BACK TO WORK

Disability management and return-to-work strategies in Canada

HONDA OWES HUGE LEGAL FEES AFTER FAILING TO ACCOMMODATE

Honda Canada has once again been hit hard financially for its decision to dismiss an employee suffering from chronic fatigue syndrome. In a case already well known in disability management circles because of the judge's $500,000 award in punitive damages and harsh rebuke of Honda's actions, the same judge has now ordered Honda to pay the legal costs of the dismissed employee to the tune of $610,000. And he once again did not mince his words when it came to admonishing Honda for its "shocking" behaviour.

Kevin Keays, now 41, was an employee at Honda's plant in Alliston, Ont., when he was dismissed for failing to see an occupational health physician at the company's request because of the company's ongoing concerns about his absenteeism. This dismissal was not only wrongful, but also "egregious," the judge said.

As he saw it, instead of accommodating Keays's disability as required by law, Honda embarked on a "hardball" approach that included harassment and retaliation. It did so, the judge believed, because Keays's absences interfered with the company's "lean" production processes. The judge showed his very obvious disapproval by awarding two years' salary in lieu of notice (which included nine months' salary in bad faith damages) and half-a-million dollars in punitive damages. The total award amounted to $720,000 (see *Back To Work*, April 2005).

After the 29-day trial, Keays argued that he should not only be reimbursed for his full legal costs, but also be paid a premium. The judge agreed. He was not at all impressed with Honda's argument that Keays should only be partially reimbursed for his costs on the grounds that he "lost" three of his six claims before the court; that is, he did not receive damages for intentional infliction of nervous shock, damages for discrimination and harassment, or damages for lost entitlement to disability benefits. "One could arrive at this conclusion based on a shallow and egocentric interpretation of the results," the judge said. "However, a fair and unbiased analysis produces a quite different conclusion."

The judge explained. Keays did not receive damages for intentional infliction of nervous shock because he had received nine months' extra salary in bad faith damages, and to award both would result in "double recovery" (Keays being indemnified twice for the same wrongful actions). Keays did not receive damages for discrimination or harassment because such claims are limited to human rights tribunals and, in any case, Honda's harassment of Keays was reflected in the half-million dollar punitive damages award.

Finally, Keays did not receive disability benefits because of a "default in pleading," but the punitive damage award went a long way to make up for that loss. "It was never intended by me for any other purpose than purely penal so as to denounce the outrageous conduct by [Honda]," the judge said of the punitive damage award. "Although a lawyer may correctly describe this aspect of the outcome of the trial to be negative, I doubt that an accountant would come to the same conclusion."

Judge awards 25 per cent premium

In awarding Keays his full costs, the judge took Honda to task for attempting to justify its insistence that Keays see the occupational health physician on the grounds that it was trying to better understand his workplace absences. If this was really the case, the judge said, why did Honda "take the low road" and totally ignore a letter from Keays's lawyer in which Keays offered to resolve the "festering impasse" by being of "further assistance." The judge said it was "shocking to see such

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a degree of intransigence on the part of a corporation of Honda's worldwide stature."

The judge then dealt with the issue of a 25 per cent premium on the legal costs. He said such a premium was warranted because Keays lacked the financial resources to fund the litigation, having received only a modest Canada Pension Plan disability benefit after his termination. "This limited income was totally inadequate to fund a case of this magnitude, especially in light of Honda's decision to defend it in such an unrelenting fashion," the judge said. "This was a classic case of David and Goliath where the 'little guy' won against all odds."

As well, had it not been for the "up-to-the present gratuitous intervention of his lawyer," Keays would never have had his day — or, more precisely, month and one week — in court "to realize this monumental result." This "cries out" for a substantial premium, the judge said. "As well, I understand from reports in the popular media that [Keays's] counsel continues to fund this litigation because Honda has the judgment herein under appeal." In the end, the judge awarded $575,000 in legal costs, plus the 25 per cent premium, for a total amount of $610,000.

Source: *Keays v. Honda Canada Inc.,* Ontario Superior Court, February 8, 2006. •

P.E.I. ADOPTS REGS ON VIOLENCE AND WORKING ALONE

Prince Edward Island has introduced new provisions dealing with violence and working alone. Amendments to its General Regulations under the *Occupational Health and Safety Act* were filed in February and come into effect on May 1, 2006.

