WorkCoverSA

A proactive approach to return to work

December 2008

"Employment is nature's physician, and is essential to human happiness" Galen AD172

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Introduction

A compensable injury that results in absence from work presents treating health providers with the challenges of managing recovery from the injury and managing any resultant disability.

If the disability is prolonged, it has adverse effects on a patient's career and economic wellbeing, and indirect health and social impacts such as decreased quality of life with an increased risk of alcoholism, drug dependency and relationship break-up [1-3]. Despite these clearly recognised adverse impacts from failed recovery and ongoing absence from work, 75-90% of long-term workers compensation claims result from apparently self-limiting, non-serious, injuries [4, 5]. Research shows that a proactive approach limits the opportunity for delayed recovery to occur and thus limits the potential for such adverse consequences to develop [6]. This publication details such an approach.

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The first consultation

There is clear evidence that the initial assessment of a work-injured patient should include an adequate history and examination [7]. On occasions this may require scheduling a further consultation to enable adequate time to be made available. Once this process has been completed your patient should be informed of the diagnosis and expected recovery. Positive messaging [8] and clear communication [21] is of great importance whenever this is appropriate. A UK study compared positive with uncertain messages in a group of patients with symptoms and no significant signs. It found that 25% more of the group who received a positive message were symptom-free compared with the group receiving an uncertain/indefinite message when contacted two weeks later [9].

An example of such an approach is shown in Case study 1.

Theoretically, management of compensable injuries should be no different to that for the same injury occurring in a non-compensable setting. However, on average, compensable injuries are slower to recover [10], so assistance is more commonly sought from other health providers with different skills. For many injuries there are a limited number of possible treatment modalities that have been scientifically tested and often many more that have not been scientifically tested (see acute low back injuries guidelines) [11]. The treating health provider should only use treatments that have been shown to be helpful, or have not yet been evaluated, and avoid those that are known to be without benefit or those that are known to be harmful.

When the medical practitioner decides that physical treatment is required and makes a referral, there are a number of principles that should be followed:

1) Be specific to both your patient and the health provider, to whom you have referred, what is expected to be achieved and in what time frame.
2) Ensure that the health provider to whom you have referred (a new member of the therapeutic team) understands the same messages that you have given to your patient about diagnosis, expected affects of treatment and prognosis. There needs to be careful and detailed communication between all members of the therapeutic team.

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3) Your patient should be regularly reviewed by the referrer and the treating medical practitioner to ensure that the expected benefits are occurring. If they are not, then treatment should be modified or ceased.

It is well recognised that patients who are psychologically distressed have poorer outcomes from a compensable injury [7]. As soon as such distress is recognised (even at the first consultation) referral to an appropriate medical expert (commonly a psychologist) should occur. Without this assistance and treatment the chances of recovery are lessened. For more information about yellow flags click here.

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Identifying capacity/capability

The most important treatment modality for musculoskeletal injuries is returning to as much of the patient's usual activity as soon as possible [12, 13]. This is not limited to work but includes the usual activities that your patient undertakes in sport, recreation and at home. Conversely, there is evidence that commencing a new activity program in the first 4-6 weeks after injury does not improve recovery rates [14].

When assessing the capacity of your patient to undertake work, asking what he/she can do is a realistic method of assessment unless there are psychological or behavioural issues. If the impression you have gained during your assessment matches what you have been told by your patient, it is likely that the information will be reliable.

Table 1 shows work capabilities which are common after musculoskeletal injuries to specific body areas [15]. Obviously each injury needs to be assessed and restrictions such as these modified for individual circumstances.

Table 1: Generic work capabilities

Note: These capabilities are also appropriate at home and for leisure activities.

Wrist • Wear splint if provided • Lifting limit – often low weights of 1-2kg • Avoid repetitive movements, particularly twisting • No exposure to vibration	**Neck** • Not to maintain neck position, except neutral for periods of > 5 minutes in one position (particularly flexed) • Not to repeatedly twist (where possible move whole body) • Not to lift more than: - 10kg with arm by side, or - 5kg with arm outstretched
Elbow • Avoid precipitating actions • No repetitive movements • Lifting limit - often low weights of 1-2kg, particularly with outstretched arm • For epicondylitis wearing of a strap is often helpful	**Low back** • Not to repetitively twist or bend • Not to lift > 5-10kg • Not to sit or stand for more than 20-30 minutes at a time • Not to be exposed to vibration
Shoulder • Generally restricted range, most commonly no greater than 45 degrees from neutral • Not to lift more than: - 1-2kg with outstretched arm - 5-10kg with arm in neutral (by side) position • Particularly no activity either at work or at home in which hands are above head height	**Knee** • Can nearly always work in a seated job **Ankle** • Can nearly always work in a seated job

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Completion of a WorkCover Medical Certificate or functional capabilities form will enable such restrictions to be utilised to identify appropriate activity at work for your patient. There is strong evidence that the health provider making contact with the employer and discussing the capability of the patient and then matching this with available work, results in improved recovery rates with shorter absence from work and a smaller chance of prolonged absence [16, 17]. In some instances there are obvious difficulties returning the patient to work and assistance will need to be obtained from a vocational rehabilitation consultant. A worksite assessment will sometimes need to be undertaken by an appropriately skilled health provider to identify suitable duties.

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The team approach

Workers compensation injuries are more complex to manage than the same injury occurring in a non-compensable setting [1]. At the very least, a compensable injury will introduce the perspectives of the employer and of the case manager into the management of the injury. Establishing co-operative relationships with all participants in the management of an injury facilitates recovery [18-22] and reduces the possibility of misconceptions.

The injured worker

As has been outlined earlier it is important to:

1) provide a positive outlook (as appropriate) at the initial assessment
2) ensure that all members of the treating health team understand and share the same information and positive messaging, as appropriate
3) establish a process to enable the undertaking of as much usual activity as possible
4) engage the employer in the return to work process
5) organise appropriate review. In the early stages of an injury this may be required twice a week to check progress – particularly in soft tissue strain/sprain injuries – as well as the effectiveness of any treatment and of activity programs.

