

# The role of the curative physician in disability management

## A literature review

by

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### Abstract

*Aims: The aim of this article is to present a literature review of the role of curative physicians in the disability management of sick-listed patients.*

*Methods: We performed a review of pertinent literature published in English between 1994 and mid-2005. We searched MEDLINE using the MeSH terms curative physician, physician's role, and disability management. Additionally, relevant MEDLINE links, bibliographic and personal literature lists, symposia, and bibliographies of selected papers were searched. Papers were selected for further review based on their content.*

*Main findings: We retrieved nearly 600 references; 52 were relevant to our subject of interest and were included in the review. Several authors emphasised the important role of the curative physician in disability management. The studies also emphasised that curative physicians can influence patients' sick leave and disability outcomes without jeopardising the physician-patient relationship. Taking an active role in disability management, however, is difficult for the curative physician, because sickness absence and work resumption are influenced by multiple factors. Therefore, cooperation between curative physicians and insurance and workplace actors is necessary and should be improved.*

*Principal conclusions: Curative physicians have an important role in disability management and should be encouraged to participate more actively in disability management.*

### Keywords

*Disability evaluation, disability insurance, employment, family physicians, occupational medicine, physician's role, rehabilitation, sick leave*

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## Samenvatting

*Doelstellingen: Het doel van dit artikel is een literatuuroverzicht te geven van de rol van de behandelende arts in het arbeidsongeschiktheids- en werkhervattingstraject van patiënten met ziekteverlof.*

*Methodes: Wij maakten een overzicht van de relevante Engelstalige literatuur gepubliceerd tussen 1994 en midden 2005. Wij zochten in MEDLINE naar de MeSH termen 'curative physician', 'physician's role' en 'disability management'. Bijkomend werden relevante MEDLINE-links, bibliografische en persoonlijke literatuurlijsten, symposia en bibliografieën van geselecteerde artikels bestudeerd. Op basis van hun inhoud werden de artikels al dan niet definitief geselecteerd.*

*Belangrijkste resultaten: We vonden bijna 600 referenties; 52 waren relevant voor ons onderzoek en werden opgenomen in dit overzichtsartikel. Meerdere auteurs onderlijnden de belangrijke rol van de behandelende arts in het arbeidsongeschiktheids- en werkhervattingstraject. De studies benadrukten ook dat curatieve geneesheren de arbeidsongeschiktheid en werkhervattingsmogelijkheden van hun patiënten kunnen beïnvloeden zonder de arts-patiëntrelatie te schaden. Het is voor behandelende artsen echter niet gemakkelijk om een actieve rol op te nemen inzake arbeidsongeschiktheid en werkhervatting: ziekteverzuim en terugkeer naar de arbeidsmarkt worden immers beïnvloed door diverse factoren. Daarom is er samenwerking tussen curatieve artsen, verzekeringsgeneeskundige instanties en de werkplaats nodig. Deze samenwerking zou verbeterd moeten worden.*

*Belangrijkste conclusies: curatieve artsen hebben een belangrijke rol in het arbeidsongeschiktheids- en werkhervattingstraject van hun patiënten en zouden aangemoedigd moeten worden om hierin een meer actieve rol op te nemen.*

## Introduction

Although disability can be defined in several ways, the World Health Organization (WHO) definition of disability is the most widely used. In the WHO International Classification of Functioning, Disability, and Health (ICF), disability is understood to be an umbrella term for impairments, activity limitations, and participation restrictions. The various ICF definitions of disability have been used extensively in areas such as rehabilitation, education, statistics, policy, legislation, demography, sociology, economics, and anthropology. Disability management also has several definitions (1, 2). For the present paper, we defined disability management as a process that coordinates all the efforts and actions of stakeholders involved in sickness absence, disability, and work resumption for the purpose of minimising the impact of injury, disability, or disease on a worker's capacity to successfully perform his or her job. In essence, disability management refers to the twofold process of 1) enabling a patient to work and maintaining the patient's ability to work, and 2) helping a patient return to work.

