

ORIGINAL ARTICLES



Chiropractors and Return-To-Work: The Experiences of Three Canadian Focus Groups

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ABSTRACT

Objectives: To explore the views of chiropractors about timely return-to-work in treating patients with musculoskeletal injuries, to identify the approaches used by chiropractors when treating injured workers with musculoskeletal disorders, and to learn about chiropractors' perspectives on the barriers and facilitators of successful return-to-work.

Design: Qualitative study of 3 focus groups of chiropractors.

Methods: Focus groups of 8 to 11 chiropractors were conducted in 3 large Canadian cities. The selected participants were experienced in treating patients with occupational musculoskeletal injuries. Standard questions were used to collect data. The data from each focus group were coded and analyzed separately and then considered in relation to each other.

Results: The participants indicated that timely return-to-work depends on patients' characteristics, severity of injury, clinical progress, the availability of work accommodation, and clinical judgment. The chiropractors commented that their treatment of



injured workers rests on their strength in diagnosis and treatment and on providing patient-centered care. Positive human relations within workplaces and the ability to accommodate the work of an injured worker were described as important in return-to-work programs. The participants believed that a bias against chiropractic is present within the medical profession and workers' compensation boards. They viewed this bias as an important barrier when assisting their patients to successfully return to work.

Conclusion: The broad approaches described by the participating chiropractors to return injured workers to work are consistent with those proposed in evidence-based practice guidelines. Better communication among chiropractors, medical doctors, and workers' compensation boards would likely decrease interprofessional tensions and improve the recovery of workers with musculoskeletal injuries. (*J Manipulative Physiol Ther* 2001; 24:309-16)

Key Indexing Terms: Chiropractic; Work; Rehabilitation; Focus Groups; Insurance

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INTRODUCTION

Work-related musculoskeletal (MSK) disorders, specifically low back pain and repetitive strain injuries of the neck and upper extremities, are the most frequent cause of work-attributable disability and work absenteeism in Canada.¹ Together, back, neck, and upper extremity injuries account for more than 50% of all workers' compensation board (WCB) claims. Each year spinal disorders put a significant socioeconomic burden on workers, employers, and workers' compensation boards.²

A variety of health care providers (including medical doctors, chiropractors, physiotherapists, and occupational therapists) are involved in the rehabilitation of workers with occupational injuries. The approaches used to manage these MSK disorders, both clinically and in the workplace, vary widely and are often based on personal and professional experience rather than on scientific evidence. The resulting confusion and opposing views make it difficult for employers, clinicians, and workers' compensation boards to design and implement appropriate rehabilitation programs for work-related injuries.

In the last decade, several studies and expert panels have recognized the effectiveness of spinal manipulation in the treatment of patients with acute mechanical back pain.^{3,4} More recent studies indicate that chiropractic care is as effective as medical care or physiotherapy in helping individuals with low back pain.^{5,8} These studies also suggest that in the general population, chiropractic care may be more expensive than usual medical care. However, the only rigorous economic analysis of workers' compensation costs that compares chiropractic and medical care for occupational low back pain suggests that both types of care are equally cost-effective.⁹

Although we have gained knowledge about the effectiveness of spinal manipulation, we know relatively little about the general approaches used by chiropractors to treat injured workers. Identifying and understanding their approaches is important for 3 main reasons. First, in an era when evidence-based practice is aggressively promoted by third-party payers but not well accepted by chiropractors, it is crucial to gain insights into the clinical decision-making process used by chiropractors.¹⁰ Second, because the new evidence suggests that the return-to-work process can be improved if all stakeholders adopt a concerted strategy, it is necessary to understand how chiropractors currently view their role in this multidisciplinary effort.¹¹ Finally, it is important to describe chiropractors' perspectives on return-to-work to assist policy makers in establishing policies that combine scientific evidence and clinical experience.

