive approach, which highlights the differing perspectives of the various stakeholders, appears a possible avenue for advancing the RTW field..." (p. 553). Likewise, for further assessing the family physician's role in DM particular, a multi-dimensional approach is required. To this end, further qualitative analysis may reveal additional solutions to the challenges physicians face in DM and/or may expand on and reinforce some of the valuable insights and indications in the present study. A large scale, quantitative (e.g. survey format) study, could evaluate stakeholder receptiveness to the solutions put forth by this study's participants, as well as estimate the impact of each specific intervention or strategy. Ultimately, an improved understanding of the physician's perspective, in conjunction with concerns of other DM parties, is essential to enable the family physician to optimally fulfill their DM role, improving disability/return to work outcomes and satisfaction for all stakeholders. This

project contributes to such an understanding by exposing the views and experiences of several family physicians in BC and providing direction for further exploration of comprehensive solutions aimed at actualizing the ideal role for the physician in DM.

### *Limitations*

By nature, qualitative research invites certain inherent influences that may remain beyond the control of the research project; however, these extraneous variables also contribute to the 'richness' of qualitative data. This richness is in fact critical to gain insight into an issue – in this case, physicians' perspectives on their role in DM. In this qualitative research design, every attempt to minimize chance of error has been made but the researcher also acknowledges that "it is not possible to achieve perfect reliability if we are to produce meaningful studies of the real world" (Taylor & Bogdan, 1998, p.9).

The sample size - seven participants - may appear to be one limitation to this research study. However, while in many cases smaller population samples may mean less reliable and/or less meaningful data, for this study enlisting a relatively low number participants was purposefully done due to the exploratory nature of the research and the requirement that the data obtained contain the level of detail (responses) necessary to capture the perspective of the physician as outlined in the research aims. In particular, to achieve the research objectives, semi-structured interviews, conducted one-on-one with physicians, were selected as the most appropriate data collection mode. As interviews require a significant amount of time and commitment from both participants and researcher, attempting to incorporate a large sample (e.g. 50 participants) was unrealistic on a practical level. Another reason why a smaller sample size was selected is that for physician populations, it is the various complexities of their professional responsibilities, some of which are outlined in the research

here, that conspire to pose difficulties to researchers' soliciting involvement with such projects as this one (e.g. difficulty in contacting physicians). This was also a factor in determining a realistic number of research participants. Thus, the sample size was appropriate for both the research goals of this project and for the characteristics of the population involved.

Implementing theoretical sampling, as described previously, the researcher attempted to acquire participants from a diverse range of backgrounds (educational) and settings, but some limitations specific to the sample may exist. Physician interviewees were determined in part by geography – attempting to gain perspective from diverse settings, including urban versus rural and Lower Mainland, BC versus Northern BC. Selecting physicians for inclusion in the project was based to some degree on researcher convenience. As such, a physician chosen because of prior association with the researcher or colleague may conceivably, given common interests or experience, have been more DM 'savvy' than other family physician counterparts. Therefore, to avoid acquiring a sample with better-than-average DM expertise, the researcher utilized the British Columbia College of Physicians and Surgeons (BCCPS) online directory to obtain names and contact information of potential participants. This ensured that by BCCPS definition the participants selected were physicians in general, family practice (the desired population of study), as opposed to physicians with a DM specialty or affiliation. Generally speaking, for any physician participants, desirability bias may have existed if participants responded to questions with answers they perceived to be more desirable (Fontana & Frey, 2000; Guzman et al., 2002) – this type of bias is a possibility within the research proposed here, and as with participant selection, may have negatively influenced the accuracy of comparison between physician practice and professional

guidelines. Interview data by nature yields indirect information (e.g. as opposed to actual observation of a physician's practice) which has been "filtered through the views of the interviewees" (Creswell, 2003, p. 186). This is not a major concern with this research however, because it is precisely the views and perspectives of the physician that were sought, in addition to the information about their professional practice.

Interviewer bias and interview questions may have also played a role in the participant's responses. Interviewer bias may conceivably have been introduced if unknowingly the interviewer employed less than ideal techniques or exhibited certain behaviours or characteristics that could have had an effect on participant response to questions; as with sampling and desirability bias, these types of influence may threaten the validity of this research (Morse & Field, 1995). Although some researcher influence is likely inevitable in qualitative research, every effort was made by this researcher to minimize interviewer influences on participant responses by implementing an open, but professional and consistent approach to interviewing participants.

The selection of key DM stakeholders may limit the applicability of these research findings when applied to the 'real world'. Realistically, several other stakeholders, in addition to the ones identified in this project, may play an essential role in returning the employee to work and in turn require effective interaction with the family physician. For example, the participants' perspectives on collaborating with other health professionals or labour unions towards DM goals was not elicited here despite the potential that significant frustrations, barriers and perhaps facilitating factors may exist for the physician in relation to these and other parties. The interview questions themselves, may also have been another limitation to the project in that by asking pre-contrived questions, the interviewer is guiding

physicians' responses, as through wording and themes. It appears this type of influence was somewhat unavoidable, because in order to maintain the thematic and theoretical orientation of the research, a semi-structured interview was required. That said, interview questions were openly designed so as to encourage participants to expand on their answers and thoughts in an attempt to acquire a broad understanding of their perspectives.