Disability management involves many possible stakeholders: the worker on sick leave; the employer and supervisors; the social security system; the occupational health services; and the health-care providers. Beaumont assessed the viewpoint of 25 stakeholders in disability management and generated a consensus statement, identifying the crucial role of general practitioners (3, 4). Beaumont's findings indicated that curative physicians need to be more aware of how important working is to the health of their patients and how important their role as physicians is in maintaining or helping their patients return to work (3, 4). Reviews provide evidence that disability management is important (1, 2, 5, 6). Although several authors emphasized the need for a multidisciplinary approach in disability management (7), much less research has been done on the curative physician's role in disability management. Our aim here is to overcome this shortcoming by reviewing the literature on the role of the curative physician in disability management.

## **Methods**

We performed an in-depth review of literature dealing with the role of curative physicians in disability management. The articles examined in this review were retrieved from the electronic MEDLINE database using PubMed. To find pertinent articles, we performed PubMed searches using the following MeSH terms: family physician, family practice, and primary health care. Articles dealing with the role of curative physicians were selected by using the MeSH term 'physician's role.' Information on disability management was gathered using the following MeSH terms: sick leave; disabled persons; disability evaluation; insurance, disability; workers' compensation; insurance; social security; rehabilitation; work capacity evaluation; employment; occupational health services; occupational medicine; occupational health; occupational therapy; work; preventive health services; insurance physicians services. Our search strategy combined MeSH terms for curative physician with the MeSH term for the physician's role and the MeSH terms for disability management. Additional manuscripts were identified by searching relevant MEDLINE links, bibliographic and personal literature lists, expert meetings, and reference lists of selected papers. We restricted our search to papers published from January 1, 1994 to September 12, 2005. Papers were excluded if they were not written in English.

We selected papers for further review if they were judged to include data or information about the role of curative physicians in disability management during patients' sick leave. The role of curative physicians during the start of sick leave (e.g. to certify the sickness absence) was recently reviewed by several authors, and thus was not further examined in the present study (8-10). The main objective of this review is to gain a greater understanding of curative physicians' role in guiding patients on sick leave to resume work and in guiding these patients through the disability management process. We also reviewed the practical difficulties that physicians may encounter when implementing disability management. Finally, we gave considerable attention to the collaboration between curative physicians and other stakeholders in disability management, because this is of great importance when attempting

to apply disability management in the daily practice of curative physicians. Papers addressing these topics were included in our review.

## Results

Our search using the combination of MeSH terms yielded a total of 473 articles. Over 100 additional articles were added from relevant MEDLINE links, among others. Fifty-two papers proved to be relevant to the subject in the present review (Table 1). We classified our review results according to 9 subtopics (Table 2). The subtopics were chosen by the authors and were based on the content of the reviewed articles.

TABLE 1. An overview of included articles by type of study

Type of study	References
review	1, 2, 5-6, 8-10, 12, 16-19, 21, 24-27, 32, 36, 54, 56
prospective intervention trial	7, 31, 45-52, 57
retrospective cohort study	20, 29-30, 40, 55
cross-sectional survey trial	13-14, 23, 41-43, 53
qualitative study	3, 28, 33, 35, 44
informative or policy-based article	4, 11, 15, 22, 34, 37-39

TABLE 2. Summary table of included topics

3.1 The curative physician can have an active role in sickness absence and acknowledge the importance of this role in disability management.
3.2 Strategies to prevent prolonged sickness absence include return to work discussions, referrals to occupational physicians and the clear description of work restrictions and options.
3.3 There are tools for curative physicians to identify patients in need of disability management.
3.4 The curative physicians' fear of a negative impact of disability management on the physician-patient relationship may be countered by a strong physician-patient relationship.
3.5 There is mounting evidence that disability management has an impact on the health outcome of the patient.
3.6 An inter-disciplinary approach to disability management is necessary because sickness absence is a complex phenomenon.
3.7 Communication with actors responsible for sickness absence benefits is necessary to understand benefit systems and discuss gradual work resumption possibilities.
3.8 Communication with actors in the workplace is necessary to address workplace accommodation.
3.9 Interventions that include the curative physician in disability management strategies are started to address the inconsistent information exchange between curative physicians, insurance and workplace parties.

### Important role of the curative physician

Our review supports the idea that the task of curative physicians in patients' sickness absences goes further than legitimising the absence from work (11). Curative physicians can discourage prolonged sickness absences by taking an active role in disability management, a

role that can begin at the moment the patient's sickness is certified. The request for a sick-note can be viewed as an opportunity to discuss work and health-related problems (12).