The treating medical practitioner

Research shows that treating medical practitioners can positively affect the chance of, and the time it takes to, recover from an injury [7, 23].
Of particular importance is:

- undertaking an appropriate assessment as soon as possible after the injury
- providing a sensible outlook that reflects normal expectation of recovery
- assessing the capacity of your patient. People who get dressed and come in to your surgery have some capability. This should be reflected in your assessment and certification.
- contacting the employer to translate the capability into work activity. Even if the work activity is not productive, just helping your patient maintain the normal routine of work attendance results

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in a greater chance of an earlier and full recovery [16, 20]. Additional benefit is obtained by the treating medical practitioner discussing with the employer ways to prevent similar injuries, or aggravations, in the future [16, 20].

- certifying total incapacity only when this truly is the situation. Generally there will be some capability and you should certify accordingly. If you cannot identify suitable work that fulfils this capacity after discussion with the employer, engaging suitable participants such as the case manager, rehabilitation and return to work coordinator or vocational rehabilitation consultant will assist this task. A delay in identifying suitable duties does not impact on your patient's entitlement to compensation. If suitable duties cannot be identified, then the medical practitioner must certify their patient's actual capacity and not change their certification to reflect work availability.

The employer

Employers are crucial participants in the recovery and return to work process. Contact by the employer to the injured worker as soon as possible after the injury to offer appropriate support and help is known to reduce the risk of prolonged recovery and thus the claim becoming longer term [20].

Similarly the provision of duties, modified when necessary, will facilitate recovery [16, 20] as will a supportive non judgemental work environment. Discussion between the employer and treating medical practitioner about appropriate duties is known to reduce recovery times and the risk of developing longer-term disability [16, 20].

The rehabilitation and return to work coordinator, and vocational rehabilitation consultant

Both of these participants in the management team assist in:

- identifying available and suitable duties in the workplace
- identifying and overcoming barriers to return to work
- informing those with compensable injuries of their legal rights and responsibilities and the completion of the required documentation.

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Rehabilitation and return to work coordinators and vocational rehabilitation consultants should be enlisted to assist in the return to work process.

The case manager

A case manager is employed by a claims agent or self-insured employer to manage workers compensation matters including:

- determining if a claim is eligible for compensation
- managing an injured worker's claim for compensation
- managing and coordinating rehabilitation and return to work plans for the injured worker
- providing advice to injured workers and employers on rehabilitation and compensation
- engaging appropriate service providers eg, vocational rehabilitation consultants to assist with return to work.

The case manager will work with key parties which may include the injured worker, the employer, the medical practitioner and other health providers to coordinate the return to work process. In all situations, contact should be maintained with the case manager.

Other health providers

The *Workers Rehabilitation and Compensation Act 1986* (the Act), enables treatments from health providers as well as medical practitioners to be reimbursed under a set scale of fees. Frequently such health providers will assist the recovery of the injured worker. Apart from medical practitioners, commonly utilised health providers include chiropractors, occupational therapists, physiotherapists and psychologists. The principles outlined on page 5 should be followed for all referrals to these health providers.

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Options for graduated return to work

Always keep in mind that your patient does not have to be **fully recovered or free from pain** before returning to safe and suitable work. Work is part of the functional recovery from injury.

There are three types of suitable duties:

- **Pre-injury** – reduced hours of the pre-injury duties that your patient has the capability to perform
- **Modified duties** – components or some of the pre-injury duties that have been included or removed to match your patient's capability
- **Alternative duties** – duties that are different from the pre-injury duties but allow your patient to remain at work or return to work

To be successful, suitable duties must be matched to your patient's capabilities. They should only continue for a limited time. Beware of certifying capacity that is significantly less than actual capacity or increasing it too slowly because this may adversely affect recovery. Ideally these duties should be productive, assist your patient to increase their physical capabilities, allow continued workplace social supports and be within your patient's psychological capabilities as they recover from injury.

Increasing capacity to work may be undertaken in a number of ways:

- **Increase in work hours** – This should occur rapidly to return your patient to pre-injury hours within a period of several weeks. This increase should occur by increasing the total work hours per day and/or the total number of working days per week. This prevents physical deconditioning and psychological sequelae thus minimising the chance of chronicity.
- **Increase in physical demands of duties** – As your patient recovers, the physical demands of duties performed should be increased eg, increasing tolerance for lifting; postures that may be more demanding, such as repetitive stooping, crouching or overhead reaching. How rapidly this is increased is dependent on the injury healing, any reconditioning required, and the availability of appropriate duties.

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- **Frequency and duration of tasks** – The work pace and the duration that tasks are performed throughout the working day are gradually increased.
- **Rest breaks** – Avoid the use of regular rest breaks (which denote inactivity and promote deconditioning) beyond the normal allocated work rest breaks. Instead, focus on restorative breaks in which there are regular rotations of tasks to allow for changes in physical demands. Some examples are:
    - changes in posture from sitting to standing/walking
    - tasks involving non-repetitive upper limb movements
    - tasks requiring no or minimal lifting.

Return to work utilising any of these alternatives should be regularly reviewed with the express aim of recognising the increasing capability which occurs as the injury heals and reflecting this in increased hours and duties.

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The time between the first consultation and six weeks from the date of injury

During this time, soft tissue injuries should generally heal and this should be reflected in increasing capability. Refer to page 19 for injuries expected to have longer healing times. Appendix 1 shows common injuries for which workers compensation is claimed in South Australia and indicative expected healing times.