Interpretation and application of the data collected may also present potential limitations. The purpose of this study was to, from the physician's perspective, discern the discrepancies, if any, between the ideal function of the physician in a DM context and their usual practice. Interview responses and physician dialogue were evaluated using content analysis and from these results future research directions are indicated, as well as recommendations that may enhance effectiveness of DM where the family physician is involved. However, in the qualitative analysis of data, the possibility exists that the researcher's interpretation may have misrepresented the opinions and insights provided by the physician participants - this may be upsetting or disagreeable to the practitioner, and ultimately compromise the validity of the research findings. Accordingly, participating physicians had the focus, purpose and type of analysis for this study reviewed with them prior to interview. In addition, the researcher made every effort to interpret data objectively and without bias. To ensure the most reliable analysis of data possible, inter-rater reliability was tested (as described in the *Data Analysis* section). However, the lack of an appropriate reliability coefficient, other than percent agreement, for this qualitative study, means that the degree of inter-rater agreement that may have occurred by chance was not accounted for. The reliability measure must therefore be interpreted with caution. Likewise, 'generalizability', or the degree to which the findings may be applied to other populations (Ryan & Bernard,



2000), in this research is significantly limited due to the small sample size. Though, despite it being inappropriate to generalize from the views and perspectives of the physicians in our sample to family physicians on the whole, or even to BC physicians, this does not minimize the value of the research findings in terms of identifying issues and concerns that may be relevant to other physician populations and therefore worthy of future research.

#### *Implications for DM*

The application of these research findings to the establishment of 'best practices' for DM are significantly limited due to the exploratory nature of this research, its exclusive focus on the physicians perspective (as opposed to that of other stakeholders), as well as certain characteristics of the project design, as describe above in *Limitations*.

Nonetheless, this study reveals some key information that may in itself serve to improve collaboration with family physicians towards achievement DM objectives. Specifically, recommendations for the DM community include:

- Provide greater DM educational opportunities for family physicians
- implement broad-based educational interventions aimed at clarifying roles and responsibilities for various DM stakeholders
- explore solutions addressing role conflict issues for physicians (e.g conflict over RTW decision-making), as these may be the most significant barrier to physicians' emulating professional guidelines
- improve communication between the family physician and DM stakeholders, especially employers
- develop collaborative strategies (e.g multi-party meeting approach) aimed at addressing workplace issues (e.g. interpersonal variables affecting return to work)
- identify and implement remedies to evaluate and improve the problematic nature of the physician-insurer interface

- establish, with individual physicians, their preferred mode of communication, as a means to reduce adversarial interactions
- develop solutions that facilitate the physician's effective performance of their DM role effective in circumstance where extraneous variables are less than optimal (e.g. absence of return to work program)
- provide better access to DM professionals for physicians who wish assistance
- promote realistic and appropriate DM related expectations of family physicians

To assess the efficacy of such recommendations, and to gain further understanding of the DM issues inherent to the physician's role, future research is clearly required.

Specifically, the qualitative assessment of stakeholder perspectives on this topic, namely insurers and employers, should be conducted, ideally followed by a large scale, quantitative study aimed at establishing viable interventions that may serve to enable physicians in the fulfillment their complex and evolving DM role.

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Appendix 1

The Role of the Physician in Disability Management:  
Assessing family physicians' view of discrepancies between  
practice and Canadian Medical Association guidelines

Phone Script\* for Initial Participant Contact

"Hello Dr. \_\_\_\_\_,

"I am currently conducting research for my masters thesis at the University of Northern British Columbia (Disability Management Program) and would like to request an interview with yourself. The interview (1 hr maximum) involves answering a series of questions relating to the physician's role in disability management. May I fax you the Information Sheet outlining the aims and methodology of this research project for your review?"

"After reviewing the introductory pages, could please let me know if you are interested in participating? Please email me at [portmanc@unbc.ca](mailto:portmanc@unbc.ca) or phone 604-892-5825."

"If you are willing to participate, I would appreciate the opportunity arrange an interview ASAP, perhaps either the end of this week or sometime next week if you are available."

"I look forward to hearing from you. Thank you for your time."

**Christine Reynolds**

\* if the physician was not reached directly on initial phone contact (e.g. if I spoke with an office manager or medical assistant and they had given me permission to send the Research Information Sheet to the physician), the above text, with minor modifications was faxed as a cover letter to the Research Information Sheet.

## Appendix 2

The Role of the Physician in Disability Management:  
Assessing family physicians' view of discrepancies between  
practice and Canadian Medical Association guidelines

Research Information Sheet

Dear Sir or Madam:

I am writing to tell you about a research project entitled "The Role of the Physician in Disability Management: Assessing family physicians' view of discrepancies between practice and Canadian Medical Association guidelines" that you may be interested in and to ask if you would consider participating. The intent of this project is to attempt to describe the physicians' perspective on their role in Disability Management, with particular attention to collaboration with key stakeholders. Your participation has been requested because as a practicing family physician, your viewpoint may contribute valuable information towards these research ends.