We found indications in the literature that curative physicians acknowledge their important role in disability management. With the aim of identifying challenges and opportunities for improved disability management and work capacity evaluation from the perspectives of general practitioners, family physicians, and internists in the USA, Pransky et al. found that more than 90% of respondents agreed that they had a role in facilitating patients' return to work (13). Guzman et al. found similar results with Canadian physicians (general practitioners, family physicians, and emergency physicians) (14). In documenting their views on helping patients to return to work, 9 out of 10 physicians agreed they had an important role in planning the patient's return to work. The most frequently mentioned facilitating factor was the physicians' ability to explain the nature and prognosis of injuries to the patient. Seventy percent of physicians pointed to their patients' misunderstandings and fears about injury as the primary barrier in guiding the patient through the sickness absence process (14). Indeed, treating physicians are in a prime position to address these misunderstandings.

#### Strategies to prevent prolonged sickness absence

In our review we found that once sickness absence was certified, several strategies were adopted to avoid prolonged sickness absence. In a publication by the Canadian Medical Association on the physician's role in helping patients return to the workplace after an illness or injury, the authors enumerate several strategies for reducing the duration of sickness absences (15). We describe some examples of the most important strategies below.

The curative physicians can discuss with the patient early in their care the idea of returning to work, and soon after include it as a specific treatment objective. Protecting the patient from unrealistic recovery expectations is also helpful. Another strategy is for curative physicians to motivate their patients to contact the occupational physician for all work-related health problems. Guiding the patient towards work resumption also includes describing work restrictions in clear and specific terms and only when necessary. Furthermore, physicians should encourage patients to assume active sick leave if no medical contraindications exist. Finally, physicians should identify potential obstacles for returning to work and search for solutions to overcome these in cooperation with the patient and other involved stakeholders.

#### Defining the patient population in need of disability management

To address the strategies listed above in an optimal way, curative physicians need to recognise 'red and yellow warning flags' surrounding a patient's disability. These flags sort out which patients with similar pathologies are at risk for extended sickness absence (16). Several authors have listed in their reviews predictors that are good determinants of prolonged sickness absence and predictors that are good determinants of work resumption (6,12,17-19). Indeed, Krause et al. identified about 100 determinants of disability and return to work (18). Most authors focused on patients with back pain, but risk factors did not appear to differ

among different types of injuries (17). Medical factors extending the duration of sickness absence include patients' biomedical characteristics such as diagnosis and treatment-specific conditions, the presence of co-morbid conditions, and medication intake. Non-medical factors include patients' demographic, psychosocial, and economic characteristics; work site characteristics; and economic variables.

In the following, we review some published tools to help curative physicians detect red flags for extended disability-related sickness absences.

MacGrail et al. offered a practical list of presenting risk factors for delayed recovery (12): 1) the patient's personal or family history of prolonged disability; 2) disability symptoms out of proportion compared to the diagnosis; 3) exaggerated pain behaviour; 4) family dysfunction; 5) history of physical or other abuse; and 6) chemical dependency. Curative physicians should be aware whether any or all of these factors are present in their patients in order to optimally manage the disability and reduce extended sickness absences.

Alternatives are the simple classification system of Bonzani et al. (20), and the Work Disability Diagnosis Interview of Durand et al. (21). Both detect possible disability prognostic factors in musculoskeletal pain patients.

Obviously, just detecting red flags for extended disability leave or sickness absence is not enough. A two-step process is needed. The physician should first be alert to the possible presence of these risk factors in their patients and then direct their care accordingly, possibly using the above-mentioned tools. The ultimate objective after all is to intervene in the factors delaying recovery and to restore active employment through appropriate rehabilitation.

#### The impact of disability management on the physician-patient relationship

Although curative physicians acknowledge their role in disability management, they still need to be encouraged sometimes to take a more active role in disability management, especially one that aims to reduce prolonged absences from work (11). Strategies are available, and practical tools to address these strategies in an optimal way have just been explicated. The fear of damaging the physician-patient relationship, however, in response to implementing disability management in practice is one important reason that curative physicians do not sufficiently address work resumption strategies (22). In our review, we found only one trial designed to address this concern (23).

