NEGOTIATING SUCCESSFUL RETURN TO WORK:
PERSPECTIVES OF NURSES WITH BACK PAIN

by

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Absences from work due to back injury and pain result in high social and economic costs. Back injuries are particularly prevalent in the nursing profession, yet some nurses return to work in spite of back pain. Interviews with ten nurses who returned to work with back pain were interpreted through symbolic interactionism and analyzed with respect to the Person, Environment, Occupation model (Law et al., 1996). Occupational re-integration was theorized to be a transaction between the Person (the successful shift in the nursing identity), Environment (negotiation of support from co-workers), and Occupation (ability to negotiate a graded workload). The results of the study suggest insights for rehabilitation therapists, nurse unit managers, and occupational health and safety practitioners assisting injured workers with their return to work. Recommendations to institutions employing nurses are made for the purpose of preventing primary and secondary work-related back injuries.
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CHAPTER 1

Introduction

Work and Health

Participation in work activities is an important determinant of mental health and socio-economic well being (Law, Steinwender, & Leclair, 1998). The physical and psychological constituents of work may negatively or positively influence health (Lynch, Krasue, Kaplan, & Salonen, 1997; Marmot, 1999). For example, Priebe, Warner, Hubschmid, and Eckle (1998) found that the opportunity to work decreased psychopathology and increased self-reported well being in individuals with schizophrenia. Albrecht and Devlieger’s (1999) interviews with 153 persons with disabilities demonstrated that high quality of life is dependent upon maintaining and successful functioning within social and work contexts. Jorn, Johnsson, and Toksvig-Larsen (1999) found that overall, patient satisfaction following knee arthroplasty was greater among patients who returned to work, suggesting that work was a valued goal following surgery. Given the importance of work to general health well being, return to work is an integral goal of the rehabilitation process (Peters, 1990; Johanning, 2000).

This study examines the process of return to work from the perspective of nurses with back pain. Back pain and subsequent disability have grown to somewhat epidemic proportions in North America. “Disability due to low back pain predominates in Western, industrialized cultures. Under age 45, back pain is the most common disability in the industrial world, and it is the most expensive health care problem between the ages of 20 and 50” (Weinstien in Hays, George, & Stolov, 1994, p. 161). It is estimated that 60% to 90%
of people are affected by back pain at some point in their lives, with first episodes of back pain occurring most frequently between the ages of 20 and 40 (Kelsey & Golden, 1988). In Canada, the prevalence of back pain is 2% (Waddell, 1992).

Eighty percent of all expenditures (treatment, assessment, and compensation) for low back pain involves only 10% of the individuals reporting back pain (Waddell, 1992). The overall cost of back pain care in the United States may be in the range of $40-100 billion annually (Gatchel, Polatin, & Mayer; Frymoyer & Cats-Baril in Reid, Haugh, Hazard, & Tripathi, 1997), and it is the second most frequent cause of medical consultation (Andersoon in Dionne & Turcotte, 1992). The incidence of back pain in Canada is similar to that found in the USA and Sweden (Spitzer in Dionne & Turcotte, 1992). Human costs, in terms of physical and psychological pain, decreased self-esteem, and role loss are inestimable (Peters, 1990). Timely return to work is thus of vital importance to the health of individuals with back pain.

The nursing profession has one of the highest rates of back pain of all industries. The rate of back injuries in hospitals among nursing personnel exceeds the national average for all workplaces (Helmlinger, 1997). According to U.S. Health and Safety Commission, nurses experience more back injuries than miners and builders (Health and Safety Commission, 1991). Statistics reveal that the rate of injury among nurses has escalated to an all time high of 17.8 cases per 100 full-time workers, and the vast majority of these cases involve back injuries (Owen, 1999). In light of the prevalence of back pain in the nursing profession, this study is of practical relevance due to the disability and costs associated with back pain. This study uses qualitative research methods as qualitative methodology is promoted to better understand the multifaceted dimensions involved in returning to work.
with back pain (Frank, Pulcins, Kerr, Shannon, and Stansfield, 1995; Hignett, 1996; Mergler, 1999). Using grounded theory, a tradition of qualitative methodology, this study will examine the experiences of 10 nurses with back pain who have successfully returned to work.

A review of the literature on return to work was conducted using Medline and CINAHL databases revealed various conceptualizations of influences that affect return to work. This review of the return to work literature provides a summary of the current scientific understanding of return to work. Returning to work with back pain and the prevalence of back pain in the nursing profession are discussed in the context of the research question—What is involved in the process of return to work for nurses with back pain?

The search for and analysis of literature on return to work was guided by the Person, Environment, Occupation model (Law et al., 1996). The encompassing nature of this model takes into account individual, contextual, and work-related components when considering any functional and behavioral performance. It is a useful construct, therefore, serves to organize the vast amounts of literature that have addressed issues involved in returning to work.

**Person-Environment-Occupation**

The Person-Environment-Occupation (PEO) model (Law et al., 1996) provides a framework for understanding the influences provided of the individual, the contextual environment, and the tasks of work on occupational performance. In this model, occupational performance is defined as “the dynamic experience of a person engaged in purposeful activities and tasks within an environment” (Law et al., 1996, p. 16). While not
explicitly stated within the model. work may be regarded as a sub-component of occupational performance. According to Law et al. (1996) occupational performance is maximized when there is an optimal overlap or fit between the aspirations and skills of the individual, the requirements of the occupation, and the environmental context within which the occupation takes place. Although the model does not provide a definition of 'optimal fit', nor does it specify the degree of confluence between the three components needed to maximize occupational performance, the PEO model does offer an illustrative schematic of the concept of occupational performance (Figure 1, below). According to the PEO model, personal, environmental, and occupational influences on occupational performance are defined as follows (Law et al., 1996, p.15-16):

**Personal Component**- The person is described in a holistic fashion that encompasses mind, body, and spiritual qualities. The actions of a person are influenced by cultural and life experiences. Self-concept, personality style, and skills, both innate and learned, likewise influence occupational performance.

