

REPORT OF THE COUNCIL ON SCIENTIFIC AFFAIRS

CSA Report 12-A-04

Subject: Physician Guidelines for Return to Work after Injury or Illness
(Resolution 407, A-02)

Presented by: J. Chris Hawk, III, MD, Chair

Referred to: Reference Committee D
(Jerome C. Cohen, MD, Chair)

1 At the 2002 Annual Meeting, the American College of Occupational and Environmental Medicine
2 (ACOEM) introduced Resolution 407, Physician Guidelines for Return to Work After Injury or
3 Illness. The reference committee recommended and the House of Delegates agreed that Resolution
4 407 be referred to the Board of Trustees for a report back, largely because there was uncertainty over
5 the number of existing guidelines and the ability of our American Medical Association (AMA) to
6 develop guidelines rather than help establish consensus on the subject.

7
8 The referred resolution asks:

9
10 That the American Medical Association Board of Trustees oversee the review of these
11 [i.e., the ACOEM Consensus Opinion, The Attending Physician’s Role in Helping
12 Patients Return to Work After an Illness or Injury] and other return-to-work documents
13 by the Council of Scientific Affairs [CSA] or other appropriate council so as to develop
14 AMA guidelines to assist physicians to appropriately and successfully guide their
15 patients in returning them to work, and report back at the 2002 Interim Meeting.

16
17 An initial report at the 2003 Annual Meeting was referred back to the Council, with a request to
18 consider the significant role physicians can play in returning patients to the workplace.

19
20 Scope of Report and Methods: The CSA believes that the development of a general guideline as
21 called for in the resolution is not possible. As Talmage notes, while physicians are often asked to
22 “describe a patient’s work abilities or work restrictions, ... there is little science available to guide
23 decisions on these questions.”^{1(p698)} Consequently, this report summarizes guidelines and policy
24 statements that were identified in the development of this report and acknowledges the role
25 physicians can play in returning patients to work. Methods used to compile information are described
26 in the body of the report. In addition, the draft report was offered to ACOEM for its review and
27 contribution to the discussion in the section on the “Role of Physicians in Returning Patients to
28 Work” below.

29
30 **AMA AND OTHER FEDERATION MEMBER POLICIES**

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32 Our AMA has limited policy on this issue. Policy H-365.999 (AMA Policy Database), Physician’s
33 Role in Returning Patients to Their Jobs, was cited in the resolution and reads, “Our AMA
34 encourages physicians everywhere to advise their patients to return to work at the earliest date

1 compatible with health and safety.” This expresses a general outlook, and the policy was reaffirmed
2 in the sunset report at the 2000 Annual Meeting.

3 Also relevant, but dealing with a narrower range of issues, is Policy H-30.974, Return to Work
4 Following Successful Rehabilitation for the Disease Alcoholism and Other Chemical Dependencies.
5 It reads, “Our AMA reaffirms the concept that successful treatment of patients with the disease
6 alcoholism, or other chemical dependencies, followed by appropriate medical supervision and
7 monitoring on a continuing basis, will allow most individuals to return to meaningful, productive
8 employment and resume full responsibility of their normal job assignment or profession.”
9

10 As noted in Resolution 407 (A-02), ACOEM has developed a consensus opinion statement entitled
11 The Attending Physician’s Role in Helping Patients Return to Work After an Illness or Injury, the text
12 of which is included as an appendix to this report. The ACOEM statement was issued in April 2002
13 as a Consensus Opinion “to clarify the role of the attending physician in the patient’s return to work.”
14 It provides guidance for physicians regarding the development of a treatment plan, including efforts
15 to facilitate a patient’s return to work, and commonly encountered problems such as maintaining
16 patient confidentiality and assisting with plans for accommodations at work. The statement provides
17 general guidelines for assessing and treating illnesses or injuries that affect one’s ability to work
18 without regard to where or how the illness was contracted or the injury was incurred. As a Consensus
19 Opinion, the ACOEM material derives from committee work and agreement but does not necessarily
20 have the backing of scientific proof or research.
21

22 The ACOEM statement was itself based on a 1997 policy statement from the Canadian Medical
23 Association (CMA) entitled The Physician’s Role in Helping Patients Return to Work After an Illness
24 or Injury (http://www.cma.ca/staticContent/HTML/N0/12/where_we_stand/return_to_work.pdf,
25 accessed April 14, 2004). That statement, which was updated in 2000, says:
26