Your participation in this project will involve one interview, approximately 1 hour in length, during which you will be asked to respond to a series of questions about your insights into disability management and your practice. The interview should not be viewed as a "test" - I am simply interested in overall perceptions or views. All information that you provide is held in strict confidence.

With consent, interviews will be recorded and stored in a locked cabinet in the lab at the University of Northern British Columbia. Your names will be removed from all responses/recordings and replaced with code numbers to preserve confidentiality. Back-up copies of each tape recording will be made and stored in an alternate locked cabinet in the UNBC lab. Audio tapes will then be transcribed (transcriptionist to sign confidentiality agreement) and these documents will also be securely stored in the UNBC lab. All data and copies thereof will be stored as described above for a period of seven years after which time they will be securely destroyed. Throughout the data collection, transcription and data analysis processes, access to data and copies will be restricted to the researcher (myself, Christine Reynolds), the project supervisor (Dr. Shannon Wagner) and the transcriptionist.

Please be assured that once you volunteer to participate, you can still withdraw from the study at any time with no consequence and any information collected from you will be withdrawn and securely destroyed. To the best of my knowledge, there are no inherent risks associated with participation in this research project; benefits include the opportunity to convey the physicians' perspective on Disability Management and thereby contribute to a better understanding of their needs, concerns and views, in relation to other stakeholders in this field.



If you would like to participate in this project, please complete and return the attached informed consent sheet and feel free to keep this information letter for further reference. In exchange for your participation, I will provide a UNBC mug as a nominal gift in appreciation of your interest and time. A copy of the final results can be attained, upon completion of the project, by contacting me directly.

Thank you very much for your time and consideration. I look forward to hearing from you; if you have any further questions please contact myself at [portmanc@unbc.ca](mailto:portmanc@unbc.ca) or phone project supervisor, Dr. Shannon Wagner, at 250-960-6320. If at any time, you have concerns about the research project or the researcher, you may contact the UNBC Office of Research at 250-960-5820.

Sincerely,

***Christine Reynolds***  
Masters Student - Disability Management Program  
University of Northern British Columbia

## Appendix 3

The Role of the Physician in Disability Management:  
Assessing family physicians' view of discrepancies between  
practice and Canadian Medical Association guidelines

Participant Consent Form

I have read the information letter concerning the research project entitled The Role of the Physician in Disability Management: Assessing family physicians' view of discrepancies between practice and Canadian Medical Association guidelines" being conducted by Christine Reynolds of the University of Northern British Columbia.

I understand that all information gathered for this project is to be used for research purposes only and will be considered confidential. I also understand that permission to participate may be withdrawn at any time.

I will participate: \_\_\_\_\_ Yes \_\_\_\_\_ No

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (Print Please): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Best times to call: \_\_\_\_\_

If you would like more information about this project, or to obtain research results, please contact myself (Christine Reynolds) at [portmanc@unbc.ca](mailto:portmanc@unbc.ca) or, phone project supervisor Dr. Shannon Wagner at 250-960-6320. Alternatively, please provide your phone number below and I will contact you as soon as possible.

Name: \_\_\_\_\_

Phone number: \_\_\_\_\_

Best Times to call: \_\_\_\_\_

## Appendix 4

The Role of the Physician in Disability Management:  
Assessing family physicians' view of discrepancies between  
practice and Canadian Medical Association guidelines

Physician Interview Questions and Rationales

- 1) Demographic variables (age, gender, ethnicity, location)  
How long have you been practicing medicine?

*Rationale: The basic demographic characteristics of the participants will be noted in order to maintain a balanced, theoretical sampling of physicians in BC.*

- 2) What if any formal Disability Management (DM) or Occupational Medicine training/education have you received,  
a) as part of your medical school curriculum?  
b) post-grad?  
c) in the last 2 years?

*Rationale: The literature suggests that for family physicians, Disability Management specific educational opportunities are insufficient and this may be one of the reasons for the CMA guidelines not being fully realized (Beaumont, 2003; Pransky, 2004; Dorrell, 2002). This question will provide an estimate of the level of physician awareness of DM principles and best practices.*

- 3) The CMA policy statement titled *The Physicians Role in Helping Patients Return to Work After Illness or Injury*, as well as provincial policy statements on this topic, emphasize the employee/employer relationship as central to DM decision-making and that the physician's role is to provide information outlining restrictions/limitations (Canadian Medical Association, 2001). In other words, Canadian medical associations suggest that whether or not a worker is able to return to work should ultimately be up to the employee and employer, with information from the physician used as guidance.

- a) What do you think about this as the suggested ideal role for the physician in DM?