Radosevich et al. examined the non-dependent effects and the joint effects of disability prevention and patient-provider relationship to health status and patients' satisfaction with their provider (23). They found a negative association between disability prevention and overall satisfaction with the health-care provider. This finding seemed to support the concern among some primary care providers that incorporating disability prevention into their practice could result in patient dissatisfaction directed toward the provider. However, when disability prevention was built on a sound patient-physician relationship, it enhanced patient satisfaction and patient outcome (23).

The impact of disability management on the health outcome of the patient

Another reason for not implementing disability prevention in practice is the misconception among curative physicians that they cannot affect the sickness absence outcome of their sick-listed patients. Pransky et al. showed that 25% of primary care physicians believed they had little influence over disability outcomes (13). Our review, however, provides indications to the contrary.

Mounting evidence shows that actions of curative physicians *do* influence the health outcome of patients (24). Some authors reviewed studies published on physician-patient communication in which patient health was an outcome variable. The data used in these reviews mainly concerned short-term or intermediate-term health outcome parameters. Stewart et al. proved that effective physician-patient communication affects emotional health, symptom resolution, function, and physiological measures such as blood pressure and blood sugar level (25). Similarly, the study of Ong et al. showed that patient satisfaction, compliance, and recall of information improved if physicians endeavoured to communicate with their patients (26).

Few authors have reviewed the association between physician-patient communication and long-term patient outcome parameters such as recovery, sickness absence benefit, and work resumption. One exception is Nordin et al., who concluded that the patient-health care provider relationship can hamper return to work (27). More research is necessary, but it seems logical that physician-patient communication would affect sick leave and disability. The following authors made an attempt to address this need.

Tarasuk et al.'s qualitative research on the experience of patients with work-related back pain suggested that the information provided by health-care workers and the patients' perceptions interact (28). Specifically, their perception about whether their back problems were permanent and their attitudes about returning to work were influenced by the nature of information they received (28).

Dasinger et al. pointed to the potential benefit of enhanced communication between the curative physician and the patient to reduce sickness absence duration (29). He conducted a retrospective cohort trial including patients with a sickness absence exceeding 1 month due to low back pain. A positive return-to-work recommendation was associated with a 60% higher work-resumption rate. The impact of the curative physician's communication was largely confounded by injury and workplace factors. The latter resulted in the important conclusion that the study findings could be even more pronounced if workplace parties had been involved in the disability management (29).

Hiebert et al. conducted a retrospective cohort study on patients with uncomplicated lower back pain resulting in sickness absence from work. Work restrictions were prescribed in 43% of the patients (30). The authors compared the probability of two different patient groups (those with work restrictions vs. those without work restrictions) to return to work. The period examined was within one year after the onset of back pain. In both groups, nearly all patients, with or without restrictions, resumed some type of work (including accommodated,

modified, or gradual work). Seventy percent of patients with work restrictions returned to unrestricted work, whereas 100% of patients without work restrictions returned to unrestricted work (30).

Hall et al. conducted a non-controlled, prospective study on a cohort of patients sick-listed for acute lower back pain (31). The aim of this study was to evaluate the association between the patient's outcome and the physician's recommendation for restricted or unrestricted work resumption. In contrast to Hiebert et al.'s results, a work-restriction recommendation in Hall et al.'s study was associated with a lower return to any work status (47%) compared to a recommendation for unrestricted work resumption (84%) (31). One possible explanation for this discordance is the duration of the follow-up period for the two studies: Hiebert et al. followed patients for one year, whereas Hall et al. followed patients for 4 months.

These studies illustrate the influence curative physicians can have on the disability outcome of patients, emphasising the need for physicians to take an active role in disability management.

#### An interdisciplinary approach to disability management

Taking an active role in disability management and in implementing strategies to avoid prolonged patient sickness absences is a difficult task for curative physicians, because multiple factors influence sickness absence and work resumption. It is not reasonable to expect curative physicians to know all the details of work-related or insurance-related issues relating to disability management. But one should understand that recovery might depend on all these factors. Recognising that multiple factors within several systems impact the success of returning to work, physicians involved in disability management are urged to communicate and cooperate.