The general objective of our study is to document the experiences of chiropractors with returning injured workers to work in 3 Canadian provinces (Manitoba, Ontario, and Quebec) that operate under different workers' compensation legislative arrangements. There are 3 specific objectives. First, the study explores the views of chiropractors about when injured workers with MSK conditions should return to work. Second, it aims to identify the specific approaches used by chiropractors in treating injured workers with these conditions. The third objective is to describe chiropractors' perspectives on the barriers and facilitators of successful return-to-work.

Workers' Compensation Regulation for Chiropractic in Manitoba, Ontario, and Quebec

In Manitoba, WCB claimants are entitled to receive primary care treatment from a physician or a chiropractor. The clinical management of a claim is supervised and controlled by the Workers' Compensation Board.¹² In March 1998 the Manitoba WCB introduced clinical practice guidelines for chiropractic treatment.¹³ The guidelines established significant limits on the duration of chiropractic care and were specific to the type and severity of injury. The allowable duration of chiropractic manipulation for spinal injuries ranges from 3 weeks for predominantly symptomatic cases to 6 weeks for cases with significant loss of spinal mobility and 10 weeks for complicated cases involving other factors such as comorbid conditions or a history of back pain. Once the worker's case has been cate-

gorized, the WCB notifies the worker and the treating chiropractor of the anticipated maximum treatment duration. Two weeks before the maximum time specified, the WCB provides notice to the worker and chiropractor of the date on which the WCB's responsibility for chiropractic treatment will conclude.¹³ Requests can be made for an extension of treatment beyond the maximum duration allowed by the WCB.

In Ontario, the Workplace Safety and Insurance Act includes chiropractic treatment as part of a worker's entitlement in an allowable claim. Initial treatment by chiropractors is limited to a period of 12 weeks, and any additional treatment must be preauthorized by the Workplace Safety and Insurance Board.¹⁴ In 1997 the Ontario government enacted Bill 99, which outlined a number of changes related to return-to-work. Bill 99 made it the responsibility of both the employer and the worker to maintain contact with each other and cooperate in establishing early and safe return to work.¹⁵ In addition, the health care practitioner is now required, at the request of an injured worker or his or her employer, to supply information on the worker's functional abilities. Furthermore the position of nurse case manager was created to coordinate the delivery of timely and appropriate health care by providing an integrated approach across the system.¹⁶

In Quebec the Act regulating occupational injuries grants physicians the role of sole gate-keeper.¹⁷ The Quebec WCB or Commission de Sante et Securite au Travail (CSST) relies on physicians to manage the recovery of a claimant. It is the physician's responsibility to provide a diagnosis, prescribe the necessary treatments, determine whether modified duties are necessary, and assess whether the work proposed by the employer is suitable for the injured worker. Therefore for chiropractic care to be reimbursed by the CSST, an injured worker must be referred by a medical doctor. The College of Chiropractors of Quebec, the Quebec Chiropractic Association and the Quebec WCB are currently working toward implementing a pilot project that would allow chiropractors to manage WCB claims in a way that is similar to that of physicians.

METHODS

Design

We conducted one focus group of practicing chiropractors in each of three Canadian provinces (Manitoba, Ontario, and Quebec). These provinces were selected because they operate under distinct workers' compensation legislation and have adopted different administrative protocols to guide the chiropractic treatment of injured workers.

Study Sample

Purposeful sampling was used to select the study participants.¹⁸ Included in the sample were chiropractors who practiced in the main metropolitan area of their respective province (Winnipeg, Toronto, or Montreal) and who saw a relatively high volume of workers' compensation cases in 1997. Chiropractors seeing a high volume of workers' com-

Table 1. Descriptive and practice characteristics statistics of the Winnipeg, Toronto, and Montreal focus groups