With respect to workplace violence, the new regulations require employers to assess the workplace to determine whether workers are at risk of injury from violence — "violence" being defined as the threatened, attempted or actual exercise of physical force by someone other than a worker. If a risk is identified, employers must establish policies, procedures and work environment arrangements to eliminate or minimize the risk. They must also establish procedures for reporting, investigating and documenting incidents of workplace violence, as well as inform and train workers in related matters.

As for working alone, the regulations require employers to develop and implement written procedures that protect workers, as far as reasonably practicable, from the risks of working alone. Employers must also train workers about these procedures.

The Workers' Compensation Board has published guides on complying with the new violence and working alone regs. They are available at www.wcb.pe.ca under "What's New." •

BREAKING NEWS

Roundtable publishes mental health plan

A toolkit for employers on how to deal with mental disabilities in the workplace is included in the newest report from the Global Business and Economic Roundtable on Addiction and Mental Health.

Released at the end of March, the 150-page report outlines the strides that have been made in addressing workplace mental health issues in Canada and what employers still need to do to improve the mental health and productivity of employees. The "how-to" portion of the report — called "Employers Getting Started" — includes 11 modules, one devoted to mental health disability management and return to work.

The report, *2006 Business and Economic Plan for Mental Health and Productivity*, is available at www.mentalhealthroundtable.ca. Watch for more information in the next issue of *Back To Work*.

YUKON SEEKS INPUT ON RE-EMPLOYMENT, OTHER COMP ISSUES

Should employees be mandated by law to accommodate injured workers? If so, should the nature of the duty vary depending upon the size of the employer or the industry?

These are two of the many questions Yukon is asking as it seeks feedback on various options for changing the territory's *Workers' Compensation Act*. As part of its review of the Act, the Workers' Compensation Review panel has published a 178-page paper that sets out various options for amending the Act in four categories: (1) governance, (2) assessments, (3) benefits and (4) appeals, legal and policy issues.

Written submissions are being accepted until June 15, 2006. For a copy of the discussion paper, go to www.wcbactreview.gov.yk.ca. •

IWH RESEARCHERS TACKLE BACK BELTS, WHIPLASH RECOVERY

Patients with whiplash injuries who are treated too aggressively in the month following their injury may take longer to recover than those who get less treatment. And there is no convincing evidence that wearing back belts in the workplace reduces injury or lost time following an injury.

These are the conclusions reached by Institute for Work and Health scientists in two separate studies. The results of the studies were recently reported in the Winter 2006 edition of the Institute's quarterly newsletter *At Work*. For information, visit www.iwh.on.ca. •

PEER SUPPORT THE KEY TO MILITARY'S STRESS PROGRAM

Canadian soldiers who suffer from post-traumatic stress disorder can seek the support of fellow soldiers who have gone through the same thing, thanks to an innovative program conceived by Lt. Col. Stephane Grenier. **By Mark Rogers and Cindy Moser**

Their journeys begin in different, now notorious, places like Rwanda, Somalia, former Yugoslavia and Afghanistan. But many Canadian soldiers on peace support operations around the world — as witnesses to atrocities and death — come home to face further misery: their own anxiety, depression or post-traumatic stress disorder.

Lieutenant Colonel Stephane Grenier is no stranger to this phenomenon.* A veteran of the United Nations' mission to Rwanda in 1994, he witnessed what we have come to learn was a horrific genocide: the death of almost one million people during a civil war that lasted less than five months.

Upon his return 10 months later, he had a sense of not belonging. He suffered recurring nightmares and flashbacks. He began having troubles being around family and co-workers and started isolating himself. He felt ashamed about his inability to cope.

He sought psychiatric help, but because he felt compelled to minimize the impact of his tour in Rwanda, he was misdiagnosed, which left him feeling even more frustrated and misunderstood. He threw out his newly prescribed medications and vowed to get over his problems on his own.

For two years, he tried masking his deteriorating condition by becoming a workaholic but, in time, his increasingly aggressive attitude toward his superiors and increasingly antisocial behaviour with his colleagues became all too evident. Finally, a colonel took him aside. He acknowledged Grenier's uncharacteristic behaviour and the hardships he had been through over the past years.