*Rationale: The physician's role in DM is often viewed by other stakeholders as that of a gatekeeper in terms of releasing patients' to return to work and for certifying disability related absence (Ontario Medical Association Committee on Medical Care and Practice, 1994). However, physicians (and other parties) are unsatisfied with the practice of the physician making decisions in isolation (MacBride & Delvin, 1994). The purpose of this question is to explore individual physician opinion/interpretation of the new guidelines for their role in DM.*

- b) How does your personal practice and experience compare to this proposed function/role for the physician?

*Rationale: This question aims to determine to what degree the physicians interviewed feel they emulate the CMA recommendations (where the employer/employee is ultimately responsible for return to work decision making) in their practice.*

- c) What recommendations do you have that may help reduce any discrepancies between this ideal and reality?

*Rationale: The literature identifies several barriers for physicians in performing their role as per professional guidelines. These include time constraints, lack of educational opportunities, and possible conflicts with their advocacy role (Beaumont, 2003). This question seeks to elicit individual physicians' insight as to potential solutions that may enable them to close the gap between current practice and their proposed DM role.*

- 4) What are some of your greatest frustrations/concerns when working with DM stakeholders towards return to work – specifically, in regards to:

- d) Employers?
- e) Private insurers?
- f) WCB?
- g) Patients/workers?

*Rationale: Different DM stakeholders have different expectations of the family physician. Frustrations may naturally arise due to differences in opinion over who should make return to work decisions (MacBride & Delvin, 1994). This question intends to identify, from the physicians perspective, the specific challenges associated when collaborating with key stakeholders in the DM/return to work process.*

- 5) What solutions do you suggest for these issues with:

- h) Employers?
- i) Private insurers?
- j) WCB?
- k) Patients/workers?

*Rationale: The purpose of this question is to provide physicians with an opportunity to suggest process or practice solutions that may address any issues outlined in Question 4) and hopefully result in recommendations for more effective DM.*

- 6) What is your preferred mode of communication with DM stakeholders?

(e.g. phone, fax, email)

*Rationale: Pransky, Shaw & Clarke (2004) describes interpersonal communication as “a powerful yet untapped strategic opportunity to improve outcomes in work disability” (p.632) and further, that relating modes of communication to satisfaction of DM parties is key. This question aims simply to identify what the preferred modes of communication are for physicians when working with DM stakeholders.*

- 7) What has your experience been in collaborating with employers who offer return to work or DM programs? How would you say these programs affect patient outcomes?

*Rationale: Historically, physicians have typically been guarded or protective of the patient when it comes to return to work (Makdession, 2000; Harder, 2004), due in large part to a lack of awareness about the workplace, particularly job demands and availability of modified or safe work. Now, early return to work and DM programs have become somewhat commonplace and are seen as representing a win-win-win for employees, employers and physicians (Krauser, 1994). This question attempts to ascertain the family physician's overall experience when involved with employer-based DM initiatives, and the influence of these programs on patient outcomes, when compared to organizations without such programs.*

- 8) What proportion of your patient load would you say is involved with return to work or DM issues at any given time? Or, what proportion of your day do you spend dealing with return to work or DM issues?

*Rationale: A U.S. study determined that primary care physician involvement with patients' return to work and disability issues comprised, on average, 10% of a physicians' practice (Pransky, Katz, Benjamin, & Himmelstein, 2002). This question intends to establish a general idea of the proportion of Canadian physicians' workload that is DM related; in particular, those physicians practicing in British Columbia. The greater the scope of physicians' practice that is dedicated to DM, the more critical their fulfillment of their proposed role become*

- 9) Case Example 1: A patient has been attending an occupational rehabilitation program and the treating therapists have deemed him/her 'fit to return to modified work'. The employer is offering 'light' work and a gradual return to work schedule has been arranged, but the patient comes to you and communicates that they do not feel ready to return to work. What would you do in this situation?

*Rationale: The physician's statement or decision about return to work is often viewed as final and absolute (Pransky et al., 2004) and this can be a source of misunderstanding and frustration for stakeholders. For instance, employers may*

*feel frustrated at how easily they perceive physician's provide 'off-work' notes (Makdessian, 2000). This case is an example of where the physician is put in the difficult position of conflicting demands or recommendations from various stakeholders, not the least of which is the employee who is requesting to remain off work. Asking a physician how they would handle such a situation will offer valuable insight into the variety and also the similarities between physicians' approaches to this type of scenario both in terms of communication and fulfilling their prescribed DM role.*

- 10) Case Example 2: A patient has suffered an acute lower-back strain that is now, in your opinion, 80% resolved. The patient comes in to see you and asked for a note to his employer saying he is able to return to his job 'full duties'. He is keen to return to work but you have not heard from the employer and do not know anything about the demands of his job. What would you do in this situation?