The management strategies which should be utilised during this time include the following:

1) Undertaking regular structured review of the physical and psychological condition of your patient, particularly focusing on these questions:
    a) Is recovery proceeding as anticipated? If not is my diagnosis correct, or did I miss something? Should I further investigate?
    b) Are any treatments, such as physiotherapy, assisting recovery? If not they should be changed or ceased. The treating medical practitioner should require regular communication from any health provider who is providing treatment.
    c) Is there an expected increase in capability and, if not, is there an understandable reason for this?
    d) Is my patient satisfied with what is happening and the progress being made?
    e) Are there indicators of psychological distress and, if so, is further action required.
2) If the injury is substantial or your patient does not appear to be coping well with the physical demands of work and/or home, is there a need for a worksite assessment and/or an assessment of activities of daily living (ADL) to see what assistance or modifications will assist recovery?
3) Is the relationship with the rehabilitation and return to work coordinator, employer and vocational rehabilitation consultant (if engaged) mutually supportive and productive? If not, can the issues be resolved satisfactorily, perhaps by contact with the case manager?
    Are there other reasons for delays in recovery which are not directly related to the injury, such as other illnesses, conflict at work, external psychological stresses such as relationship break-up, or family illness? If so, how can these be disentangled from the compensation claim? Is a request for continued certification more related to such issues than to the injury? How do I, as the treating medical practitioner, continue to be caring to,

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and support my patient, yet not accede to such behaviours ie, how do I say no? For more information about yellow flags click here.

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The six week consultation

Six weeks after the occurrence of a soft tissue injury is a crucial time. At this time healing is generally expected to have occurred and thus there should be a sustained improvement in symptoms and an increase in capability. When deconditioning has occurred during the acute phase of the injury, and this is relevant to work capacity, then recovery of full capability will often take longer than six weeks. (A very crude rule of thumb is that every one day of inactivity requires two days of full activity to achieve the same level of musculoskeletal capability). It is to be expected that those who have not recovered by six weeks from the date of injury will be experiencing psychological issues from the ongoing pain and fear of the future at the least, and often from other psychological stressors that existed at the time of injury or have subsequently developed [7].

The consultation at six weeks after injury should be undertaken in a structured manner and outcome measures should be increasingly utilised. The consultations should at the least address the following:

1) The history of the injury and its progress from the time of injury to the six week consultation.
2) What does my patient think has helped and hindered their progress?
3) What are their present symptoms?
4) What activities are they doing at work and at home?
5) Is each treatment resulting in improvements in symptoms/functional capability (often the patient will say a treatment is helping when it is only providing some short term relief of symptoms rather than assisting recovery)?
6) What medications are being taken and with what effect? How much is my patient smoking, drinking alcohol, using marijuana, or using other substances?
7) How is my patient coping psychologically? How are things with the supervisor and workmates? How are things at home? Is there more irritability at home? How is my patient sleeping?

Often a psychological screening instrument such as the Kessler Psychological Distress Scale (K10) or Örebro Musculoskeletal Pain Screening Questionnaire (ÖMPQ) [24, 25] will affirm there are risk factors for significant psychological issues and thus the development of long-term problems.

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When psychological or behavioural issues occur, adding psychological treatment will increase the chance of a full recovery [7]. A careful physical re-assessment should be done particularly assessing for evidence that an alternate diagnosis may explain the lack of progress, and also, assessing for inconsistencies and behavioural features.

At this stage it is generally wise to undertake relevant investigations to ensure, as far as possible, that there are no unexpected reasons for the lack of recovery. However such investigations commonly identify incidental degenerative change [26] and the patient should be warned of these prior to the investigation and advised they will not explain the present symptoms.

If there is no physical reason to explain the delayed recovery, the treating medical practitioner has the problem of managing a distressed patient who may already have some of the physiological changes of chronic pain knowing that activity is paramount to his/her ultimate recovery. Generally psychological assistance will assist this difficult management issue but on occasions the best prognosis will be achieved by negotiating and certifying activity that is both painful and that your patient may not want to undertake.

An example of such an approach is shown in the Case study 2.

Other strategies that can be utilised are:

- referral to a specialist medical practitioner. Such referral can have the dual purpose of making sure there is no missed alternative diagnosis and of ensuring that your management plan is appropriate
- referral for other allied health treatments such as massage and acupuncture
- participating in a case conference with your patient, the rehabilitation and return to work coordinator and any other appropriate participants, such as a vocational rehabilitation consultant. While case conferences may be requested by a treating health provider, it is only a case manager who has the authority to authorise that the costs will be met
- requesting a work site assessment and/or an assessment of daily living
- specifically addressing issues of pacing of activities.

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The 12 week and later consultations

By 12 weeks after a painful soft tissue injury there will generally be central nervous system physiological changes of sensitisation which means that returning to activity is essential if recovery is ultimately going to occur. The same process that was undertaken at the consultation for six weeks after the injury should be carefully repeated, but the following questions should receive even greater emphasis than at the six week review:

1) Is there an alternative explanation for the symptoms? Specialist review to check there is no alternative cause should normally be undertaken. In general such a review is more likely to assist when it is undertaken by specialists with an understanding of workplace issues, such as occupational or rehabilitation physicians.
2) What is the patients understanding of the injury, the prognosis, and their ability to undertake social and work activity?
3) There must be compromise to your patient’s psychological health from the pain experience and from their fear of the future. What are their fears and anxieties? How are they coping with the issues caused by their injury? Again review, and generally, treatment from a psychologist will assist.
4) A program of graduated activities must be established to maximise the chance of recovery. Whenever possible this should include more activity at the worksite.
   Sometimes there will be a direct conflict between the treating health providers therapeutic decision that this is the required management, and the patient fearing this is not appropriate and they will aggravate or re-injure themselves. If a careful and sympathetic discussion, which will often be assisted by a separate case conference with all participants, does not calm the very reasonable concerns of the patient, treating medical practitioners may be left with no alternative but to issue a certificate with which the patient is unhappy.
5) At this stage referral to an authorised pain management program is generally appropriate. The chances of success are greater with early referrals.
   The COPER Program conforms to the guidelines issued by the International Association for the Study of pain (IASP)[27].
   Referral to the COPER Program will result in an assessment of the patient’s suitability for a full treatment program. If such a program is indicated, the case manager is required to authorise the payment of such services and should be contacted for such authorisation.