	Winnipeg (n = 11)	Toronto (n = 10)	Montreal (n = 8)
Age; median (range) (y)	44 (36-49)	34 (27-46)	37(31-48)
Sex (male)	100%	80%	100%
Year of graduation; median (range)	1981 (1977-1987)	1990 (1977-1994)	1987(1974-1991)
Practice (group) (%)	27	100	88
Other disciplines included in group practice (range)	Chiropractors, massage therapist (1-2)	Chiropractors, medical doctors, physiotherapist, massage therapist, kinesiology, occupational therapist, psychologist, nurse, dietician, chiropodist, acupuncturist (2-7)	Chiropractors, medical doctors, massage therapist, dietician, acupuncturist, psychologist, fitness trainers (1-5)
Rehabilitation clinic (%)	0	67	13
Referral source	Patient, employer	Patient, medical doctors, nurse, employer	Patient, chiropractor, medical doctor, physiotherapist
WCB patient (range) (%)	8-20	5-40	0-5

pensation cases were selected because of their clinical experience in managing occupational injuries.

Two recruitment strategies were used to gather the provincial samples. The Workers' Compensation Board of Manitoba and the Workplace Safety and Insurance Board of Ontario provided us with a list of 20 to 25 chiropractors from Winnipeg and Toronto, respectively, who saw the most compensation cases in their respective province in 1997. A different strategy was used for the Montreal sample, because Quebec chiropractors are not recognized by the workers' compensation law as primary care providers. To select the Montreal participants, we asked well-respected chiropractors from Montreal to provide names of potential candidates.

The size of the focus groups varied from 8 to 11 chiropractors. In Winnipeg 11 of 13 contacted chiropractors agreed to participate. In Toronto 11 of the 18 contacted chiropractors participated, whereas in Montreal 8 of the 12 chiropractors who were approached took part in the focus group.

Data Collection

All focus group discussions included a series of standard questions that inquired about 3 general themes of the return-to-work process. As an introductory question, the participants were asked for their thoughts on the "best time for an injured worker to return to work." Second, they were asked to speak of their experiences in returning injured workers to work and to provide examples of barriers and facilitators they had encountered in their practice. Third, participants were asked to identify and discuss any characteristics of the worker, third-party payer, or workplace that may influence successful return-to-work.

The focus groups were conducted in English by the same facilitator (J.C.) in Winnipeg and Toronto and in French by a different facilitator in Montreal. The discussions were taped, and hand-written notes were recorded by a research assistant. The tapes were transcribed verbatim. In Ontario, because of technical difficulties in tape recording, the focus group underwent follow-up by semistructured taped telephone interviews with individual chiropractors. This process allowed the Ontario chiropractors to elaborate on the points that had been summarized in handwritten notes.

Analysis

Facilitators met at the conclusion of each focus group discussion to review the group process and identify major themes. After the tapes were transcribed, the transcripts were reviewed and coded for major themes. We started with the major categories "barriers and facilitators of return to work" as they related to the employment setting, the worker, the rehabilitation system, and the payer. Further categorization was done according to the common themes that emerged from the initial analysis.

The results were summarized according to the major content areas and described with the use of quotes from the group discussions to illustrate the points being made in the interpretation. The analysis of the Winnipeg and Toronto data was done by J.C., and the Montreal material was analyzed by S.D. The Montreal report was translated into English for the final compilation of results and analysis of themes. Software programs were used to assist in this process: Q.R.S. NUD*IST for the English data and ATLAS.ti for the French material.^{19,20}

A researcher who had not been involved in other aspects of the study reviewed the study transcripts and the written report to provide an independent check on the accuracy and integrity of the results that were reported.

RESULTS

Participating Chiropractors

Chiropractors from Winnipeg were slightly older and graduated earlier in the 1980s than those from the other two provinces (Table 1). The Toronto group included two female chiropractors, whereas the Winnipeg and Montreal groups were composed entirely of male chiropractors. Winnipeg chiropractors were more likely to practice solo. All Toronto chiropractors practiced in multidisciplinary settings, and two thirds indicated that they worked in a rehabilitation clinic (Table 1). The Winnipeg chiropractors reported that WCB patients comprised a median of 10% of their practice, whereas it was 15% for the Toronto participants and 4% for the Montreal chiropractors (Table 1).