*Rationale: As with Case Example 1, this case provides a practical situation from which we may grasp the individual physician's DM practice style and skill when it comes to resolving return to work issues where multiple stakeholders are involved. In contrast to Case Example 1, in this scenario the patient is eager to return to work, which may, ironically, pose its own problems.*

*Additionally, the aggregate information collected from responses to the two case examples may provide information for the development of DM best practices for the two sample scenarios. At the very least, these cases will highlight any discrepancies between the physicians practice and the proposed ideal role for the physician, as well as reveal any inter-physician variability in resolving DM issues.*

Appendix 5

The Role of the Physician in Disability Management:  
Assessing family physicians' view of discrepancies between  
practice and Canadian Medical Association guidelines

Transcriber Confidentiality Agreement

This statement is to acknowledge the confidential nature of data (both in original audio form, and in print form) obtained in the research study "The Role of the Physician in Disability Management: Assessing family physicians' view of discrepancies between practice and Canadian Medical Association guidelines" and that as such that all data and any copies thereof, will be held in strict confidence - not to be disclosed to any party other than the research investigator, unless otherwise indicated by law (British Columbia).

Transcriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (Please Print): \_\_\_\_\_

Organization: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Witness signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (Please Print): \_\_\_\_\_

Appendix 6

C.Reynolds thesis research

The Role of the Physician in Disability Management:  
Assessing family physicians' view of discrepancies between  
practice and Canadian Medical Association guidelines

**DATA CODEBOOK**

**Data coding categories by unit of analysis (interview questions)**

Christine Reynolds

February 17th 2006

Disability Management Masters Degree Program

University of Northern British Columbia



- 1) Demographic variables (age, gender, ethnicity, location)  
How long have you been practicing medicine?

*Rationale: The basic demographic characteristics of the participants will be noted in order to maintain a balanced, theoretical sampling of physicians in BC.*

**Question 1)** no coding

- 2) What if any formal Disability Management (DM) or Occupational Medicine training/education have you received,
  - a) as part of your medical school curriculum?
  - b) post-grad?
  - c) in the last 2 years?

*Rationale: The literature suggests that for family physicians, Disability Management specific educational opportunities are insufficient and this may be one of the reasons for the CMA guidelines not being fully realized (Beaumont, 2003; Pransky, 2004; Dorrell, 2002). This question will provide an estimate of the level of physician awareness of DM principles and best practices.*

**Question 2)** no coding

- 3) The CMA policy statement titled *The Physicians Role in Helping Patients Return to Work After Illness or Injury*, as well as provincial policy statements on this topic, emphasize the employee/employer relationship as central to DM decision-making and that the physician's role is to provide information outlining restrictions/limitations (Canadian Medical Association, 2001). In other words, Canadian medical associations suggest that whether or not a worker is able to return to work should ultimately be up to the employee and employer, with information from the physician used as guidance.

- a) What do you think about this as the suggested ideal role for the physician in DM?

*Rationale: The physician's role in DM is often viewed by other stakeholders as that of a gatekeeper in terms of releasing patients' to return to work and for certifying disability related absence (Ontario Medical Association Committee on Medical Care and Practice, 1994). However, physicians (and other parties) are unsatisfied with the practice of the physician making decisions in isolation (MacBride & Delvin, 1994). The purpose of this question is to explore individual physician opinion/interpretation of the new guidelines for their role in DM.*

- d) How does your personal practice and experience compare to this proposed function/role for the physician?

*Rationale: This question aims to determine to what degree the physicians interviewed feel they emulate the CMA recommendations (where the employer/employee is ultimately responsible for return to work decision making) in their practice.*

- e) What recommendations do you have that may help reduce any discrepancies between this ideal and reality?

*Rationale: The literature identifies several barriers for physicians in performing their role as per professional guidelines. These include time constraints, lack of educational opportunities, and possible conflicts with their advocacy role (Beaumont, 2003). This question seeks to elicit individual physicians' insight as to potential solutions that may enable them to close the gap between current practice and their proposed DM role.*

**Question 3) Coding:**

- 3. a)
  - 1 physician agrees with CMA proposed ideal / do not accept
  - 2 physician disagrees with CMA proposed ideal / accept
  
- 3. b)
  - 1 physician reports their practice emulates ideal
  - 2 physician reports their practice sometime close to ideal, but not quite
  - 3 physician reports their practice differs from proposed role
  
- 3. c) physician recommends solutions addressing:
  - 1 time constraints
  - 2 education
  - 3 role conflict - conflict with physician's advocacy role OR conflict between roles of various stakeholders (e.g. who should be making the RTW decision)
  - 4 other

- 4) What are some of your greatest frustrations/concerns when working with DM stakeholders towards return to work – specifically, in regards to:
- a) Employers?
  - b) Private insurers?
  - c) WCB?
  - d) Patients/workers?