Inter-physician cooperation is recognised as a key element in successfully guiding the patient on sick leave to return to work. Frank et al. emphasised in a literature review dealing with secondary prevention of disability that work resumption for injured patients was most likely to be successful if all the different stakeholders involved in disability management coordinated their efforts (32). Williams et al. drew a similar conclusion after reviewing the literature on perspectives of workplace disability management (1). Friesen et al. investigated the barriers and facilitators for returning to work (33). The data were the perspectives of the different stakeholders involved in disability management. A wide range of various stakeholders identified the lack of communication with or between stakeholders as a major external barrier to successfully arranging work resumption of sick-listed patients (33).

These reviews emphasise the need for curative physicians to communicate. Curative physicians' roles in disability include effective communication among all the involved medical providers and the employer (34).

### Communication with actors responsible for sickness absence benefits

In this sphere, curative physicians obviously need to cooperate with insurance parties to obtain better insight into the benefit system. This enhanced understanding enables physicians to give proactive advice on gradual work resumption.

Gradual work resumption is an important tool for rehabilitation; synonyms are active sick leave or progressive return to work. The main principle of gradual work resumption is individual assistance tailored to the actual needs and situation of each employee on sick leave. In essence, gradual work resumption is a restriction in work hours. Work hours are progressively increased, with the ultimate aim of enabling patients to resume full-time work. In most countries, the social insurance company must approve the scheme for gradual work resumption, as this option is financially supported by the social security system.

Arranging active sick leave in Norway requires cooperation between the general practitioner who recommends the scheme, the employer who permits the modified work hours, the National Insurance Administration that approves and finances the scheme, and of course, the sick-listed patient who benefits from the scheme. Scheel et al. reported that, although broadly supported politically and embraced by most of the important stakeholders' national organisations, general practitioners in Norway rarely recommended active sick leave (35). She noted that 35% of general practitioners were unaware of the active sick-leave scheme, perhaps explaining its underusage. This lack of information probably influences a curative physician's decision to motivate patients on sick leave toward full work resumption (35).

One option for removing this obstacle is for curative physicians to contact the insurance physician for information on sickness absence benefit procedures. Because the insurance physician assesses a patient's incapacity to work and eligibility for benefits, he can discuss a patient's sickness absence course with the curative physician.

### Communication with actors in the workplace

While curative physicians need to cooperate with insurance parties, as a second step they also need to cooperate with workplace actors.

Wyman et al.'s review of the literature on evaluating patients for return to work supports this idea, concluding that curative physicians need workplace information (36): they need workplace information on accommodations in the work environment (37, 38). In assessing fitness for work, curative physicians should look beyond a specific disease or impairment of patients. Functional limitations of patients may be overcome by work adjustments, modifications, or accommodations. Guzman et al. found that treating physicians considered the willingness of the workplace to accommodate injured patients as the main facilitating factor for helping patients return to work (14). According to 21% of the physicians, non-supportive workplace parties were perceived as a significant barrier in work resumption. The most frequently requested change to improve the rate of sick-listed patients returning to work was better workplace accommodations (48%). From our review, however, we feel that curative physi-

cians should exert themselves more in obtaining information about the possibilities for tailoring work to the patient's abilities. For example, Pransky et al. showed that 71% of physicians simply asked the patient about alternative workplace duties (13). This strategy is questionable, since patients are often unaware of available accommodations or alternative duty.

Curative physicians also need workplace information about the patient's job content in order to prescribe work restrictions. Patients can often return to work without initial duty restrictions. When restrictions are necessary, the curative physician should detail the specifics of the patient's fitness limitations that certify the patient for light duties or specific shortened hours (11,36). The specifications should address the need for equipment adaptation, and the time period during which restrictions apply should be documented (36). Pransky et al. showed that, in communicating work restrictions to workplace parties, only one third of physicians specified in detail what the patient could or could not do (13). Vague restrictions are counterproductive for employers.

One option for physicians desiring to obtain workplace information is to contact the patient's employer. Many workplaces have an occupational medicine office or health services. These departments should be able to provide the physician with job qualification summaries and accommodation possibilities (36, 39).

Unfortunately, limited and poor cooperation of curative physicians with workplace parties has been reported for several countries (40-43). In the UK, Parker observed the apparent lack of general practitioners' interest in using occupational health services to help patients with disabilities. Moreover, there was much misunderstanding about the specific tasks of occupational health services (41).