27 The physician’s role is to diagnose and treat the illness or injury, to advise and support the
28 patient, to provide and communicate appropriate information to the patient and the employer
29 and to work closely with other involved health care professionals to facilitate the patient’s
30 safe and timely return to the most productive employment possible. Carrying out this role ...
31 requires physicians to recognize and support the employee-employer relationship and the
32 primary importance of this relationship in the return to work [and] to have a good
33 understanding of the potential roles of other health care professionals and employment
34 personnel in assisting and promoting the return to work.
35

36 The Canadian statement begins with the premise that “absence from one’s normal roles, including
37 absence from the workplace, is detrimental.... Physicians should therefore encourage a patient’s
38 return to function and work as soon as possible, after an illness or injury....” The document then
39 outlines principles on the role of physicians in the return-to-work plan; notes possible conflicts that
40 can arise in making decisions on return to work, including possible liability issues that stem from
41 decisions; discusses patient confidentiality and the management of medical information; and
42 concludes with comments on billing for return-to-work services. The CMA document is based on
43 earlier work by provincial medical associations in Alberta, Manitoba and Ontario.
44

45 In preparing this report, the CSA collected other statements and invited Federation members to
46 submit relevant statements from their societies; only a handful of statements were received. A
47 MEDLINE search of the literature since January 2000 using the phrase “return to work” and restricted
48 to reviews in English found just over 100 articles, most dealing with particular clinical conditions
49 (e.g., musculoskeletal injuries, chronic pain). None suggested guidelines on the general issue of return
50 to work.

1 Among the documents found was a position statement, Early Return to Work Programs
2 (<http://www.aaos.org/wordhtml/papers/position/1150.htm>, accessed April 14, 2004), which was
3 developed in September 2000 by the American Academy of Orthopaedic Surgeons (AAOS) and the
4 American Association of Orthopaedic Surgeons. While it goes beyond the preceding statements by
5 briefly noting the potential need to deal with chronic pain and encouraging safety and prevention
6 measures such as accident reporting and ergonomic investigations, like the previous statements, it
7 expresses general principles in support of “safe early return to work programs that help injured
8 workers improve their performance, regain functionality, and enhance their quality of life.” The
9 statement also asserts that “studies have demonstrated that prolonged time away from work makes
10 recovery and return to work progressively less likely.” The statement nominally deals with workers
11 who are injured rather than ill, but the guidance provided seems appropriate for patients regardless of
12 the nature of the complaint.

13
14 Information was also provided by the American College of Obstetricians and Gynecologists (ACOG)
15 and the American Society of Addiction Medicine (ASAM). Both deal with a narrower range of issues.
16 The ACOG position is found in its *Guidelines for Perinatal Care, 5th Edition*, published with the
17 American Academy of Pediatrics. It simply advises that most women with an uncomplicated
18 pregnancy “can continue to work until the onset of labor” and that they can plan to return to work
19 “several weeks after an uncomplicated vaginal delivery,” although “the patient’s individual
20 circumstances should be considered when recommending resumption of full activity.” (p. 107)

21
22 Similarly, the ASAM public policy statement focuses on a narrow issue, in this case returning to work
23 after treatment for alcoholism and other drug dependencies. The ASAM statement is available on the
24 Internet (<http://www.asam.org/ppol/Returning%20to%20Work%20People%20Treated%20for%20Alcoholism%20and%20Other%20Drug%20Dependencies.htm>; accessed April 14, 2004) and
25 dates from 1989. The statement notes that a majority of people treated for chemical dependencies
26 “return to full health and productivity,” and consequently, ASAM “strongly recommends that all
27 employers pursue a policy of early identification of alcoholism and other drug dependencies in their
28 employees, with provision for appropriate treatment and return to their career track without
29 prejudice.”

30 31 32 CONSISTENCIES AMONG STATEMENTS

33
34 The three general statements (the AAOS, ACOEM, and CMA documents) are in substantial
35 agreement, making the following points:

- 36
37 • Quick return to work following an illness or injury is the desired outcome, regardless of the
38 source of the illness or injury (i.e., it need not be work-related).
- 39 • The physician’s role is to facilitate the patient’s return to work in as timely and safe a manner
40 as possible, with safety considerations applicable to both the patient and the patient’s
41 coworkers and society generally.
- 42 • The physician should communicate with both the patient and the patient’s employer, sharing
43 information as appropriate while ensuring patient confidentiality.
- 44 • The physician may suggest appropriate accommodations in the workplace and restrictions
45 concerning the patient’s activities.