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6) Medication may be useful and should be considered. There is an established place for drugs which can modify the pain experience of patients who are sensitised with or without neuropathic pain [28, 29]. Such drugs include the tricyclic antidepressants and some of the primarily anti-epeliptic drugs such as gabapentin and pregabalin. When using such medication the prescribing medical practitioner should be sure that there is adequate justification for its use and establish the expected goals from such treatments. Review must occur to ensure its use is achieving the desired outcome.
Be wary of opioids. There is evidence that about 20% of patients do not gain any pain relief [30] and further evidence that chronic use in musculoskeletal pain is not associated with improved pain control or quality of life [31]. Benzodiazepines are problematic in musculoskeletal injury. They should only ever be prescribed for short-term use because of the risk of dependency, and they have the added disadvantage that they can cause or aggravate depression. In addition care should always be exercised with opioids and benzodiazepines because they can have deleterious effects on activities of daily living and work performance.

Injuries expected to have longer healing time

There are a number of conditions which are expected to have a longer healing time than common soft tissue injuries. Examples include some crush injuries, some fractures, nerve disruption and sciatica. For such injuries recovery and return to a normal life is expected to ultimately occur, but at a slower rate than injuries that heal more quickly such as sprains and strains.

These injuries should be managed in exactly the same manner that has been outlined in this section but with the expectation that recovery is likely to take longer and that difficulty in coping psychologically is more likely.

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Suggested strategies for managing common return to work barriers

This section documents many of the more common return to work barriers with some of the potential strategies that may help their resolution.

With patients

Problem	Suggested strategy
Your patient is not recovering as quickly as expected	Review the diagnosis to make sure there is not an unsuspected cause for the ongoing symptoms. Explore psychological issues particularly fear of re-injury or aggravation. Explain that research shows that activity is very important for recovery.
Your patient reports work activity aggravates their symptoms	Review and modify work tasks if needed. Consider work site assessment. Discuss issues with rehabilitation and return to work coordinator, vocational rehabilitation consultant.
Your patient wants a new, or different, job.	Advise your patient that a workers compensation injury is not a valid reason for a change in career unless they are assessed as not being able to recover enough to return to pre-injury employment or long term modified employment. The evidence shows that the best chance of a full recovery is returning to pre-injury work.
Your patient wants more time off work	Explore the reasons for this request with your patient. If there is not an understandable reason, explain that activity which includes return to work is essential for recovery.
Your patient has a pre-existing disability aggravated by work either physical or psychological.	This should be managed as though the full disability was caused by the compensation incident but the claim is to be discontinued once they have recovered to their pre-aggravation status.
Your patient's report of their disability doesn't match with your clinical judgment.	Discuss this with your patient. Seek opinion from other members of the management team. Obtain specialist review.

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Your patient does not attend work as per their certificate.	Try and find out if there is a legitimate reason for this. If there is not, do not issue a certificate to 'cover' them. The issue is then a case management problem.
Your patient keeps missing appointments.	Discuss the reason with your patient. Refuse to backdate certificates. Ultimately, your patient may need to find an alternative source of care if their behaviour is too disruptive.
Your patient requests a back-dated certificate.	It is only legal to provide these if you are personally aware that your patient was incapacitated for the period requested.
Your patient says they will change medical practitioners if you do not do what they want.	Workers have the right to change medical practitioners. Advise them that this is their choice but your role is to assist their recovery and you will be managing them with that purpose.
Your patient says that there are no suitable work duties.	Discuss with your patient's employer. Contact the case manager to organise a work site assessment. Continue to certify the actual capacity of your patient.
I try contacting the employer but I cannot get through as they do not return calls.	Get your staff to contact the case manager and advise him/her of the problem and request they get the employer to make contact.
I cannot talk to the employer because the patient has withdrawn medical authority to share information.	You can advise the employer about the contents of the certificate. Information about capacity is able to be shared with the employer. Find out why the authority has been withdrawn and consider whether you are prepared to keep managing the patient under these circumstances.
Your patient was given a certificate to commence return to work but returns saying employer wants certificate rewritten for total incapacity because there is no suitable work available.	The certificate is a legal document and reflects your opinion as to your patient's capacity and as such it should not be changed. Advise the case manager of this situation and suggest a work site assessment. Advise your patient that if they are sent home, then entitlement to workers compensation benefits still remains.

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Employer fears re-injury.	Explain the evidence about risks of re-injury. Explain that return to work is vital for recovery. Work with employer to ensure return to work is appropriate for your patient. A workplace assessment may assist in reducing and managing these concerns.
Employer does not want to participate in return to work. Your patient's job is no longer available.	Advise case manager/vocational rehabilitation consultant. The employer has a statutory obligation to participate but it is not your role to try and enforce this. Your role is to manage the injury which includes identifying and certifying capacity.
Employer frustrates return to work progress.	Document this. Advise case manager/vocational rehabilitation consultant. Suggest to your patient that the Union be advised because they will often assist. As a last resort, consider advising ombudsman if this meets with unsatisfactory action.
Employer is resistant to costs of required job modification.	This will normally be managed with the worksite assessor. However it may be possible for the cost of worksite modifications to be met by the compensating authority so the employer should undertake this discussion.
Your patient was employed on a short-term contract which has expired, or was a casual.	The Act mandates that there is an entitlement to compensation until they have recovered to their pre-injury status even if the formal contract of employment has ceased.

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Problems with case management

Problem	Suggested strategy
The case manager is never available.	Contact the team leader or supervisor and explain your frustrations.
The case manager/ vocational rehabilitation consultant keeps changing.	Unfortunately the compensation workforce is very fluid and changes of personnel and of roles are frequent. It is therefore important that you ensure that all communication is clear and complete.
How do I find out the status of the claim?	Ask your patient, who will receive a letter, advising them once a decision has been made or contact the case manager.
The claim has not been accepted yet your patient needs treatment.	A provisional liability decision to pay compensation (including treatment) is required to be made within seven days of claim notification. Prior to that approval, treatment can be provided under Medicare and the costs subsequently claimed against WorkCover if they are then approved. Alternatively if there is to be a delay, the treatment can be approved as part of a rehabilitation and return to work plan. However this inclusion is at the total discretion of the case manager.
Your patient has a separate condition eg, obesity, which needs treatment because it is impacting their recovery.	Such conditions are not covered under the legislation but treatment may be authorised for a non- compensable condition when such treatment is needed to assist the recovery of the compensable injury. Such treatment should only continue while benefit is occurring and the compensable disability continues. Contact the case manager.
Why is there such a delay in claims acceptance? It is causing my patient to become anxious and angry and is impeding their recovery.	The Act requires that claims need to be assessed to ensure that they conform to the legal requirements of the Act before they are accepted. Sometimes this takes longer than anyone wishes. One reason for this delay can be delays in practitioners providing needed information.

