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The time required to return to work is a topic that is broader than the concerns of breast cancer victims. It includes all reasons for medical absence from the job and all causes of variations in the time required to return to work.

Except in cases of fraud and long-term disability, employees care about returning to work because they wish to restore regular earnings and benefits, reestablish themselves in their normal work routines, and generate feelings of well-being and normalcy. Employers care because medical leave is expensive and the sooner a person returns to work the less it costs and the faster trained productivity is restored. Policy-makers care because they want to lower the costs and improve the performance of all aspects of the medical delivery system.

Complex Interactions with the Work Environment

The policy concern is made more important and complex by the widening influence of health maintenance organizations (HMOs), by the trend toward shortened hospital stays, and because the private sector is providing less comprehensive employee health insurance in this age of expanding service sector jobs and greater use of part-time, contract, and "rent-an-employee" schemes.[1]

Satariano and DeLorenze demonstrate that return to work behavior following a medical intervention is complex and very hard to predict. Their work also makes the point that progress in understanding this complex behavior will be made one study at a time.

Their research is important because it is another brick in the wall of knowledge and provides guidance for employee assistance programs and others concerned with timely return to work.

Employers want trained, experienced, and productive employees on the job. Knowing who might or might not be off the job or require extra support to return to work should lead to better utilization of employee assistance services, rehabilitation services, and other possible interventions. Similarly, this knowledge should assist public service, rehabilitation, and medical services providers in identifying persons for whom their interventions are most helpful.

The fact that race was used as the major distinction between the two groups of women returning to work after breast cancer is of questionable value for employers and policy makers. An employer could not implement a program to support absent employees or assist them in return to work based on race. Policy makers could not write intervention prescriptions based on race alone.

While there is a statistically significant difference between the numbers of black and white women on medical leave three months after diagnosis, race is neither the cause, nor the predictor. What is important is to uncover the true predictors of slower return to work and the root causes of the slower return to work.

In the November/December 1995 issue of *Public Health Reports,* Kaufman and Cooper noted:

> Although it is universally applied as a stratification variable, race has absolutely no scientific meaning... While accepting that news travels slowly across the interface of academic disciplines, it is worth noting that among the various fields that study human populations, only medicine and epidemiology stubbornly adhere to a biological interpretation of race.
>
> Our beliefs about race and its relationship to health and disease are influenced by the particular methodology of innate racial differences that has evolved within our society.[2]

Any prescription written from the Satariano and DeLorenze analysis must be based on the identification of the factors other than race that determine length of stay off the job after breast cancer. These are the important findings for improving quality of life and speeding return to work because the difference observed and attributed to race, as the authors suggest, might be due to the type of work done by the white and black women in the study, the physical demands of their jobs, their need for assistance with transportation, the attractiveness of their jobs or some combination of these factors.

Case managers, employee assistance personnel, and others working with persons who are off the job can use data related to the required functional demands of a job and related disablement. They cannot predicate their interventions on skin color. Researchers can measure the

upper-body demands of a specific job and survey the need for and ability to use specific forms of transportation as early indicators of the need for specific help to return to work in a timely fashion.

The *Boston Globe* recently reported that there was a 40% drop in workers' compensation claims between 1991 and 1995 in Massachusetts.[3] It went on to report that this resulted in a $500 million savings for Massachusetts employers. The savings were attributed to: (*a*) stiffer fines and imprisonment for fraud; (*b*) stricter medical guidelines; and, (*c*) elimination of the backlog of claims. It is important to note that none of the savings were related to the timing of return to work, job redesign, or reassignment to another type of work. It is also important to note that none of the decline was attributable to changes in the type of provider—from an indemnity plan to an HMO, for example. Workers' compensation programs would do well to pay attention to this and similar studies because they paid some $34 billion in benefits six years ago, in 1989.

A history of absenteeism is a useful predictor that employers can use to trigger closer surveillance and offers of support and assistance.

Studies have shown that length of stay off the job is correlated with prior attendance record and severity of injury or medical condition, appropriate and inappropriate physician recommendations, and quality of work site as well as a number of other factors. Each of these factors is worthy of further research.

The factor of prior work history, especially a history of absenteeism has been found to be correlated with a longer stay off the job following an injury or medical intervention. While not a causal factor, a history of absenteeism is a useful predictor that employers can use to trigger closer surveillance and offers of support and assistance.

Similarly, severity of injury or disease is a predictor of timing of return to work.[4] In these cases the employer or the employer's agent needs to make early contact and maintain a close relationship with the employee. Since the feeling of disability is subjective and the real need may be to make accommodations, it is imperative that the employer know the factors influencing return to work and remain in contact with the absent employee.

A factor, mentioned in this study, about which we know very little is physician practice and its relationship to return to work. We know that different physicians have different practice habits. We know that some are more efficient than others and some have better outcomes than others. Employers and epidemiologists should track differences in physician practice and relate it to the time necessary for return to work.

Finally it is clear that working conditions play a role in the length of stay off the job. It has even been determined, for example, that extraordinary absences from a specific work site can be an indication of poor supervision. People simply do not like to go to work when the work environment is not to their liking.

All of these and other factors need to be studied further to get to the multiple causes of the periods of time needed to return to work from a wide variety of conditions. Well-run companies followup early and often with employees who are off the job for medical reasons.

Satariano and DeLorenze have added to this body of knowledge in a positive way. The need now is for further research and discovery of a means to communicate these insights to employers, policy makers, and employees.

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