46
47 These points would be consistent with good medical practice and are in harmony with existing AMA
48 Policy H-365.999.

1 As noted above, the ACOEM statement is a Consensus Opinion, meaning it is based on agreed-upon
2 general principles of sound medical judgment rather than an evidence base for a specific clinical
3 situation. In fact, in its guidance for physicians, the statement suggests that the “medical treatment or
4 care plan should consist of current best medical practices and be evidence-based, when possible.” A
5 recent review identifies nearly 100 factors affecting return-to-work outcomes and notes that the
6 effects of each vary across phases of the process of return to work following illness or injury.² Given
7 the wide range of illnesses or injuries, some of which would be work-related and specific to particular
8 modalities, it would be difficult to assemble something beyond the general principles outlined in the
9 AAOS, ACOEM, and CMA statements. At the same time, as shown by the ACOG and ASAM
10 statements, special issues may arise for particular groups within the general patient population, and
11 this too contributes to the difficulty in formulating guidance beyond the statements cited above.
12

13 In other words, given the limited science, most situations would generally best be considered in the
14 light of particular clinical presentations in which the treating physician using sound medical judgment
15 can practice in accordance with that judgment and the evidence base. To the extent that randomized
16 controlled trials have been used in studying return to work, the CSA is unaware of any that deal with
17 other than particular clinical conditions. The literature includes randomized controlled trials on a
18 range of topics, ranging from back pain to hemorrhoids to upper extremity disorders, but none on the
19 general topic. Variations in workers compensation laws may also affect the provision of care and
20 return to work across this country; for example, commentators³ attribute the unusually low rate of
21 return to work in California to adversarial relationships between workers and employers in contested
22 workers compensation claims even though payments to workers are only average.
23

24 ROLE OF PHYSICIANS IN RETURNING PATIENTS TO WORK

25
26 According to the 2000 census, nearly 50 million people reported some type of long-term disability,
27 including some 33 million people of working age (16-64 years). Among this working age population,
28 21 million, or 11.9% of that age group, reported a condition that affected their ability to work.⁴ The
29 benefits of working and the deleterious effects of not working due to unemployment or medically
30 associated disability (temporary work absence or permanent withdrawal from work) are well known.
31 Considerable research in the fields of vocational rehabilitation, psychology, economics, and sociology
32 indicates that medically associated disability has negative effects beyond physical health, and can
33 have profound impacts on the overall well-being and quality of life for patients.⁵⁻⁷
34

35 For patients whose ability to work is at issue, input from their physician can have substantial
36 influence, direct and indirect, over the outcome. Patients rely on their physicians for guidance about
37 coping with illness and injury. This issue regularly confronts treating clinicians in multiple
38 specialties, and most if not all employers and disability benefits administrators rely on treating
39 physicians as the most logical third-party corroborators of fact and as the source of informed and
40 appropriate data regarding an employee’s ability to work and any need for protective restrictions.
41 Primary care physicians deal with return-to-work issues in nearly 10% of patient visits.⁸ The current
42 medical education system does not routinely teach physicians how to manage patients in a way that
43 explicitly fosters functional recovery or preservation, and stories of malingering or doctor-shopping
44 are well known. Primary care physicians who work to minimize their patients’ disability achieve
45 better health outcomes as well as greater patient satisfaction,⁹ even while employment and financial
46 factors may strongly influence return-to-work outcomes.¹⁰
47

48 In particular, the physician’s role in facilitating early return to work is to directly address risk factors
49 for prolonged disability such as functional disability¹¹⁻¹³; distress, fear or avoidance, maladaptive
50 coping, and negative expectations regarding return to work¹¹⁻¹⁶; anxiety and depression^{11,13,16}; and
51 pain.^{11,13} According to Jennifer Christian, MD, an ACOEM member who provided the CSA with

1 information on return-to-work issues, studies are ongoing to evaluate the effectiveness of
2 comprehensive screening and intervention efforts for patients at high risk of developing prolonged
3 disability (written communication, April 2004).