That gave Grenier enough confidence to finally seek help and get treated for post-traumatic stress disorder (PTSD). "The understanding and empathy that [the colonel] showed that day was probably the most significant event that had occurred since my return from Rwanda," Grenier says.

The experience drove Grenier to search for a solution to the stigma, shame and isolation endured by sufferers of PTSD. His review of the literature convinced him that social support was the key to recovery. Then, in the fall of 2001, a distraught infantryman who had served both in the Balkans and in Africa crashed his SUV into the headquarters of an Edmonton army base. Grenier requested and received permission to visit the soldier.

He asked the soldier if a peer support program would have helped him, and the man's positive response motivated Grenier to put forward a recommendation to develop a support program for those suffering from deployment-related stress disorders. In October 2001, the idea got the official okay from the Department of National Defence, and the Operational Stress Injury Social Support Program (OSISS) was born.

WHAT THE PROGRAM LOOKS LIKE

Peer support is the bedrock of the OSISS, operated on behalf of the Canadian Forces and Veterans Affairs Canada. The program is delivered by 17 peer support co-ordinators (PSCs) scattered across the country, all of whom are paid federal government employees. The co-ordinators have first-hand knowledge of the challenges facing the people they have been hired to help. That's because they themselves have suffered from an operational stress injury (OSI) such as PTSD.

The role of PSCs is to increase the level of social support to serving military personnel and veterans who are showing symptoms of PTSD, depression or anxiety. They do this by providing one-on-one sessions to victims, organizing and conducting peer support groups, selecting and managing volunteers (fellow OSI sufferers who are also available to offer one-on-one support) and conducting outreach sessions. (A year ago, the program was expanded to include five family peer support co-ordinators who do similar work while focusing on the families of OSI victims.)

Grenier, the OSISS program manager within the Department of National Defence, co-manages the program with a colleague at Veterans Affairs in Charlottetown and four staff in Ottawa. The program incorporates a management team that includes a psychiatrist, a psychologist and a social worker. This team ensures only suitable people are hired as peer support co-ordinators and also ensures that Grenier and his team "are within the boundaries of good practice" and have "taken clinical advice into account" before making important program decisions.

The newest addition to the program is a speakers' bureau. It includes selected veterans who have experienced mental health problems who can speak

* Grenier's personal story is adapted from "The Operational Stress Injury Social Support Program," a chapter in an upcoming book *For Those Who Bore the Battle: Combat Stress Injury, Theory, Research and Management* (part of the Routledge Psychosocial Stress Book Series), edited by Charles Figley. The rest of the article is based on an interview with Grenier by Mark Rogers.

with credibility to others within the Canadian Forces. The aim is to change the "hard" attitudes about mental health within the organization.

WHY PEER SUPPORT?

According to Grenier, the need for peer support for people suffering from PTSD and other mental health problems is vital because, sadly, support and compassion for people struggling to overcome mental health problems is in short supply in society at large. While care and compassion towards people who have suffered a physical injury comes naturally, the same cannot be said for people afflicted with mental health problems.

Compounding the problem, Grenier says, is the fact that people suffering from mental health problems often feel some degree of shame and guilt. As a result, they begin to isolate themselves, making their condition worse. "OSISS is trying to nip this in the bud by providing social support to those who are suffering, and by trying to educate management … on how to deal with their employees or people who are suffering from these conditions," he says.

Peer support works for people with PTSD and other mental health disorders in a number of ways, says Grenier. First, the peer has been down the same path and can offer **hope** to the sufferer and the sense of **not being alone**. The peer has "walked the walk," says Grenier, and can say to the sufferer, "Listen, buddy, you'll get over this, trust me. Let's walk down the path of recovery together." The peer does not doubt the sufferer's condition or experiences — and certainly does not consider the victim weak because of them.

Second, peer support works remarkably well at encouraging **treatment compliance**, says Grenier. As he explains, the peer can say to the sufferer who feels like flushing his or her medication down the toilet because the side effects are worse than the initial symptoms: "Believe me, you are making a mistake. I made that mistake, too." Or the peer can tell a sufferer who is reluctant to follow other therapeutic advice from a psychiatrist that the person is "just going to have to suck it up because the doctor is right," says Grenier. "When a peer says it, that is when it strikes home."