Timely Return-To-Work

One participant indicated that there is "no recipe or magic rule" to determine the appropriate time to return injured workers to work. The decision is based on clinical judgment

and factors such as the worker's age, medical history, type and severity of the injury, and history of a similar problem. Furthermore the participants noted the importance of considering the patient's job demands, the nature of the workplace, and the availability of job accommodation.

The participants indicated that a worker does not need to be free from pain to return to work. In fact, early return-to-work is seen as preferable when work is safe and when the worker's functional abilities are compatible with his or her job.

I tell my patients that I will put them back to work when it is reasonably safe to put them back to work. I don't demand that they're at 100% or anything like that. So that's going to vary according to the type of industry they are in. If they work in an office they would probably go back to work a lot faster than if they're working on a concrete truck (chiropractor in Manitoba).

Overall, judgments about return-to-work are based on chiropractors' experience and intuition, their expectation of the patient's recovery, readiness to return to work, and the availability of work accommodation. The discussion indicated that most injured workers return to work by the fifth or sixth week after injury.

Approaches Used by Chiropractors to Manage Occupational Injuries

Chiropractic's strength in diagnosis and treatment. Several participants stressed that chiropractic is an effective treatment for back pain and other occupational MSK conditions. Their diagnostic and therapeutic skills were identified as the key factors in promoting recovery in injured workers. Further, by managing cases within their clinics, they are able to eliminate the unnecessary delays associated with seeing a specialist and to eliminate x-ray referrals, thus providing timely treatment. Some chiropractors stressed that manipulation is central to their management and that it accounts for "95% of why we get people back to work faster." Others described more varied approaches that included physical modalities, exercise, nutrition, and acupuncture. One respondent described his initial approach as follows:

I would do an examination to best identify where the real problem is, and how extensive it is, and then we start a program of therapy, adjustment of course is the key, mobilization of other joints, resting, applying some self-therapy at home. Ice, walking, stretching, a little bit of isometrics, whatever. I am very big into nutrition. I try to get them to realize that broken down tissues need a little extra attention with vitamins. I'm very big on Vitamin C (chiropractor in Manitoba).

Overall, the participating chiropractors emphasized that establishing a therapeutic plan that involves a close and consistent collaboration with the patients is essential to ensure recovery.

Patient-centered care. Participants described the interaction with their patients as an important component of their practice. An essential element of this patient-clinician interaction is the building of a therapeutic relationship based on a common understanding of the condition and the formulation of realistic expectations. Several chiropractors stressed that this relationship be established on the first visit.

If I haven't grasped what he wants from me, then I've missed the problem and I am much less likely to help him. I'm convinced that this must be done on the very first visit. There's something magical in this. If I've understood what the patient wants from me, and he understands what I'm going to do with him, then I have a good chance of succeeding (chiropractor in Quebec).

Positive communication was identified as an important aspect of patient treatment. The participants noted that patients are often fearful about the long-term consequences of their injury and that reassurance about the favorable natural history of soft-tissue injuries is essential. They added that another key recommendation made to patients is the need to remain physically active.

If I get them right then [in the initial stages], and I explain to them, "Look, we know now—the literature tells us right now—that the sooner I get you moving and back to what you usually do, the better off you're going to be, and your life will be so much better, not only at work but recreationally and socially—with your family, with your sports functions. So my goal, and I want it to be your goal if at all possible, would be that!" (chiropractor in Ontario).

Moreover, several chiropractors saw it as part of their role to act as patient advocates, stating that other clinicians and the compensation system are biased against workers with soft-tissue injuries. They saw the need to empower patients to take responsibility for themselves and avoid the passive role. One participant describes his approach:

I am encouraging them especially to take responsibility for their lives, and to do things on their own and to make up their own minds....I'm always encouraging them to make decisions and to plan with me what their limits might be today and tomorrow, and let's set a goal here for this week, one day at a time, whatever (chiropractor in Manitoba).