4
5 **RECOMMENDATIONS**

6
7 The Council on Scientific Affairs recommends that the following statements be adopted in lieu of
8 Resolution 407 (A-02) and that the remainder of this report be filed:

- 9
10 1. That our AMA encourage members of the Federation to undertake the development of
11 evidence-based guidelines on return to work and functional recovery that address the unique
12 elements for their specialties or particular laws and regulations in their geographic areas.
13 **(Directive to Take Action)**
- 14
15 2. That Policy ~~H-30.974~~ H-365.999 be amended by insertion to read as follows, “Our AMA
16 encourages physicians everywhere to advise their patients to return to work at the earliest
17 date compatible with health and safety and recognizes that physicians can, through their care,
18 facilitate patients’ return to work.” **(Modify Current HOD Policy)**
- 19
20 3. That our AMA consider convening a Federation task force to evaluate the role of physicians
21 in facilitating early return to work for patients with medically associated disability, and to
22 provide guidance for physicians in accomplishing this task. **(Directive to Take Action)**

Fiscal Note: \$2,871

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Appendix

The American College of Occupational and Environmental Medicine's statement can be found online at <http://www.acoem.org/guidelines/consensus/> (Accessed April 14, 2004.)

ACOEM Consensus Opinion Statement

April 14, 2002

**The Attending Physician's Role in Helping Patients Return to Work
After an Illness or Injury**

Approved by the ACOEM Board of Directors on April 14, 2002

Introduction

Because prolonged absence from one's normal roles, including absence from the workplace, is detrimental to a person's mental, physical, and social well being, this policy addresses the role of attending physicians in assisting their patients to return to work after an illness or injury. A safe and timely return to work benefits the patient and his or her family by enhancing recovery, reducing disability, and minimizing social and economic disruption. The attending physician's role is to diagnose and treat the illness or injury, to advise and support the patient, to provide and communicate appropriate information to the patient and the employer, and to work closely with other involved health care professionals to facilitate the patient's safe and timely return to the most productive employment possible. Carrying out this role requires physicians to understand the patient's roles in the family and the workplace. It requires physicians to recognize and support the employee-employer relationship and the central importance of this relationship in the return to work. Finally, it requires physicians to have a good understanding of the potential roles of other health care professionals and employment personnel in assisting and promoting the patient's return to work.

Position Statement

The American College of Occupational and Environmental Medicine (ACOEM) recognizes:

that a fundamental purpose of medical care is to restore health, to optimize functional capability, and to minimize the destructive impact of injury or illness on the patient's life;

that prolonged absence from one's normal roles, including absence from the workplace, is detrimental to a person's mental, physical, and social well being;

that a return to all possible functional activities relevant to the patient's life as soon as possible after an injury or illness has many beneficial effects;

that physicians positively affect the likelihood and rapidity of healing by setting clear expectations for recovery with patients.

The specific purpose of this position statement is to clarify the role of the attending physician in the patient's return to work. Physicians should encourage a patient's return to function and work as soon as possible after an illness or injury, provided that return to work does not endanger the patient, his or her coworkers or society, and does not conflict with existing federal, state, or local regulations. A safe and timely return to work benefits the patient and his or her family by enhancing recovery, reducing disability, and minimizing social and economic disruption. Through improvement of health outcomes,

a safe and timely return to work also preserves a skilled and stable workforce for employers and society and reduces demands on health and social services as well as on disability plans.

ACOEM supports cooperation between the employee and his or her employer with the use of medical input, advice, and support from the employee's attending physician and other involved health care professionals. Treating physicians are advised to consult with specialists in occupational and environmental medicine or other available resources when additional expertise is required to assess a situation and/or facilitate timely, effective, and safe return to work.

Guidance for Physicians

Physicians should make sure that the care plan for their patients supports a timely return to work and activities of daily living. The medical treatment or care plan should consist of current best medical practices and be evidence-based, when possible. The treatment plan should identify the best sequence and timing of interventions for the patient. Elapsed time away from normal daily routines including work should be minimized. Unnecessary delays in healthcare service and other obstacles in the care plan should be identified. Identified obstacles should be addressed and discussed, when relevant, by those involved in the patient's return to work, bearing in mind that some delay in return to work may be appropriate if required by employer policy, good business practice, or statutes.