Third, peer support provides the sufferer with a **safe contact**, one the person is more likely to call or reach out to in times of trouble because the sufferer knows he or she will not be judged. "People suffering from mental health problems … are extremely sensitive to their surroundings … and when they see someone who gives the slightest lift of the eyes or shrug of the shoulders, they immediately detect judgement," Grenier says. "And this is what you don't get when you employ consumers of mental health. There is no judgement, so it is extremely safe to access support through those mechanisms."

> [I]t was not so easy to make the case that former PTSD sufferers or those who had battled depression would be good candidates for providing peer support ….

Fourth, peers can help sufferers **return to work** because they help reframe their reality and, thus, reduce the anger the sufferer feels towards the organization. Again, Grenier explains. People with mental health problems have often been called on the carpet for performance issues at work, so they are angry at their bosses. Without help, these people are likely to "stay in their basements," where they will "fester" and "get angrier at the corporation," making it less likely that they will ever go back. But a peer helps "reframe" those feelings by saying something like: "You probably would have done the same damn thing as the boss because you wouldn't have known any better. Now, when you go back, do a good job, forget what happened in the past, and your reputation will precede you."

BUILDING IN SAFEGUARDS

While a lot of evidence supports the efficacy of peer support groups run by fellow sufferers (e.g., breast cancer support groups), it was not so easy to make the case that former PTSD sufferers or those who had battled depression would be good candidates for providing peer support, says Grenier. Their inclusion has not come without some struggle, he says, especially from clinicians.

Doctors and psychiatrists were worried about the prospect of peer support workers exacerbating their own mental health problems and perhaps suffering a relapse. They also worried about maintaining the boundaries between clinical practices and social support services. As Grenier says now, "the first thing a doctor or psychiatrist would tell you is you have to be very careful."

So, for over four years, Grenier has worked with clinicians, psychiatrists, psychologists, mental health nurses and social workers to imbed boundaries and self-care mechanisms into the program that ensure the health and clarify the role of peer support workers. "It took four-and-a-half years to build the credibility," he says. This credibility is achieved in a number of ways.

Recruitment: Recruiting the right people to become peer support co-ordinators is a critical first step. The process, somewhat *ad hoc* to begin with, is now formalized. Potential candidates are referred to the OSISS medical advisor, who then talks with the health professional who made the referral to review the job requirements and determine if the candidate is sufficiently recovered.

If so, the medical advisor meets with the candidate to discuss the work. If the candidate is still interested, a formal medical screening is completed and signed by the candidate's treating clinician. The candidate is then vetted by the OSISS medical management team and, if successful, scheduled for an interview in accordance with the *Public Service Employment Act.*

Volunteer peer support workers are not subject to a formal interview process. Instead, they are recruited by PSCs. However, the same medical screening from a treating psychiatrist is still necessary.

Training: For successful candidates, two weeks of training in some of the fundamental aspects of peer support follows. PSCs are trained in a number of areas, including conflict resolution, crisis management, suicide intervention, problem solving, self-care, active listening, group work and volunteer management. They are also brought up to date on the referral resources available within the government and in their communities.

Part of the training that is "extremely important," says Grenier, is teaching PSCs about boundaries, "making sure they don't go out there wanting to save the world" because, if they do, they "will probably crash and burn within a year or two." Peers need to know their own limits in terms of their abilities to help clients. They cannot expect to solve all of their clients' problems.

Peers are also trained to respect boundaries in terms of their role versus that of health practitioners. That is, peers are trained not to "treat" their clients by conducting therapy sessions, for example, but to refer them to the appropriate resource. Instead, peer supports are taught to be empathetic, to provide practical and emotional support, and to act as lay consultants and referral agents.

Finally, peers are taught how to offer positive peer support. "I strongly feel — and the clinicians around OSISS certainly support this — that, left to its own, peer support can be destructive," says Grenier. "If you take five people suffering from depression and you put them around a table with a pot of coffee with no guidance, no leadership, no structure, their discussion might at times be more negative than positive." Therefore, PSCs are taught what positive peer support is and how to achieve it.