In the Netherlands, Buijs et al. questioned occupational physicians and general practitioners. Cooperation in their practices was poor, but both groups wanted to improve (42). Anema et al. found that occupational physicians communicated with the curative physician for 19% of patients sick-listed with lower back pain for 3-4 months (43). With regard to curative medical practices, occupational physicians reported significant return-to-work hindrances, such as extended clinical waiting periods (43%) and duration of treatment (41%), and the views of the curative physician regarding return-to-work of the patient (25%).

In the USA, Westermorland et al. examined the perspectives of stakeholders in disability (including persons with disabilities and workplace parties) regarding work re-entry for persons with disabilities (44). The stakeholders concluded that good communication skills with all parties could be an important tool for enhancing return to work.

#### Interventions that include the curative physician in disability management

Inconsistent communication between curative physicians and insurance parties or workplace parties probably accounts for a proportion of patients on extended sick leave, as well as for some patients not returning to work. This is the rationale behind several intervention trials aimed at testing a concerted approach to increasing effective communication and coopera-

tion among all stakeholders involved in disability management (45-51). Most, but not all, of these studies showed promising results. We will briefly consider each one in turn.

Haase et al. conducted a prospective study with a historical control group in Germany (45). Included patients had difficulties returning to their jobs after being out on disability. For patients allocated to an intervention group, systematic cooperation between the occupational physician and the rehabilitation physician allowed sick-listed patients to return to work sooner than the control group, which did not receive the intervention. The intervention appeared to persist, as patients in the intervention group had fewer sick-leave days in the year after discharge compared to the control group (45).

Another concerted approach intervention was tested by Scheel et al. in a randomised controlled study in Norway (46). These authors assessed two interventions aimed at optimising the use of active sick leave. The first, a passive intervention strategy, had no effect. It focused only on general practitioners, aiming to improve their knowledge about active sick leave. The hypothesis was that if the physicians were more aware of the active sick leave option, it would be prescribed more often in appropriate situations. The hypothesis, as operationalised, was unsupported. The second, an active intervention strategy, included occupational physical therapists who facilitated and coordinated communication among all parties. Active sick leave was prescribed for significantly more patients in the active intervention group, increasing to 18%; only 12% of control group were prescribed active sick leave (46).

Another promising concerted approach was taken by Donceel et al. This randomised, controlled trial for lower back pain patients on subacute sick leave was implemented in the context of testing guidelines for proactive disability management by Belgian social insurance physicians (47). The guidelines included 1) an early first work incapacity assessment; 2) cooperation with the curative physician and the occupational physician; and 3) information given to the patients about gradual work resumption, expected duration of sickness absence, and enhanced physical exercise for back problems. A control group of sick-listed patients did not receive the efforts encompassed by the guidelines. Application of the guidelines to patients in the intervention group increased the rate of gradual work resumption to 23%, whereas the rate of gradual work resumption in the control group was only 4%. Frequency of long-term sickness absence, defined as absences exceeding one year, also dropped from 18% to 10% (47).

Another Belgian initiative by Mortelmans et al. focused on producing a structured collaboration between the social insurance physicians and the occupational physicians (48). The physicians attended interdisciplinary meetings and used a communication form to structure their information exchange for patients under their care on subacute sickness absence. The non-randomised controlled study failed to demonstrate a positive effect of structured collaboration on the work resumption outcome of patients. One explanation for this result is that curative physicians were not explicitly included in the model (48).

In Sweden, a recent large collaboration project was initiated between the social insurance system, health services, and social services aimed at identifying and overcoming obstacles in the complex rehabilitation-to-work process (49). As with other concerted approaches, support for more coordination among the stakeholders in disability management was recommended by the authors (49).

Similar results have been reported for concerted approaches in North America. Wiesel et al. conducted a 10-year prospective study aimed at preventing primary and secondary musculoskeletal injury (50). A plan was put into place to improve cooperation when differences of opinion occurred among the physicians. The occupational physician contacted the curative physician to discuss the diagnosis and treatment plan when this situation arose. The curative physician often took advantage of this communication. He used the second opinion of the occupational physician to convince less-motivated patients to return to work when appropriate (50).