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Appendix 1: Healing and recovery times

Research conclusively shows that average recovery from injury, with or without surgery in those with a compensable injury is substantially slower than that from the identical injury in those without any entitlement to compensation [32-35]. The studies which show this match other factors which might have an impact such as age, sex, type of injury etc which means that this delay is not due to different healing times after injury but rather associated behaviours or psychological influences.

The following table lists the most common injuries for which workers compensation is paid in South Australia [4] and indicative healing times after the injury. The table has been compiled using information from multiple sources including textbooks [36, 37,] the Medical Disability Adviser [38] and from the Health and Rehabilitation Unit of WorkCoverSA [4].

For soft tissue injuries it is accepted that complete healing occurs, at most, six weeks after the injury. Even for such injuries it is generally accepted that as healing occurs, the injured person's capabilities increase so that increasing capability including work capability precedes full healing.

While the capability is increasing there will often be a need for the activities that the injured person is undertaking to be modified particularly in those work tasks that have heavier physical demands. When a decrease in symptoms and an increase in capability is not occurring within the time frames shown, there should be a careful re-assessment to ensure that an alternative diagnosis does not explain the apparently delayed recovery. If an alternative diagnosis is not found, then it is likely that the delay is due to behavioural or psychological reasons.

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Body area affected: Hand/wrist

While healing occurs for injuries to one upper limb, activities using the other limb are usually able to be undertaken.

Condition	Expected healing time	Notes
Wrist sprain/strain	Up to 6 weeks	Most wrist sprains recover in 2-4 weeks. Splinting will often assist in the restoration of function.
Laceration involving skin and subcutaneous tissues	Up to 2 weeks	Activity can continue while healing occurs, particularly if the affected area can be kept dry.
Laceration involving tendons	Up to 6 weeks for extensor tendons Up to 12 weeks for flexor tendons	Particularly after flexor tendon repair, specific therapy to restore function will generally assist recovery.
Carpal tunnel syndrome – medically managed		A reduction in symptoms may occur. Exposure to vibration and repetitive forceful gripping should be limited.
Carpal tunnel syndrome – surgically decompressed	2 weeks	Decompression reduces the pressure on the nerve and thus should enable rapid reduction in symptoms.
Bruises/contusions	2 weeks	If there is significant associated tissue injury, particularly with a crush injury, healing may be slower.
Tendonitis/ Tenosynovitis	2-4 weeks or longer	If the precipitating activity is ceased, resolution generally occurs in 2-4 weeks. If not, symptoms may continue indefinitely.
Fracture	4-12 weeks	The rate of healing for a fracture depends on the type and location of the fracture and whether surgical intervention is required.
Ganglion treated conservatively	0-2 weeks	Most ganglions are symptom free. If there are symptoms, a short period of rest may assist symptom resolution.
Ganglion treated surgically	2 weeks	Recovery should occur without further treatment.

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Body area affected: Elbow

While healing occurs for injuries to one upper limb, activities using the other limb are usually able to be undertaken.

Condition	Expected healing time	Notes
Medial or lateral epicondylitis	6-12 weeks if causative activity is stopped	This condition may become chronic. Removal of the causative activity in the acute phase generally results in control or resolution of symptoms. Avoiding repetitive twisting and gripping activities in the position of elbow extension and pronation is also of great assistance in managing the symptoms in the acute phase. Use the arm with the palm up and the elbow held by the side.
Sprain/strain	6 weeks	Most strain/sprain injuries should heal in 2-4 weeks.
Bruises/contusions	2 weeks	If there is significant associated tissue injury, particularly with a crush injury, healing may be slower.
Fracture	4-12 weeks	The rate of healing for a fracture depends on the type and location of the fracture and whether surgical intervention is required.
Laceration involving skin and subcutaneous tissues	Up to 2 weeks	Generally activity can continue while healing occurs, particularly if the affected area can be kept dry.

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Body area affected: Shoulder

While healing occurs for injuries to one upper limb, activities using the other limb are usually able to be undertaken.

Condition	Expected healing time	Notes
Sprain/strain	6 weeks	Most non-specific strain/sprain injuries should heal within 6 weeks
Rotator cuff tendinopathy	2-12 weeks	Rotator cuff tendinopathy without impingement should resolve with removal of the causative activity and restricting shoulder movement to the pain free range in the acute (first 6 weeks) phase.
Impingement syndrome	2-12 weeks	Removal of any causative activity will assist healing. Conservative treatment may be unsuccessful. There will generally be a pain-free range of shoulder movement and the ability to continue activity within that range of movement.
Dislocation	3-12 weeks	Healing depends on whether it is the acromioclavicular or glenohumeral joint which is dislocated, the amount of associated injury and if surgical intervention is required. In most instances healing should occur within 6 weeks.
Bruises/contusions	2 weeks	If there is significant associated tissue injury, particularly with a crush injury, healing may be slower.

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Body area affected: Neck/cervical spine

Condition	Expected healing time	Notes
Sprain/strain including whiplash	40% have recovered by 4 weeks, 60% have recovered by 6 weeks, 85% are recovered by 3 months	Symptoms are frequently recurrent. The chance of recovery is maximised by undertaking as much activity as can be tolerated and by not keeping the neck in a flexed position for periods of more than 10-20 minutes.
Cervical nerve root lesions – treated conservatively	6 weeks-2 years	Generally these lesions spontaneously improve with most recovery occurring in the first 12 months.
Cervical nerve – treated surgically	6 weeks-6 months	If cervical fusion has also occurred, then heavy physical activity will need to be avoided until the fusion is solidly healed.