*Rationale: Different DM stakeholders have different expectations of the family physician. Frustrations may naturally arise due to differences in opinion over who should make return to work decisions (MacBride & Delvin, 1994). This question intends to identify, from the physicians perspective, the specific challenges associated when collaborating with key stakeholders in the DM/return to work process.*

**Question 4) Coding**

4. d) physician describes frustrations with *employers* relating to

- 1 communication
- 2 education
- 3 confidentiality - (e.g. physicians worried about disclosing medical info, or employer asks for private info)
- 4 workplace issues/interpersonal/union, etc. (e.g. supervisor doesn't support RTW, lack of accommodation/modified work)
- 5 other

4. e) physician describes frustrations with *private insurers* relating to

- 1 communication
- 2 education
- 3 process/contractual agreements/ policy – e.g. the methods, protocols and procedures inherent to interaction/collaborating with private insurers
- 4 role conflict- conflict with physician's advocacy role OR conflict between roles of various stakeholders (e.g. who should be making the RTW decision)
- 5 other

## Question 4) Coding cont...

4. f) physician describes frustrations with *WCB* relating to
- 1 communication
  - 2 education
  - 3 process/contractual agreements/ policy – e.g. the methods, protocols and procedures inherent to interaction/collaborating with WCB
  - 4 role conflict - conflict with physician's advocacy role OR conflict between roles of various stakeholders (e.g. who should be making the RTW decision)
  - 5 other
4. g) physician describes frustrations with *patient / worker* relating to
- 1 communication
  - 2 education
  - 3 workplace issues/interpersonal/union - (e.g. worker does not like job, worker unwilling perform modified work)
  - 4 entitlement mentality - worker feels 'they are owed' something, such as time off, compensation etc.
  - 5 confidentiality
  - 6 psychological or psychosocial issues - (e.g. worker has developed a co-morbid psychological condition affecting RTW, OR worker has non-medical issues (psychosocial, but excluding workplaces issues) affecting RTW)
  - 7 other

- 5) What solutions do you suggest for these issues with:
- a) Employers?
  - b) Private insurers?
  - c) WCB?
  - d) Patients/workers?

*Rationale: The purpose of this question is to provide physicians with an opportunity to suggest process or practice solutions that may address any issues outlined in Question 4) and hopefully result in recommendations for more effective DM.*

**Question 5) Coding:**

- h) To address frustrations with *employers*, physician suggests solutions relating to
- 1 communication
  - 2 education
  - 3 confidentiality - e.g. physicians worried about disclosing medical info, or employer asks for private info
  - 4 workplace issues/interpersonal/union - e.g. supervisor doesn't support RTW, lack of accommodation/modified work
  - 5 other
- i) To address frustrations with *private insurers*, physician suggests solutions relating to
- 1 communication
  - 2 education
  - 3 process/contractual agreements/ policy – e.g. the methods, protocols and procedures inherent to interaction/collaborating with private insurers
  - 4 role conflict- conflict with physician's advocacy role OR conflict between roles of various stakeholders (e.g. who should be making the RTW decision)
  - 5 other

## Question 5) Coding cont...

- j) To address frustrations with *WCB*, physician suggests solutions relating to
- 1 communication
  - 2 education
  - 3 process/contractual agreements/ policy – e.g. the methods, protocols and procedures inherent to interaction/collaborating with WCB
  - 4 role conflict - conflict with physician's advocacy role OR conflict between roles of various stakeholders (e.g. who should be making the RTW decision)
  - 5 other
- k) To address frustrations with the *patient / worker*, physician suggests solutions relating to
- 1 communication
  - 2 education
  - 3 workplace issues/interpersonal/union - (e.g. worker does not like job, worker unwilling perform modified work)
  - 4 entitlement mentality - worker feels 'they are owed' something, such as time off, compensation, etc.
  - 5 confidentiality
  - 6 psychological or psychosocial issues - (e.g. worker has developed a co-morbid psychological condition affecting RTW, OR worker has non-medical issues (psychosocial, but excluding workplaces issues) affecting
  - 7 other

- 6) What is your preferred mode of communication with DM stakeholders?  
(e.g. phone, fax, email)

*Rationale: Pransky, Shaw & Clarke (2004) describes interpersonal communication as "a powerful yet untapped strategic opportunity to improve outcomes in work disability" (p.632) and further, that relating modes of communication to satisfaction of DM parties is key. This question aims simply to identify what the preferred modes of communication are for physicians when working with DM stakeholders.*

**Question 6)** no coding



- 7) What has your experience been in collaborating with employers who offer return to work or DM programs? How would you say these programs affect patient outcomes?

*Rationale: Historically, physicians have typically been guarded or protective of the patient when it comes to return to work (Makdessian, 2000; Harder, 2004), due in large part to a lack of awareness about the workplace, particularly job demands and availability of modified or safe work. Now, early return to work and DM programs have become somewhat commonplace and are seen as representing a win-win-win for employees, employers and physicians (Krauser, 1994). This question attempts to ascertain the family physician's overall experience when involved with employer-based DM initiatives, and the influence of these programs on patient outcomes, when compared to organizations without such programs.*

**Question 7) coding**

7. a) experience

- 1 physician has some experience with patients involved with RTW programs
  - (i) positive experience
  - (ii) negative experience
- 2 physician has no experience with patients involved with RTW programs

7. b)
- 1 physician reports RTW programs have positive effect on patient outcomes
  - 2 physician reports RTW programs have no effect / no difference on patient outcomes
  - 3 physician reports RTW programs have a negative effect on patient outcomes

- 8) What proportion of your patient load would you say is involved with return to work or DM issues at any given time? Or, what proportion of your day do you spend dealing with return to work or DM issues?