Similarly, in Canada, Loisel et al. included cooperation among occupational physicians, curative physicians, and ergonomic therapists in a randomised controlled return-to-work trial (51). Patients having back pain and with 4 weeks of work absence were recruited to participate in a rehabilitation programme. Patients were assigned to 4 treatment groups: no treatment, occupational intervention, clinical intervention, and full (occupational and clinical) intervention. The occupational intervention included a visit to an occupational physician, collaboration between the occupational physician and the curative physician, and an ergonomic work-site evaluation of the job. The clinical intervention included a visit to a medical specialist followed by back-care education at a back school if no specific underlying condition was found, and functional rehabilitation therapy by early therapeutic return to work. Patients in the full intervention group returned to regular work 2.4 times faster than those receiving the usual care. Loisel et al. concluded that close association between occupational and clinical care is extremely important to help this patient group make progress toward work resumption (51).

Finally, Faber et al. tested an inter-physician communication-training programme for occupational physicians and general practitioners in the Netherlands who were treating lower-back pain patients on sickness absence for 3 to 12 weeks (52). Implementation of this cooperation training was evaluated in a non-randomised, controlled intervention study. Improved inter-physician communication, however, failed to optimise return to work times for the patients. Indeed, patients in the intervention group resumed work significantly later than did the control group. One explanation for this result is that communication takes time and therefore can extend disability management (52).

While the last study had an effect opposite to what was hoped, on balance, several experimental trials supported the hypothesis that enhancing communication and cooperation between curative physicians and other stakeholders involved in disability management reduce the time patients are out on sickness absence.

## Discussion

Our review supports the idea that curative physicians have an important role in disability management. By implementing disability prevention principles in their medical practice, curative physicians can experience the satisfaction of not only successfully treating a medical or behavioural health problem but also of helping the patient return to a healthy level of functioning.

We recommend additional education and training for curative physicians in the issues of sickness absence and disability. Several authors support this need. Gething et al. showed that general practitioners have difficulties in keeping up to date on disability issues, and that they support the need for supplementary disability training (53). Pransky et al. also underscored that physician education on disability management is viewed as an important opportunity to improve disability-related practice, since less than a quarter of physicians they surveyed had training in this area (13).

A training course on disability management should start with an explanation of the implications of sickness absence and the potential of disability management. Sickness absence is a major health problem, as it is suspected of being associated with increased morbidity and mortality (54). Sickness absence is costly for the patient, the social security system, and employers (55). Disability management confers the psychosocial benefit of continued integration of the sick-listed patient into the work environment and the somatic benefit of early activation. Furthermore, training physicians in disability management should be preceded by an overview of the tasks, roles, and restrictions of all stakeholders in disability management, because misunderstandings may hinder cooperation. Next, physicians should be encouraged to communicate and collaborate with colleagues of other specialties involved in disability management. The benefits of cooperation through practice examples are recommended.

Instruction about disability management may already be implemented during medical training at the university. Specialty courses can also be organised in an inter-disciplinary fashion, since sickness absence and disability management cross all borders of medical specialties.

Educational or training programmes on disability and on physician cooperation in disability management have to be evaluated (56). Sliwa et al. published an article on a rehabilitation-specific communication skills training programme for attending and resident physicians in physical medicine and rehabilitation training (57). Rehabilitation patients assessed the communication skills of these physicians before and after the training programme and noted improvement (57). We recommend, however, that interventions aimed at encouraging curative physicians to have a more active role in disability management, have clear-cut outcome objectives that reach further than do the subjective impressions of patients. One should also measure the impact of such interventions on the patients' health outcome, e.g. sickness absence duration and return to work rate.

### Key messages

The curative physician can have an active role in accompanying sick-listed patients to return to their daily activities including work.

The curative physician can influence patients' sick leave and disability outcomes without jeopardising the patient-physician relationship.

The complex and multifactor sickness absence phenomenon requires a multidisciplinary approach including inter-physician cooperation.

Education and training for curative physicians in the issue of sickness absence and disability are recommended.

### Practice implication

The main practice implication is that the curative physicians do have a role in disability management and should be encouraged to fulfil this role more actively.

### Conclusions

We conclude that achieving success in guiding sick-listed patients toward resuming work may depend on the crucial role of the curative physicians in disability management. The common perception that communication is an important element in medicine today is also true for disability management. The communication between the curative physician and other parties involved in sickness absence will be a mainstay of any successful disability management practice.

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