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Body area affected: Low back (lumbosacral spine)

Condition	Expected healing time	Notes
Non-specific/benign/ biomechanical low back pain	6 weeks	While pain may continue beyond 6 weeks from date of onset, there is strong evidence that implementing active management strategies is associated with better long term functional outcomes.
Radicular pain (sciatica) treated conservatively	Up to 2 years	Most radicular pain (sciatica) responds well to conservative management (ie, surgery is not required). After 6 weeks from date of onset the risk of aggravation or a further disc protrusion has returned to pre-injury risk. As for benign low back pain, adopting active management strategies is associated with a better long- term functional outcome.
Degeneration changes/facet joint pain	6 weeks	While pain may continue beyond 6 weeks from date of onset, there is strong evidence that implementing active management strategies is associated with better long term functional outcomes. It should be noted that there is a greater likelihood of longer term symptoms with this presentation.
Bruises/contusions	2 weeks	If there is significant associated tissue injury, particularly with a crush injury, healing may be slower.
Fracture	2-6 weeks	Fractures of the transverse processes are most common and activity is resumed as tolerated. Other fractures are more significant and may require a longer healing time (up to 3 and rarely even 6 months)

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Body area affected: Hip

Provision of and certification for seated duties while healing occurs, will facilitate recovery in all injuries involving the lower limb and should occur in all instances unless such duties will disadvantage the injured worker's recovery.

Condition	Expected healing time	Notes
Sprain/strain	2-6 weeks	Hip injuries occur uncommonly in workers compensation. Recovery will be facilitated by provision of seating duties while healing occurs.
Bruises/contusions	2 weeks	If there is significant associated tissue injury, particularly with a crush injury, healing may be slower.

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Body area affected: Knee

Provision of and certification for seated duties while healing occurs will facilitate recovery in all injuries involving the lower limb and should occur in all instances, unless such duties will disadvantage the injured worker's recovery.

Condition	Expected healing time	Notes
Sprain/strain	2-6 weeks	Sprain/strain injuries generally heal in 2-6 weeks. Sometimes this is a provisional diagnosis and a different diagnosis is made when expected healing does not occur.
Bruises/contusions	2 weeks	If there is significant associated tissue injury, particularly with a crush injury, healing may be slower.
Meniscal (cartilage) injury treated surgically	2-4 weeks	Arthroscopic treatment of a damaged meniscus should be followed by rapid restoration of function arising from the damaged meniscus unless there are other concurrent pathologies within the knee joint.
Lacerations	2 weeks	Generally activity can continue while healing occurs, particularly if the affected area can be kept dry.

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Body area affected: Ankle and foot

Provision of and certification for seated duties while healing occurs will facilitate recovery and should occur in all instances except if such duties will disadvantage the injured worker.

Condition	Expected healing time	Notes
Sprain/strain	2-6 weeks	Sprain/strain injuries generally heal in 2-6 weeks. Occasionally the ankle will be immobilised while healing occurs
Bruises/contusions	2 weeks	If there is significant associated tissue injury, particularly with a crush injury, healing may be slower.
Fracture	2-12 weeks	Fractures in the ankle and foot can be slow to heal but there is generally a capability for seated activity while this occurs.
Plantar fasciitis	0-2 weeks	Plantar fasciitis is more commonly aggravated than primarily caused by work. Seated duties, modification of footwear or orthotics generally facilitate resolution of symptoms.

Other injuries

Condition	Expected healing time	Notes
Hernia – unoperated	Not applicable	On occasions, a hernia can cause symptoms, particularly pain. Until it is surgically repaired there should be a reduction in lifting and forceful strain eg, pushing, pulling.
Hernia – surgically repaired	Up to 6 weeks	While the healing structures have not attained full strength for 6 weeks after surgery, increasing activity including activity at work will normally be possible from 1-2 weeks after surgery.

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Appendix 2: Case studies

Case study 1: Non complicated recovery

Mr John Smith is a 45 year old labourer who bent over and picked up a 10kg carton at work. He noticed a mild back pain at the time which worsened over the next 24 hours. He consults you two days after the injury. He reports there is no radiation of the pain. There are no red flags and no indications of psychological distress. His past, family and social history are unremarkable. He takes Tenormin for hypertension. On examination the movements of his lumbo sacral spine are globally reduced by about 25% and there is mild tenderness from L4-S1 and adjacent musculature. There is no muscle spasm.

After he dresses and sits back down a therapeutic, positive interaction could proceed as follows:
GP: It's bad luck you sustained this injury but at least there is no suggestion that you have done any significant damage. I expect that you will get better in a short time. My role is to try and assist this natural process.

Mr John Smith responds by appearing to hesitantly accept your assessment and asks about treatment. At this stage you should explore how much distress the injury is causing which enables you to judge whether analgesia is needed and whether referral for other treatment may benefit your patient.

Mr Smith: Are you sure that's right Doc, it's very sore.
GP: As I said there's nothing to indicate significant damage. The actual injury wasn't serious and the examination shows that in particular there is no nerve damage and you are moving your back reasonably well. The amount of pain you have doesn't always indicate the severity of an injury. Do you need some help to manage the pain?
Mr Smith: It's no fun. I guess that something would be nice.
GP: There are a range of things that you can do at home which generally help you cope with the pain. You should try the use of local heat such as liniments or hot water bottles making sure you don't burn yourself, or hot showers etc. Try taking some Panadol or Panadeine but if they don't

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give enough relief please contact the surgery and I'll leave out a prescription for a slightly stronger pain killer. However the most important thing you can do to get better is to get on with as much of our normal life as you can. Apart from work, what do you normally do at home, do you play sport?

Mr Smith: I help my wife with some of the household stuff, mow the lawns and play golf once a week. I also take the dog for a walk a couple of times a week.

GP: So what of that do you think you can do at present?

Mr Smith: I'm not sure. I reckon I can still walk the dog because he's only small and I could do some of the household stuff like drying the dishes.

GP: That's good. What about the golf? If you can get down to the putting green or even only to the 19th, that will also help you get better. What about work? Is there anything you think you can do there?

Mr Smith: I'm not sure. I certainly can't do my usual job.