However, the participants also conveyed the idea that they would not abandon their patient despite the confusing and often difficult circumstances that surround an injured worker's claim.

Contact with the workplace. The level of interaction between the participants and their patients' workplaces varied. Most worked primarily with the patient, planning the time of work reentry, and said that many employers did not consult with them or value their input about the worker's case. However, some chiropractors reported that they have good relationships with local employers and are frequently and directly involved in planning return to work. One participant said that because he works "on site" for a large employer, he has the possibility to observe the physical demands of various occupations. Other participants noted that because they have limited access to workplace information, they must rely on clinical judgment when making recommendations about return-to-work.

Barriers and Facilitators of Return-To-Work

Barriers and facilitators related to the worker. Participants identified several worker characteristics that they associated with successful return-to-work. They indicated that the psychosocial characteristics of workers, including their percep-

tion of the injury, their motivation to return to work, and their expectations of the treatment and recovery are key determinants. Furthermore they emphasized that the worker's fear of job loss, fear of reinjury, and fear that the problem would become chronic also affect the outcome. One chiropractor who addressed this issue said that patients must be reassured that the risk of reinjury is less than the risk of having psychologic ill effects from prolonged work absenteeism.

Participants suggested that the workers' motivations to return-to-work are linked to their attitude toward their job and to their relationships with supervisors and coworkers. A positive attitude and environment increases the likelihood of successful return to work. After one participant had been discussing the importance of job satisfaction, another responded as follows:

I agree with you completely regarding work satisfaction and a sense of belonging. If the worker has a feeling of belonging to this industry, and is loyal to his or her employer, and feels validated, this will greatly help his or her return (chiropractor in Manitoba).

This type of environment was described as stimulating faster recovery by encouraging workers to take responsibility for their condition, including better compliance with the prescribed treatment. On the other hand, it was also mentioned that being too enthusiastic might have negative consequences if return-to-work occurs too early in the recovery process. The attitudes of workers are also believed to offer prognostic information to the chiropractors. Some participants felt confident that they can predict those who will have a delayed recovery. This claim is often heard from experienced clinicians, suggesting that they can recognize indicators of poor outcomes. One chiropractor states:

Either from the way they perceive themselves, or from general comments. Things like: "Well, I don't know how anyone's ever going to expect me to go back to the job I was doing. I mean, I'll never be able to go back to the job I was doing." Or: "If so-and-so got a disability pension for his injury, I certainly think I'll be able to get one" (chiropractor in Ontario).

Whether the presence of prognostic red flags results in a change in the plan of management used by chiropractors was not fully explored. However, there were indicators that they would adapt their treatment by putting more emphasis on reassurance and education and encouraging the patient to take responsibility for himself or herself.

Barriers and facilitators related to the workplace. Foremost among the workplace characteristics that were seen as having a positive impact on return-to-work was the ability and willingness of the employer to accommodate the worker in his or her return-to-work efforts. However, the participants acknowledged that providing work accommodation can be difficult for employers, especially when the worker's restrictions are extensive. One chiropractor described the problem as follows:

They get a little laundry list of restrictions, from whoever—from me, from the family doctor, from the company that says "no repetitive lifting, no repetitive twisting, no above arm movement" you know... 10 things! Now, they're sup-

posed to dream up a job for that person? I mean, they're left with so many restrictions they got nothing for the person to do! (chiropractor in Ontario).

The discussion indicated that positive outcomes are more likely to occur when the employer is flexible and constructive in providing accommodations for the worker. These actions seem to result in an increased motivation to return to work, less deconditioning, and fewer psychosocial problems. However, it was suggested that injured workers often perceive job accommodation as being meaningless or demeaning because of the trivial nature of the modified work offered.