Successful return to work involves primarily the employee and his or her employer with the attending physician providing detailed recommendations for graded work and activity resumption. The employee and the employer generally have an established relationship that is central to the return to work. Ultimately, the employer determines the type of work available and whether a physician's recommendations concerning an employee's return to work can be accommodated. Therefore, in cases of impairment or disability, it may be appropriate to work closely with the workplace supervisor, manager or employer representative as a partner in this process. (Under federal and state law, an employer may have legal obligations under the Americans with Disabilities Act to offer reasonable accommodations to otherwise qualified employees with covered disabilities.)

Employers increasingly recognize the value of changing the workplace to facilitate a safe and timely return to work. The employer's role is to ensure that the workplace culture supports a timely return to meaningful work, for example, by ensuring that flexible work is available and that any restrictions and limitations recommended by the patient's physician are observed. Flexible work can include modifying tasks, schedules and environmental conditions to meet the temporary or permanent needs of the patient. Employees are often unaware of their employer's ability to accommodate special needs. Direct communication by an employee with his or her employer after an illness or injury often increases the employee's perception of his or her ability to work.

With careful planning and appropriate physician input and advice to both the employee and the employer, in most cases an employee may successfully return to work before full recovery. It may be appropriate for the physician to specifically advise the patient that a timely return to appropriate work, whether the patient's normal job or a special one arranged to permit on-the-job recovery, can facilitate the patient's recuperation by assisting in restoring or improving functional capabilities. Return to any type of work assignment requires that the employee's capabilities match or exceed the physical, psychological, and cognitive requirements of the specific work being offered.

Developing return-to-work plans:

Early in the course of treatment, the physician should discuss with the patient expected healing and recovery times as well as the positive role of an early, graduated increase in activity on physical and psychological healing.

The physician should be familiar with the family and community support systems available to the patient. The physician should also be aware of the patient's general responsibilities at home and specific responsibilities at work.

The physician should facilitate the patient's return to work and activity at home by encouraging communication between the patient and his or her employer early in treatment or rehabilitation.

The physician should identify and address potential obstacles to the recovery of function and return to work as soon as possible.

When the physician believes that the patient has recovered sufficiently and can return safely to some form of productive work, the patient/employee should be clearly informed of this judgment and advised that despite continuing symptoms, resuming normal activities is an important part of the rehabilitation process.

The physician should counsel the patient and the employer about protective and preventive strategies to use at work, when appropriate.

Restrictions and Limitations:

When requested by the employer, the physician, with the patient's consent (see Respecting Patient Confidentiality and Managing Medical Information), should be as specific as possible in describing the patient's current work capabilities and any work accommodation required. The physician, with the input of the employee and employer as appropriate, may often be in the best position to envision the risks to the patient, his or her coworkers, or the public that could arise from the patient's medical condition or therapy. If the medical condition of the patient and the nature of the work performed are very likely to endanger the safety of others significantly, the physician must put the public interest before that of the patient. Physicians must specifically consider regulatory requirements regarding fitness for duty for workers who are exposed to hazardous working environments or whose duties affect public safety, such as pilots, commercial drivers, police, firefighters, and nuclear power plant workers.

The employer and employee have a responsibility to provide the physician with enough employment-related information to enable him or her to give appropriate medical advice and support. It is the employer's responsibility to provide the physician with a written job description, identifying the job risks and available work modifications, upon request. The employer has the responsibility to maintain a safe workplace and should respect medically- appropriate limitations and restrictions imposed by a treating physician or seek advice from a qualified expert before modifying them.

The physician should consider and make recommendations related to the following:

Physical and functional limitations or restrictions: The employee's functional capabilities and vulnerabilities should be considered and matched against the demands of the job and working conditions.

Limitations: Any existing constraints in the employee's physical or mental capability to perform tasks. A mild increase in symptoms with increased activity is appropriately viewed

as a non-medical issue. Patient self-report may not always be a reliable method of making this determination. Self-imposed limitations may be based on subjective perception or secondary gain. The physician is advised to rely on objectively determinable findings to the maximum extent possible.

Specific restrictions: Any protective measures required to prevent injury or foster recovery. These should be specific e.g. the exact weight and height for lifting restrictions; the amount of time per hour and per shift an activity can take place; postures to be avoided. Duration of restrictions should coincide with the expected increase in endurance associated with the increased activity of a graduated return to work.