*Rationale: A U.S. study determined that primary care physician involvement with patients' return to work and disability issues comprised, on average, 10% of a physicians' practice (Pransky, Katz, Benjamin, & Himmelstein, 2002). This question intends to establish a general idea of the proportion of Canadian physicians' workload that is DM related; in particular, those physicians practicing in British Columbia. The greater the scope of physicians' practice that is dedicated to DM, the more critical their fulfillment of their proposed role become*

**Question 8) DM workload**

- a) physician estimates patients involved with DM as proportion of patient load to be
- |   |          |
|---|----------|
| 1 | < 5%     |
| 2 | 5 – 10%  |
| 3 | 10 - 15% |
| 4 | 15 – 20% |
| 5 | 20 – 25% |
- b) physician estimates the proportion of their work day that is spent on DM
- |   |          |
|---|----------|
| 1 | < 5%     |
| 2 | 5 – 10%  |
| 3 | 10 - 15% |
| 4 | 15 – 20% |
| 5 | 20 – 25% |

- 9) Case Example 1: A patient has been attending an occupational rehabilitation program and the treating therapists have deemed him/her 'fit to return to modified work'. The employer is offering 'light' work and a gradual return to work schedule has been arranged, but the patient comes to you and communicates that they do not feel ready to return to work. What would you do in this situation?

*Rationale: The physician's statement or decision about return to work is often viewed as final and absolute (Pransky et al., 2004) and this can be a source of misunderstanding and frustration for stakeholders. For instance, employers may feel frustrated at how easily they perceive physician's provide 'off-work' notes (Makdessian, 2000). This case is an example of where the physician is put in the difficult position of conflicting demands or recommendations from various stakeholders, not the least of which is the employee who is requesting to remain off work. Asking a physician how they would handle such a situation will offer valuable insight into the variety and also the similarities between physicians' approaches to this type of scenario both in terms of communication and fulfilling their prescribed DM role.*

*The aggregate information collected from responses to the two case examples (Questions 9 & 10) may provide information for the development of DM best practices for the two sample scenarios. At the very least, these cases will highlight any discrepancies between the physicians practice and the proposed ideal role for the physician, as well as reveal any inter-physician variability in resolving DM issues.*

**Question 9) Coding**

- |    |   |   |
|----|---|---|
| 9. | 1 | physician automatically support patients request  |
|    | 2 | physician describes they would seek more information/communication/clarification for stakeholders (e.g employers, therapists) |
|    | 3 | physician describes they would seek more information from/communication/clarification with patient                            |
|    | 4 | other   |

- 10) Case Example 2: A patient has suffered an acute lower-back strain that is now, in your opinion, 80% resolved. The patient comes in to see you and asked for a note to his employer saying he is able to return to his job 'full duties'. He is keen to return to work but you have not heard from the employer and do not know anything about the demands of his job. What would you do in this situation?

*Rationale: As with Case Example 1, this case provides a practical situation from which we may grasp the individual physician's DM practice style and skill when it comes to resolving return to work issues where multiple stakeholders are involved. In contrast to Case Example 1, in this scenario the patient is eager to return to work, which may, ironically, pose its own problems.*

*The aggregate information collected from responses to the two case examples may provide information for the development of DM best practices for the two sample scenarios. At the very least, these cases will highlight any discrepancies between the physicians practice and the proposed ideal role for the physician, as well as reveal any inter-physician variability in resolving DM issues.*

**Question 10) Coding**

- |     |   |  |
|-----|---|--|
| 10. | 1 | physician automatically support patients request   |
|     | 2 | physician describes they would seek more information/ communication/ clarification from stakeholders (e.g. employer, therapists) |
|     | 3 | physician describes they would seek more information/communication/ clarification from patients                                  |
|     | 4 | other  |

Appendix 7

The Role of the Physician in Disability Management:  
 Assessing family physicians' view of discrepancies between  
 practice and Canadian Medical Association guidelines

Data Coding Record Sheet

**Question 1)** no coding

**Question 2)** no coding

**Question 3)**

<b>3 a)</b>		<b>3.a.1</b>	<b>3.a.2</b>
Physician	1	_____	_____
	2	_____	_____
	3	_____	_____
	4	_____	_____
	5	_____	_____
	6	_____	_____
	7	_____	_____

<b>3 b)</b>		<b>3.b.1</b>	<b>3.b.2</b>	<b>3.b.3</b>
Physician	1	_____	_____	_____
	2	_____	_____	_____
	3	_____	_____	_____
	4	_____	_____	_____
	5	_____	_____	_____
	6	_____	_____	_____
	7	_____	_____	_____

<b>3) c)</b>		<b>3.c.1</b>	<b>3.c.2</b>	<b>3.c.3</b>	<b>3.c.4</b>
Physician	1	_____	_____	_____	_____
	2	_____	_____	_____	_____
	3	_____	_____	_____	_____
	4	_____	_____	_____	_____
	5	_____	_____	_____	_____
	6	_____	_____	_____	_____
	7	_____	_____	_____	_____