[If the] peer support model is "robust" enough to meet the needs of PTSD sufferers within the military, then it is tough enough to help workers with depression and anxiety in more traditional organizations.

Peer support volunteers attend a mandatory three-day training program. It focuses on skills development, with less emphasis on administrative and policy issues.

Self-care mechanisms: In addition to the training, self-care mechanisms are in place to ensure that PSCs do not burn out or put themselves at risk of relapse. Every two weeks, all PSCs take part in a teleconference with a psychologist. These teleconferences focus on the well-being of the PSCs, not on their case work. Finally, all PSCs must remain in therapy with a mental health clinician and follow up their original pre-hiring medical screening with annual assessments.

ASSESSING THE PROGRAM

It is too early to make an objective assessment of the effectiveness of the program, says Grenier. The program is still dealing with the aftermath of a decade of sustained overseas operations in which thousands of soldiers were subjected to significant operational stress. Many are still reluctant to come forward because of fear of stigmatization. Indeed, Grenier coined the term "operational stress injury" to stand in for PTSD and other mental health disorders in order to put such injuries on a par with other physical injuries sustained during operations.

While he may be short on hard numbers, Grenier is not short on accolades. The military gave the program the thumbs up in an interdepartmental review. Released in January 2005, the review says the program "has been successfully implemented and is contributing effectively to meeting the social needs of CF/veterans with operational stress injuries." Veterans who have been helped by the OSISS program have penned more heartfelt endorsements on the OSISS website.

In the meantime, the outside world is also taking note. The United States Marine Corps sent its chief psychiatrist to Canada to look at the program, and a chapter describing the OSISS is to be included in an upcoming book edited by Charles Figley, founding president of the International Society for Traumatic Stress Studies, called *For Those Who Bore the Battle: Combat Stress Injury Theory, Research and Management* (part of the Routledge book series on psychological stress).

Grenier is a passionate advocate for the program. He harbours a dream of expanding the OSISS program within the federal government and the private sector. As he puts it, if his peer support model is "robust" enough to meet the needs of PTSD sufferers within the military, then it is tough enough to help workers with depression and anxiety in more traditional organizations.

For information, contact Lt. Col. Grenier at cfpeersupport@aol.com or visit www.osiss.ca. •

DOCTORS ARE FROM MARS, EMPLOYERS ARE FROM VENUS

By closing the communications gap between the human resources/disability management department and the medical community, you can go a long way toward ensuring the timely and safe return of your employees. **By Jane Sleeth**

Scenario 1: Ms. Jones, the human resources director at a high-tech company in Mississauga, Ont., had just hung up the phone after trying to patiently listen to an employee's physician berate her about the company's decision not to pay for a new asthma drug for the employee, his patient. The same physician decided that raising his voice over the phone to complain about the failure of the company's short-term disability insurance carrier to extend benefits to the employee was an appropriate way to get his point across. Ms. Jones could not believe how rude the physician had been to her and how unwilling he was to listen and try and solve the problem.

Scenario 2: Dr. Smith, a family physician practising in Richmond, B.C., could not understand why a provincial Ministry department, the employer of one of his patients, would not listen to his advice about returning an employee to work. The patient had lost vision in one eye, had undergone heart-valve replacement surgery the year before and was diabetic. The doctor felt frustrated when the employer sent the employee for an independent medical exam, which caused the employee to become angry and more confused about her conditions. The doctor also asked why the employer kept sending him letters and more forms to fill out, despite the fact that he had completed a form just three weeks prior. Dr. Smith wanted to know how he could convey his message to the employer so that he would not feel compelled to "protect" his employee from what he thought was a harassing case manager and supervisor.

Scenario 3: Mr. McMillan, a supervisor at a bank branch in Calgary, Alta., complained that he had a doctor's note in his hand regarding his employee, but he had no idea how to read the note (apart from the handwriting), let alone accommodate the employee's return to work. The employee was a customer service representative who had been away for four weeks due to recurrent depression.