Social or environmental limitations or restrictions.

Schedule modifications: Should be noted when return to a normal schedule is medically appropriate.

Medical aids, adaptive equipment, or personal protective equipment.

Whenever possible, the physician should state whether these recommendations are permanent or temporary and give an estimate of recovery time. Also, the physician should give the date when the patient's progress and his or her work restrictions will be reassessed.

When a difference of opinion exists between the employer's and the employee's views of the situation, it is appropriate for the attending physician first to attempt to educate the employee, the union and/or the employer with the permission of the patient; or request where available assistance from an occupational physician. If these services are unavailable, the attending physician may recommend or facilitate a resolution of the conflict. ACOEM recommends that conflict-resolution processes be put in place to address all participants' concerns. Processes like binding arbitration, for example, are frequently already in place as part of the employer's human resources policies and contracts.

Respecting Patient Confidentiality and Managing Medical Information:

Medical records are confidential. In general, physicians should not give information to anyone concerning the condition of a patient or any service rendered to a patient without the patient's consent. However, there are some exceptions to this rule. For example, in most cases, state law provides for at least a partial waiver of the right to medical confidentiality for workers' compensation claimants. Physicians should be aware of the legal requirements in their state and be aware that physicians are still under the Health Insurance Portability and Accountability Act (HIPPA) for other areas that are not covered by the partial waiver.

Consistent with the general rule concerning a physician's duty to keep patient information confidential, the physician should not provide medical information about the patient to the patient's employer without the patient's authorization. For instance, if an employer requests information about the patient's medical condition or treatment, prior patient consent should be obtained. Consent should be specific rather than general. Written authorization for such disclosure is desirable. However, communication with the employer about the ability to work and perform specific tasks is not medically confidential.

The physician must distinguish between medical information needed to facilitate eligibility for benefits and that required to facilitate return to work. A physician's report should be tailored to the intended audience. For example, a report directed to an employer should contain only information

that the employer needs to know to assist the employee in his or her safe return to work (for example, restrictions and limitations) or manage a workplace safety program (for example, description of circumstances or mechanism of injury). In contrast, a report directed to an insurance claims administrator should also contain all diagnostic and treatment information reasonably necessary to adjudicate the claim, if the physician has obtained a complete release.

The American Medical Association's Code of Ethics states that physicians must respect the patient's right to confidentiality except when this right conflicts with the physician's responsibility to the law, or when the maintenance of confidentiality would result in a substantial risk of substantial harm to others or a direct threat of harm to the patient; and in such cases, must take all reasonable steps to inform the patient that confidentiality will be breached. The AMA holds that legislation should be enacted in all jurisdictions to protect physicians from liability associated with such decisions.

The patient has the right to examine and obtain a copy of his/her medical records. The patient should receive a copy of all return-to-work documentation that is prepared by his or her attending physician. Patient access to records may be denied only if the physician reasonably believes that the patient or others will suffer substantial physical, mental or emotional harm because of information contained in the records. A physician should be aware that, if access is denied and the patient challenges the physician's decision, the onus is on the physician to justify denial of access.

Billing for Return-to-Work Services:

Physician time spent on such return-to-work activities as telephone calls, correspondence, and forms has value to patients, employers and benefits administrators. While filling out forms and writing excuse notes for patients have been generally considered a professional courtesy and part of the medical visit, these activities take time as well as professional knowledge and judgment on the part of the physician. Therefore it is appropriate for physicians to be reimbursed for time spent on these services. In particular, it may be appropriate for physicians to charge separate fees (unless prohibited by law or contract) when they are asked to review pages of materials supplied by an employer or claims payer, to answer detailed questions, to fill out disability-related forms, or to write letters or special reports regarding return to work.

Conclusion

ACOEM believes that physicians who follow the principles outlined in this policy will improve the outcomes of their care for their patients and their families, their communities, employers and society.

This statement has been adapted from a policy adopted by the Canadian Medical Association in March 1997. The current version was proposed by the Work Fitness and Disability Section of the American College of Occupational and Environmental Medicine (ACOEM), adopted by the ACOEM Board of Directors in April 2002, and submitted to the American Medical Association.