**Question 4)**

<b>4) d)</b>		<b>4.d.1</b>	<b>4.d.2</b>	<b>4.d.3</b>	<b>4.d.4</b>	<b>4.d.5</b>
Physician	1	_____	_____	_____	_____	_____
	2	_____	_____	_____	_____	_____
	3	_____	_____	_____	_____	_____
	4	_____	_____	_____	_____	_____
	5	_____	_____	_____	_____	_____
	6	_____	_____	_____	_____	_____
	7	_____	_____	_____	_____	_____

<b>4) e)</b>		<b>4.e.1</b>	<b>4.e.2</b>	<b>4.e.3</b>	<b>4.e.4</b>	<b>4.e.5</b>
Physician	1	_____	_____	_____	_____	_____
	2	_____	_____	_____	_____	_____
	3	_____	_____	_____	_____	_____
	4	_____	_____	_____	_____	_____
	5	_____	_____	_____	_____	_____
	6	_____	_____	_____	_____	_____
	7	_____	_____	_____	_____	_____

4) f)		4.f.1	4.f.2	4.f.3	4.f.4	4.f.5
Physician	1	_____	_____	_____	_____	_____
	2	_____	_____	_____	_____	_____
	3	_____	_____	_____	_____	_____
	4	_____	_____	_____	_____	_____
	5	_____	_____	_____	_____	_____
	6	_____	_____	_____	_____	_____
	7	_____	_____	_____	_____	_____

4) g)		4.g.1	4.g.2	4.g.3	4.g.4	4.g.5	4.g.6	4.g.7
Physician	1	_____	_____	_____	_____	_____	_____	_____
	2	_____	_____	_____	_____	_____	_____	_____
	3	_____	_____	_____	_____	_____	_____	_____
	4	_____	_____	_____	_____	_____	_____	_____
	5	_____	_____	_____	_____	_____	_____	_____
	6	_____	_____	_____	_____	_____	_____	_____
	7	_____	_____	_____	_____	_____	_____	_____

**Question 5)**

5) h)		5.h.1	5.h.2	5.h.3	5.h.4	5.h.5	5.h.6
Physician	1	_____	_____	_____	_____	_____	_____
	2	_____	_____	_____	_____	_____	_____
	3	_____	_____	_____	_____	_____	_____
	4	_____	_____	_____	_____	_____	_____
	5	_____	_____	_____	_____	_____	_____
	6	_____	_____	_____	_____	_____	_____
	7	_____	_____	_____	_____	_____	_____





**Question 6)** no coding

**Question 7)**

**7) a)** 7.a.1i\* 7.a.1ii\*7.a.2

Physician	1	_____	_____	_____
	2	_____	_____	_____
	3	_____	_____	_____
	4	_____	_____	_____
	5	_____	_____	_____
	6	_____	_____	_____
	7	_____	_____	_____

\* if an answer falls under a) 1 it must be either (i) or (ii)

**7) b)** 7.b.1 7.b.2 7.b.3

Physician	1	_____	_____	_____
	2	_____	_____	_____
	3	_____	_____	_____
	4	_____	_____	_____
	5	_____	_____	_____
	6	_____	_____	_____
	7	_____	_____	_____

**Question 8)**

**8) a)** 8.a.1 8.a.2 8.a.3 8.a.4 8.a.5

Physician	1	_____	_____	_____	_____	_____
	2	_____	_____	_____	_____	_____
	3	_____	_____	_____	_____	_____
	4	_____	_____	_____	_____	_____
	5	_____	_____	_____	_____	_____
	6	_____	_____	_____	_____	_____
	7	_____	_____	_____	_____	_____

<b>8) b)</b>		<b>8.b.1</b>	<b>8.b.2</b>	<b>8.b.3</b>	<b>8.b.4</b>	<b>8.b.5</b>
Physician	1	_____	_____	_____	_____	_____
	2	_____	_____	_____	_____	_____
	3	_____	_____	_____	_____	_____
	4	_____	_____	_____	_____	_____
	5	_____	_____	_____	_____	_____
	6	_____	_____	_____	_____	_____
	7	_____	_____	_____	_____	_____

<b>Question 9)</b>		<b>9.1</b>	<b>9.2</b>	<b>9.3</b>	<b>9.4</b>
Physician	1	_____	_____	_____	_____
	2	_____	_____	_____	_____
	3	_____	_____	_____	_____
	4	_____	_____	_____	_____
	5	_____	_____	_____	_____
	6	_____	_____	_____	_____
	7	_____	_____	_____	_____

<b>Question 10)</b>		<b>10.1</b>	<b>10.2</b>	<b>10.3</b>	<b>10.4</b>
Physician	1	_____	_____	_____	_____
	2	_____	_____	_____	_____
	3	_____	_____	_____	_____
	4	_____	_____	_____	_____
	5	_____	_____	_____	_____
	6	_____	_____	_____	_____
	7	_____	_____	_____	_____

Rater Name: \_\_\_\_\_ Signature: \_\_\_\_\_