Several participants mentioned that company size affects the return-to-work process. Larger companies have more opportunities for modified work placements, and they benefit from the expertise of occupational health and disability management specialists. Smaller companies were seen as less well equipped to treat injured workers and reintegrate them into the workplace. A chiropractor from Quebec believed that small employers are more likely than larger ones to appeal claims made by workers. However, examples were given of small employers who demonstrate a caring attitude toward injured workers.

I have had several patients who work for small businesses and industries where the employer paid for the care. The employer would call the office and say "Listen, this is a good employee, and we don't have an insurance plan at the office, but send me the bill." And this is a major help for these patients who feel really understood and supported, because they feel important in their employers' eyes. I find that this makes people quite pro-active in the treatment, people who follow recommendations and all that (chiropractor in Quebec).

The chiropractors stressed that good human relations within the workplace positively influence return-to-work. More important, the caring and proactive attitudes of an employer who values a worker seem to motivate the worker to return to the workplace without unnecessary delay. On the other hand, employers with a negative attitude who "poison work relations" by showing a lack of trust were seen as creating unnecessary tensions that impede the return-to-work process.

Barriers and facilitators related to rehabilitation. Participants expressed the strong belief that their expertise in the diagnosis and treatment of back and other soft-tissue injuries is of great value in facilitating return-to-work. This expertise allows them to treat patients with soft-tissue injuries with more confidence and enthusiasm than is the case with medical doctors. One participant suggested that medical doctors' emphasis on prescribing analgesics to alleviate pain fails to address the underlying source of the problem. Moreover, he added that this approach could possibly put a worker at risk of aggravating his or her injury if he or she is returned to work prematurely.

Lack of specific training in chiropractic colleges about the management of workers' compensation cases, however, was presented as a barrier. One participant indicated that although chiropractic colleges provide good clinical training, they fail to equip chiropractors with the tools necessary

to manage some of the challenges of daily clinical practice. He mentioned that education regarding the political context of treating injured workers would be helpful because it has a strong impact on the well-being of the patient.

If we were trained properly-and it's not just chiropractors, it's physicians, it's physiotherapists, it's everybody-if we were trained to understand what a patient's rights are, or at least to understand the politics, and to understand what our responsibilities are, I think everything could be a lot easier! (chiropractor in Ontario).

Moreover, it was believed that education about policies and the legal obligations of injured workers within the compensation system would enable chiropractors to be better advocates for their patients. For example, they could help facilitate the payments of patients' benefits. It was believed that this could prevent the negative downward spiral created by the antagonistic relationships with the company or the workers' compensation board.

A common theme voiced by participants was that the medical community has a bias against chiropractic. This bias precludes the establishment of a level of communication and teamwork approach that is necessary to optimally manage cases. Although some participants cited good working relations with other health care providers in their community, the following view was more common among participants:

It's a bit like the doctor who says: "No, no, your back is too inflamed! Don't go to the chiropractor." Because he believes that a spinal alignment on an inflamed section is not pertinent or is dangerous. It's as if our ability to be the judge were taken away from us. If someone is in a position to judge, it's us, and what's more, it's assumed that that's all we do, and that if we don't do spinal alignments, there's nothing else we can do as a chiropractor! (chiropractor in Quebec).

Although this bias is at the professional level, several chiropractors indicated that they have good working relationships with physicians at an individual level. Some participants practicing in multidisciplinary settings discussed the advantages of good interdisciplinary communication and explained that these interactions allow for a more comprehensive management of cases.

Barriers and facilitators related to the payer. The bureaucratic demands placed on health care providers were viewed as a barrier to providing optimal treatment to injured workers. These demands include completing multiple forms, managing frequent breakdowns in communication and unnecessary delays, and dealing with workers who believe that their needs are not adequately met by the workers' compensation boards.