GP: Well lets sort out what you can physically do and I'll then ring your boss and see if we can find something you can do while your back gets better. So how much do you think you can lift?

Mr Smith: Not much, I don't know.

GP: Well let's get an idea. How many 2 litre bottles of soft drink could you lift at one time without making your pain significantly worse?

Mr Smith: Two, probably three.

GP: And I guess that you find twisting and bending hurts.

Mr Smith: Yes that's right.

GP: OK. Can you stick around while I ring your employer/rehabilitation and return to work coordinator and see what they have that fits with these restrictions?

Mr Smith: OK.

GP then contacts employer and talks to the rehabilitation and return to work coordinator, Simon Rogers. He explains that Mr Smith has a non-specific low back strain and he has certified him as fit to return to work, initially for four hours per day, with restrictions of not to repeatedly lift, or to lift more than 5kg at a time, not to repetitively twist or bend and not to stay in one position for more than 20 minutes at a time. When asked about possible work, Mr Rogers says that Mr Smith can pack small fittings into plastic bags, pack the bags into cartons and then seal the cartons. He can have a stool so he is able to sit or stand as he wishes and can leave the workstation to walk around if required. Mr Rogers says that he will make sure someone takes the full cartons away from the workstation. Mr Smith agrees that he feels he can do this work.

You provide the appropriate certificate and arrange to review Mr Smith in three days time.

The next review, after Mr Smith has been certified to undertake three days of alternative duties at four hours per day:

GP: So how are you going? Have you been managing with these duties, which of them do you find are easy? Are you having problems with any of the work? What do you think we can do to make it easier for you?
Mr Smith: It's OK I guess. It's still pretty sore but at least it's no worse. Nothing is particularly making it worse. I think I just need a bit more time.
GP: But that's good that you've coped with that work. How have your workmates and boss been?
Mr Smith: They've been fine. They've been helping when I need it.
GP: How are things at home? Are you doing much?
Mr Smith: No, not much although I have taken the dog for a walk and helped with the dishes.
GP: I reckon that's great. You're doing more and it's not got worse so things are on track. Have you been following the treatment plan we worked out?
Mr Smith: Yes.
GP: Good. Let's just have a quick look at you.

GP undertakes examination which is similar to that on the first consult.
GP: That examination is much the same as last time I saw you which shows that you are coping with things at present. I want you to continue at the same level at work but I reckon it would be good if you took the dog for a walk every day and slowly increase the distance. Not only will that help you get better but it will make the dog even happier. What are you going to do on the weekend?

Mr Smith: Not much. I haven't got anything planned.
GP: You play golf don't you?
Mr Smith: Yes, generally, but not this weekend.
GP: That's a pity. Do you think you could do a bit of putting practise?
Mr Smith: I'm not sure. I guess I could give it a try.

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GP: Why don't you do that, but time it so you can meet up with your mates when they finish the round so you can all go to the club house together. I'll see you after work on Monday.
Mr Smith: OK.

Four days later.
GP: So how are you going?
Mr Smith: Not bad. It's feeling better and I can do a bit more.
GP: Great. Let's just check and see how you're moving.

GP does brief examination.
GP: Yes, you are able to move better than before. How did the weekend go and how's the dog?
Mr Smith: It was good. I did a bit of putting. Not much and caught up with my mates. The dog can't believe his luck getting a walk every day.
GP: Well things are obviously on the way. What do you think about work?
Mr Smith: Oh I can't go back to my normal job.
GP: I agree but I think you could increase to six hours per day of the present duties. What do you think?
Mr Smith: Yes, I guess so.
GP: Why don't we go up to six hours for the rest of this week and I'll see you in a week's time.
Mr Smith: OK.
GP: When you come back, it would be good if you brought Mr Rogers so we can work out how to best assist your ongoing recovery.

Over the next three weeks Mr Smith is gradually re-introduced to his usual job, initially on a modified basis with the more musculo skeletally demanding tasks being excluded but they are then slowly introduced.

Mr Smith's return to work illustrates two of the strategies which can be utilised (alternative work and reduced hours) to assist recovery from an injury.

The full recovery has been positively influenced by:

- the positive proactive attitude of the treating general practitioner

- the early positive involvement of the worksite, particularly the support from the worksite coordinator
- the provision of suitable duties
- Mr Smith being prepared to remain as active as possible, both at home and at work.

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Case study 2: Delayed recovery

Mrs Anthea McDonald is a 37 year old enrolled nurse who six weeks ago was assisting a patient transfer from the bed to a chair when the patient 'dropped' causing immediate low back pain radiating down the back of her right leg to the knee. While you commonly see her, she has seen another general practitioner because you were away on holidays. She reports the pain is much the same as at the time of the injury despite her having physiotherapy three times per week, taking eight to 10 Panadeine Forte per day which "help a little bit" but the resultant constipation troubles her, and Diazepam at night to help her sleep. She is obviously distressed and is requesting a certificate and some more Panadeine Forte.

You elect to book a 40 minute appointment two days later, provide a certificate until then, give her a prescription for 20 Panadeine Forte and say you feel you will be able to help once you've gained a full understanding of what's going on. You also forewarn her that you think there will be some changes to her present treatment especially as it is pretty obvious they are not working for her.

Two days later.
GP: Good morning Mrs McDonald. It's good to see you again. As we discussed the other day I want to get a full understanding of what's going on, so I want to go back over the accident, what's happened since and then do a full examination and then we'll discuss what to do next. Is that OK?
Mrs MacDonald: Certainly doctor, I just want to get better. It's awful.
GP: Sure I understand, but you're here so that we can start some changes to make things better. Perhaps we can start by you telling me what happened.
Mrs McDonald: Well I was helping Mrs X get from her bed to her chair when she just 'dropped' on me. I tried to catch her but couldn't and I hurt my back. This has happened before and I've told them there should be two nurses but they won't take any notice. It's their fault and my back's stuffed because of them.
GP: Gee that's really unfortunate. I'll want to talk to your work people later about what you are able to do at work. Would you like me to take this issue up with them? Can you tell me again where it hurts?
Mrs McDonald: Yes, they need to get their act together so someone else doesn't get hurt. The pain is in my low back and also in my bottom and it goes down the back of my leg.