These three real scenarios — all told to me by people asking for my advice — play themselves out on a daily basis in workplaces across Canada. No wonder employers and physicians seem to think the other party comes from another planet! To borrow from a popular book title, the communications between the medical community and employers leaves us thinking that "Doctors are from Mars, Employers are from Venus."

In reviewing these scenarios, it becomes clear that doctors and employers do not speak the same language, resulting in communication gaps and relationship breakdowns between them. This does little to help the main player in all of this — the employee who has an impairment or disability and needs to be accommodated in order to return to the workplace. The question is this: How has this communication breakdown happened and what can human resources (HR) and disability managers do to overcome the gap and break down the divide that exists between physicians and employers?

A large task? Perhaps, but it begins by looking at "the two planets" if you will — that is, by understanding the needs and wants of employers and doctors. This gives rise to some practical steps that you, as the HR or disability management professional, can put into place within your disability management program to allow the medical community to work with you toward the single most important goal: ensuring your employees receive the best medical care so that, as much as possible, they can be returned to a safe, healthy workplace and regain their ability to contribute to the workplace and earn a living.

COMPARING NEEDS AND WANTS

During my consultations with hundreds of employers and physicians across Canada over the last 23 years, I have become well acquainted with the needs and wants of each party. These are listed below. Note that, just because a need or want appears on the list, that does *not* mean it is appropriate for one party to expect or ask it of the other.

Employers want and need:

- to have a clear understanding of an employee's impairment, prognosis, treatment plan and return-to-work timing;
- to get guidance on when to return an employee to work and when to move an employee along in the RTW plan;
- to get guidance on how to return an employee to work and how, exactly, to accommodate the employee;

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- to be told when a condition is not a *bona fide* impairment or disability and when an employee is avoiding work or "playing the system";
- to get information that will help solve a grievance in a unionized environment (i.e., the doctor as gate keeper);
- to have regular and timely communications with health practitioners;
- to get help in determining the work-relatedness (or not) of an injury or illness;
- to maintain a productive and profitable organization;
- to be told when an employee can be let go from the workplace following injury or illness that has resulted in long-term or repeated absences; and
- to be able to ask that an employee be referred to a specialist when a case is politically or medically complex.

Physicians want and need:

- to protect the patient above all else;
- to protect the privacy of the patient;
- to not be gatekeepers for employers, insurance companies or compensation boards;
- to not have to tell an employer exactly how to accommodate a patient or that the employer is doing a bad job of accommodating the patient;
- to see as many patients in a day in order to earn a living and pay office overhead and insurance costs;
- to stop providing doctor's notes to certify an absence of an employee after only one to three days of absence;
- to minimize paperwork associated with insurance, workers' compensation and employer notes and forms;
- to get paid for completing the paperwork required by insurers, workers' compensation boards and employers, and for undertaking other forms of communication with these parties;
- to avoid lawsuits or complaints to the provincial college of physicians; and
- to avoid referring patients to specialists.

To improve your communications with physicians, the needs and wants listed above must be narrowed down to those that are *appropriate* and *prudent* for the employer to ask or expect of the physician and for the physician to expect of you.

As the employer, you have a right to expect the following:

- to have a clear understanding of the employee's impairment, prognosis, treatment plan and return-to-work timing;
- to get guidance on when to return the employee to work;
- to be told when a condition is not a *bona fide* impairment or disability;
- to have physicians and other health practitioners communicate with you using a mutually agreed-upon method, timetable and payment schedule;
- to maintain a productive, profitable and safe organization; and
- to be able to ask that an employee be referred to a specialist when a case is medically complex (e.g., a psychological impairment or multiple medical impairment).

As for physicians, they have a right:

- to protect the patient's rights and health, which includes guiding the employee back to the workplace following injury or illness (because evidence-based medicine indicates that this improves the health and functional outcomes of a patient);
- to protect the privacy of the patient by sharing only appropriate information with the employer and with the employee's signed consent;
- to *not* be gatekeepers for employers, insurance companies or workers' compensation boards;
- to see as many patients in a day to earn a living and pay office costs;
- to stop providing doctor's notes to certify an absence after only one to three days of absence;
- to request that the paperwork from an

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CHECKLIST

Talking to family docs

❑ Ask the right medical professional the right question. Do *not* ask medical specialists or family physicians to comment on functional abilities. This is the specialization of physiotherapists, occupational therapists and psychologists.