Frequent changes in personnel responsible of a claim within the compensation system were identified as a barrier to successful return-to-work. This practice was viewed as a measure to ensure that claims adjudicators maintain their objectivity in administering claims. However, they described that this management strategy can have negative consequences on the worker who feels "like a number" in a system that is highly depersonalized. Some participants believed that adjudicators cannot make well-informed decisions because they are often unfamiliar with the case or with chi-

ropractic practice. Consequently, they viewed the claim adjudicators as poorly qualified to make judgments about chiropractic treatments.

A CSST (WCB in Quebec) agent, without being a doctor, makes a therapeutic judgment on the situation, and can say "I'll give you eight visits" (to a chiropractor). Who is she to determine the number of sessions or what does she base this number on? (chiropractor in Quebec).

Moreover, the chiropractors expressed concerns that the decisions taken by the adjudicators are not based on standard criteria and that the unpredictability of these decisions make the treatment and return-to-work planning difficult. Many participants believed that the WCBs are biased against chiropractors. The well-established predominance of medical doctors who tend not to understand or appreciate the benefits of chiropractic treatment but who are in positions of authority and influence within the WCB was viewed as having a negative impact on chiropractors' ability to provide optimal treatment. Medical doctors within the WCB were described as having the power to adversely influence workers' treatment and coverage. The bias against chiropractors was also attributed to adjudicators and others within the WCB.

I have had situations where a patient has come in acute pain and vacillated as to whether she was going to fill in her compensation report, and decided to phone the compensation board to find out what the procedure is, and had been told by whoever was on the phone there "What are you doing seeing a chiropractor? You should be seeing a medical doctor!" (chiropractor in Manitoba).

Overall, chiropractors saw their profession as underrepresented within the decision-making bodies and review panels within the compensation boards. This situation has fostered a sense of isolation and frustration for the chiropractic profession. The antagonism generated by these policies was described as harmful to the cooperative teamwork that is seen as essential for the good treatment of injured workers.

DISCUSSION

We designed a qualitative study to explore the views and experiences of chiropractors about return-to-work. The study has allowed us to investigate 4 broad domains of factors that affect return-to-work: the workplace, worker characteristics, the rehabilitation approaches used by chiropractors, and the policies and practices used by the payer. The qualitative design provided us with the best method to collect data about this complex issue. The traditional epidemio-logic designs are not well suited to explore individual experiences and views relating to such multifactorial questions. Our study represents the first step in understanding how chiropractors engage themselves in the "multi-stakeholder" efforts to return injured workers to work. The chiropractors' views about the appropriate time for injured workers to return to work were consistent with accepted guidelines for management of back pain.³ The AHCPR guidelines state that activity recommendations for the employed patient must consider the patient's age, general demands, and physical demands of the job. Furthermore the guidelines recom-

mend that clinicians help the patients establish activity goals in consultation with their employer.³ Regarding the duration of chiropractic manipulation, the AHCPR guidelines do not specify a limit on duration or frequency but recommend that it should be discontinued if it does not result in increased function after 1 month of treatment.³ The recent imposition of relatively strict limits on the duration of coverage of chiropractic treatment in Manitoba was described by several participants as severely limiting their autonomy. Furthermore the Manitoba guidelines were viewed as interfering with their ability to build an effective relationship with the injured worker and removed any flexibility in planning return-to-work.

The chiropractors' expertise in treating patients with soft-tissue injuries was a recurring theme. The participating chiropractors described that a high level of expertise and confidence is important when treating patients who are fearful about the repercussions of their injury on their current and future physical and financial well-being. This fear and sense of vulnerability among patients was previously documented in a qualitative study of patients with back pain who received treatment in Ontario community clinics.²¹ In their study Tarasuk and Eakin²¹ highlighted the importance of workers' interactions with health care professionals in shaping their experience of back pain and disability.