GP: How far does it go and are there any pins and needles or numbness?

Mrs McDonald: It goes down the back of my thigh to my knee. There're no pins and needles or numbness.

GP: Have you found anything that helps reduce the pain?

Mrs McDonald: It's better when I sit down but it stiffens up and is worse when I get up. Lying down is better but as soon as I try and turn over in bed it's very sore.

GP: How are you sleeping?

Mrs McDonald: I keep waking up when I move. The Diazepam certainly helps me to sleep though.

GP: How are your bowels and your urine?

Mrs McDonald: They're OK although the Panadeine Forte are making me constipated.

GP: How are you finding the pain?

Mrs McDonald: It's awful. I can't get away from it and the pills only help a bit. I hate it.

GP: How are things at home?

Mrs McDonald: My husband's very helpful and understanding but he's useless at cooking and his idea of cleaning is terrible. He doesn't have a clue. And the kids don't understand why I can't pick them up or play with them. Fortunately my mother comes and helps a couple of times a week.

GP: How about work. Have you heard from them?

Mrs McDonald: Yes the Director of Nursing rang me several times. She has been sympathetic and said she's sorry for what happened. Fat lot of use that is, it's not her back that's stuffed.

GP: Well. I think there's a good chance your back isn't stuffed but what about the people you work with.

Mrs McDonald: Well a couple of them have rung and Jean has popped around for a cup of coffee a couple of times.

GP: Is there anything else that is worrying you, or that you think I should know?

Mrs McDonald: It's just awful. You know I've been having physio which is great for two or three hours afterwards but then it hurts just the same.

GP: OK. Let's do an examination to see if there's anything to find.

GP undertakes a physical examination including a neurological examination and an assessment of behavioural (Waddells) signs. Mrs McDonald gets dressed and sits down.

GP: I'm really pleased with my examination. I couldn't find any indication that you've done a serious physical injury. While I was doing the examination, it was obvious you still have some pain and discomfort. I guess that you're not enjoying things.
Mrs McDonald: Who would enjoy it?
GP: Because it's been going on for so long, I want to get an X-ray just to make sure there's nothing unexpected happening. Is that OK?
Mrs McDonald: It will be good to get some answers.
GP: In fact I don't expect the x-rays will give us any answers. What I expect is that you'll have the normal changes of arthritis that we expect everyone at your age to have, and nothing else. These changes won't explain your pain but at least we'll know.
Mrs McDonald: OK.
GP: OK let's organise it. In the meantime I want to start to change your treatment. One of the things we know is that people who keep as active as they can are more likely to get better. I know you haven't been doing much but it's important for your recovery that you do more. What I will do is ring your physio and get him to start an exercise/activity program. What about things at home.
Mrs McDonald: With my mum I can manage.
GP: OK, that's good. See if you can do a bit more each day. Going for walks is good and if you can do stuff at home which means you are not lifting more than five kilograms (5 litres of milk or soft drink), don't twist and bend too much and don't stay in the same spot for too long.
Mrs McDonald: What about hanging out the washing?
GP: You need to be careful doing that. Have you got a trolley in which you can carry the basket out to the line?
Mrs McDonald: Yes I have.
GP: Well don't push yourself too much but if you can lift the washing easily out of your washing machine, take it in the trolley to the line and lower the line so its not too hard to reach, that should be OK.
Mrs McDonald: I think I'll get my husband to keep doing it.
GP: I also want to give you a referral to a colleague of mine, who will help you by teaching you ways to make the best of things while your back gets better. She is a psychologist and these are the skills they have to help people like you.
Mrs McDonald: OK, I guess. You're sure she will help?
GP: I'm certain. She is a very important part of the team that I work with to help people like yourself. It's also important that we start to reduce some of the medication. She will help with your

pain but I also want you to try rubbing it with heat rubs and having a hot shower if it gets really bad. I'd like us to aim for no more than six Panadeine Forte per day and I do want you to cut the diazepam back to 1 ½ per day. While diazepam is useful to help you sleep, it sometimes causes people to get depressed and we don't want that.

Mrs McDonald: No. It's bad enough as it is without that.

GP: So we'll gradually reduce it, starting at 1 ½ per day. I don't want you to stop it suddenly because that may cause some problems.

Mrs McDonald: OK. How am I going to sleep?

GP: Well I expect that the changes we're starting will reduce your pain so that by the time we stop your diazepam you won't need anything else. If you do, there are other things we can use. The other thing we'll need to do is to find some activities at work you can do. Have you thought about that?

Mrs McDonald: I don't know what to think. They caused this but I miss work and they have been really nice.

GP: OK, I understand that. Tell me what you think you can do?

Mrs McDonald: I can't do much at present. Maybe I could help with feeding some patients.

GP: What we will do is give your back a week or two to start to settle down. In the meantime, let's contact the workplace rehabilitation and return to work coordinator and see what can be found for you to start off with. It would be good if you could go and meet her so you can both think about what's OK and then let me know. It would also be good if you talked to the psychologist about your feelings about work.

Mrs McDonald: So you really think it will get better?

GP: As I said before there's no indication of anything serious so that's what I expect. But it won't happen overnight and basically the most important thing to get better is that you need to get on with things. That's not always going to be a lot of fun which is why we're going to organise the treatments we've discussed and why we're doing things gradually but yes I believe that you should be OK in a few months.

Mrs McDonald: I'll see you after the x-ray.

The important features of this stylised consultation:

- Enough time was allowed to enable an appropriate assessment to be done.
- The treating medical practitioner repeatedly gave positive messages about the future.
- The treating medical practitioner adopted a problem solving approach.

- Appropriate health providers (physiotherapist and psychologist) were identified who could assist in Mrs McDonald's recovery.
- The workplace issues were identified, discussed and plans were made for the workplace to become part of her management and recovery.
- The radiology was organised but Mrs McDonald was given evidence based information that degenerative change was likely to be detected and such changes would neither explain her symptoms, nor would these have been caused by the injury at work.
- Strategies were commenced to reduce the medication.

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