❑ Develop forms to be sent to family physicians that only ask generally about an employee's impairment. Ensure the forms request information about prognosis, treatment plans and return-to-work timing based on medical grounds.

❑ Pay family physicians for the time taken to complete forms, to call you back or to undertake any other form of communication with you.

❑ Understand the Canadian Medical Association's and your provincial medical association's position on the role of family physicians in return to work, as well as the position of the Ontario Medical Association on the role of doctors in certifying illnesses; that is, employers should trust their employees and cease requesting these notes during the first few days of absence (see *Back To Work*, January 2005).

❑ Understand the strengths and skills of family physicians. Family physicians are a referral source to specialists when the medical evidence indicates they should make a referral. It is *not* the role of family physicians to "save the system money" by attempting to treat *bona fide* complex conditions in their offices first.

❑ Have a basic understanding of evidence-based medicine and the "gold standards" for care so you are more comfortable when talking to doctors. If this is not realistic, it is a good idea to hire a third-party case management firm to act as the liaison among the employee, employer and the medical community.

❑ Do not ask family physicians how to accommodate an employee within your workplace. Family physicians know little about your workplace or the demands of the work (even if you send a job demands analysis). The workplace parties must determine how to modify a job and accommodate a worker.

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insurance company, workers' compensation board and employer be concise and consistent (ideally, using universal forms from all parties);

- to get paid for completing the paperwork required by insurers, workers' compensation boards and employers, and to get paid for undertaking other forms of communication with these three parties; and
- to refer patients to specialists when a *bona fide* medical/functional condition indicates that the employee should be referred, in particular for patients with musculoskeletal injuries (who should be referred to physiotherapists, occupational therapists and chiropractors) and with moderate to severe levels of psychological illness (who should be referred to psychiatrists and psychologists).

The narrower lists above show that both parties — the HR professional as employer and the family physician — need to more fully understand and alter their needs and wants. In aligning these needs and wants, each party will then be able to understand each other's imperatives and, as a result, know how, when and why to ask the other party for specific information.

Numerous steps can be easily taken within your workplace to ensure that the communications between the employer and physician are improved (see box on page 7). Understanding the wants and needs of the family physician is an important first step in your ability to develop a plan and process that will anticipate these requirements. As long as the bottom line is to ensure an employee's timely, safe and productive return to work, the notion of the two parties coming from different planets will dissipate over time. •

CIRPD sponsors healthy workplace competition

Workplaces that have successfully implemented strategies to improve workplace health, productivity and innovation are being invited to tell their stories — and perhaps win a $500 award in the process. The Canadian Institute for the Relief of Pain and Disability (CIRPD), organizers of the "Business Health—Employee Health" conference taking place in Vancouver July 7-9, are sponsoring a poster competition that will showcase healthy workplace best practices. Case studies are due by April 26, 2006. For information, call (604) 684-4148 or visit www.cirpd.org.

DM course offered as part of IAPA annual conference

Dianne Dyck, a Canadian specialist in the field of disability management and author of *Disability Management, Theory, Strategy and Industry Practice*, is delivering a two-day course on the fundamentals of disability management on April 29-30, 2006, in Toronto. The professional development course, a pre-conference offering from the Industrial Accident Prevention Association, can be used to gain credit towards the first two modules in the Return-to-Work Co-ordinator Program offered through the National Institute of Disability Management and Research. The course has also been recognized for certification maintenance points by the BCRSP, ABIH and CRBOH. The cost is $600. For more information on the course or on the IAPA's annual conference, visit www.iapa.ca/conference.

DMEC annual conference taking place in San Diego

The 11th annual absence and disability management conference from the Disability Management Employers Coalition is taking place this year in San Diego, California, from July 16-19. Titled "Cents and Sensibility: Achieving a Healthy and Profitable Workplace," the conference features sessions within six tracks: workers' compensation, behavioural health, return-to-work and stay-at-work, legislation and legal requirements, integrated disability and absence management, and employer best practices.

For more information, e-mail admin.dir@dmec.org or visit www.dmec.org. •

BACK TO WORK

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