Furthermore the feeling of permanent vulnerability experienced by the patients with respect to their treatment and prognosis was linked to the uncertainty they experience when interacting with physicians and therapists. In a study of chiropractic practice, chiropractor-patient interaction was characterized as promoting patient acceptance and validation, fulfilling expectations, providing explanations, and engaging the patient's commitment.²² Furthermore Coulehan²² noted that aside from manipulation, the chiropractic clinical approach is a key component in the therapeutic effectiveness of chiropractors. This is consistent with the discussion in our focus groups but contrasts with the approaches that the participants perceived as being used by medical doctors. The participating chiropractors said that physicians do not see patients as frequently as chiropractors do and do not like to treat patients with soft-tissue injuries, especially back pain. This view echoes the sentiments expressed by one group of community physicians in a qualitative study of their attitudes to practice guidelines on low back pain.^{23,24} In that study the concept of "therapeutic nihilism" was developed and described as the belief that the physician cannot do much to help patients with non-pathologic low back pain. This view is reflected in practice guidelines that emphasize the interventions to be avoided rather than providing concrete recommendations about patient treatment.

Despite being confident in their ability to effectively treat injured workers, chiropractors in all 3 provincial focus groups believed that there was a bias against chiropractic, both within the medical community and the compensation system. They believed that their exclusion and isolation interfered with their ability to offer optimal care to their

patients and to contribute to the team approach that is recommended in return-to-work programming.¹¹ Some participants attributed this bias to the deep influence that the medical model has within compensation boards and to the fact that the medical doctors shape and control rehabilitation programs. Coulehan²² notes that communication between medical doctors and chiropractors is problematic and generally consists of the physician responding to chiropractic referrals rather than initiating referrals to the chiropractor. Our results are compatible with a national survey of chiropractors that found that the rate of medical referral was higher in Ontario and lower in Manitoba.²⁵ This difference may be attributable to the higher frequency of Ontario chiropractors practicing in multidisciplinary clinics.

The level of tension that exists between the chiropractors and the compensation boards varied across provinces. In Ontario some optimism was expressed in response to the introduction of nurse case managers. Although the Quebec chiropractors felt excluded from the workers' compensation system, some valued the flexibility and independence of practicing outside of the system. Participants in all provinces described the problems that result from interacting with a large bureaucracy, where the potential for adversarial relations is enhanced by judgments about the legitimacy of claims. Concerns about legitimacy of claims was also a major theme in interviews of injured workers in a previous qualitative study of patients visiting Ontario Community Clinics.²¹ It is important that these concerns about the perceived legitimacy of their injuries was associated with delayed return-to-work in a cohort of injured workers in Ontario.²⁶

This qualitative work must be kept within its original context and cannot be used to make general inferences about chiropractic. Because our sample was small and not representative of all Canadian chiropractors, our results cannot be generalized to the chiropractic community at large. A small number of chiropractors were selected because they saw a relatively high volume of workers' compensation cases. Female chiropractors and those older than 50 years were under-represented. Furthermore we sampled from 3 provincial urban centers, and our results may not apply to chiropractors practicing in other provinces or in rural areas. Finally, data collected in focus group research may be biased by the "group effect" or by participants who are more outspoken and opinionated than others. In all focus groups we have attempted to minimize this bias by engaging all participants in the discussion and by balancing the time available for answering between all chiropractors.

This work provides the basic information to better understand chiropractors' views on return-to-work. The collected qualitative information is essential to generate sound research hypotheses to be explored on a representative sample of Canadian chiropractors. Future studies should focus on the acceptability practice guidelines by chiropractors, the impact of the perceived biases by the medical profession and workers' compensation boards on return-to-work, and the communication problems identified by the participants.

CONCLUSION

Our study has explored the experiences of a select group of chiropractors from 3 Canadian provinces. The analysis is based on data collected through focus group discussions of chiropractors from Winnipeg, Toronto, and Montreal. The broad approaches used by these chiropractors to return injured workers to work are consistent with those proposed in practice guidelines for the treatment of patients with low back pain. Better communication and understanding among chiropractors, medical doctors, employers, and workers' compensation boards would likely decrease interprofessional tensions and improve the recovery of workers with musculoskeletal injuries.

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