**Environmental Component**- The environment is comprised of cultural, socio-economic, institutional, physical, and social elements.

**Occupational Component**- Occupation is composed of activities and tasks that an individual may engage in over a life span. "Occupations are defined as those clusters of activities and tasks in which the person engages in order to meet his/her intrinsic needs for self-maintenance, expression, and fulfillment" (Law et al., p. 16).

**Occupational Performance**- Occupational performance is described as the transaction between the person, environment, and occupation. Occupational performance may be measured objectively by observation or subjectively by self-report.
Figure 1. PEO Model.

Occupational performance is compromised, illustrated by a decreased area of OP, when an illness or disease process affects the confluence between the three components (Figure 2).

Figure 2. Compromised occupational performance as a result of a back injury.
If an individual experiences a back injury, physically she/he may not be able to perform the activities and tasks of an occupation in a work or home environment.

A strength of the PEO model is its capacity to encompass a diverse range of factors that might influence an individual's capacity to return to work. The review of the literature pertaining to return to work has therefore been structured with respect to the individual, the environment, and the occupation.

**Individual factors that affect return to work.**

Of the many individual factors that could influence an individual’s capacity return to work, several studies have identified that demographic and psychological variables are most salient. In particular, physical condition, age and gender appear to strongly affect the capacity to return to work (Torgen, Punnett, Alfredsson, & Kilbom, 1999; MacKenzie et al., 1998). Hess, Ripley, Mckinley, and Tewksbury (2000) found that they were able to predict return to work following a spinal cord injury with nearly 80% accuracy based on individuals’ age, sex, marital status, ethnicity and education. Similar studies of the capacity of individuals to return to work with diabetes (Mayfield, Deb, & Whitecotton, 1999), back pain (Lee, Chow, Lieh-Kak, Wong, & Chan, 1989; Feuerstien, Berkowitz, & Huang, 1999; Vendrig, 1999; Adams, Mannion, & Dolan, 1999) and musculoskeletal soft tissue injuries (Crook, Moldofsky, Shannon, 1998; Crook & Moldofsky, 1998) support the importance of demographic factors. However, there are inconsistencies in the literature concerning which factors are most important. These inconsistencies likely result when authors focus on demographic factors to explain return to work to the exclusion of environmental and occupational factors. For example, in the literature on soft tissue injury Hudak, Cole, and Frank (1998) note that part of the poor prognostic consistency across studies is attributable to
"...extraordinary social contextualization of return to work/recovery following a soft tissue injury" (p.33). Thus, while the reviewed studies may illuminate the concept of return to work, they demonstrate only a part of the whole in the process to return to work. Magrega, Spencer, and McDaniel (1993) assessed the predictive value of 13 demographic variables on 51,944 injured workers. These researchers found that it was not possible to develop a model predicting return to work based solely on demographic variables without taking into account other factors such as environmental influences and the workers' perceptions.

Some studies regarding return to work are highly specific to particular diagnoses, in that ability to return to work is directly related to the nature of the illness (Van der Naalt, Van Zomeren, Sluiter, & Minderhoud, 1999; Katz et al., 1998; Wolfe & Hawley, 1998). The limitations experienced by individuals in their attempts to return to work within these studies are not easily extrapolated to individuals with other diagnoses.

In terms of psychological influences, the emotional state of injured individuals has also been found to affect work re-integration. Burton, Polatin, and Gatchel (1997) demonstrated that anxiety, depression, and substance abuse, which are common among individuals with chronic pain, have negatively affected return to work. In their study, psychiatric examination of 330 patients referred for treatment of low back pain revealed that 136 of those patients were found to have evidence of psychiatric disease. Studies by Cats-Baril and Frymoyer in Weiser and Cedraschi (1992), and Dorceel and DuBois (1999) support evidence of psychiatric dysfunction along with primary diagnoses of physical pathologies in individuals who experience difficulty returning to work. The difficulty of attributing the problems experienced by individuals attempting to return to work with physical pathology to psychiatric and emotional factors is determining the extent to which pain contributes to
emotional and psychological conditions. It may be that physical distress contributes to mental distress and not vice versa. Certainly both, in interaction, must be accounted for in the study of return to work.

Pain, fear of pain and self-efficacy are individual factors, but they are developed and therefore must be considered within broader social and cultural contexts. Pain associated with injury or pathology can limit function and reduce the ability to return to work (Sullivan, Stanish, Waite, Sullivan, & Tripp, 1998). The Gate Control theory, which accounts for the influence of psychological and social factors as modulators of pain (Melzack & Wall, 1996), is the predominant theory used to describe and understand pain. In this theory the central nervous system acts as a “gate”. The individual does not respond to pain reflexively; rather the individual is in control of one’s reactions to the noxious stimuli. One’s reaction to sensory input, including pain, is influenced by cultural factors, past personal experience, attention, anxiety, and expectations (Melzack & Wall, 1996, p.289). Melzack and Wall provide a descriptive example to demonstrate that pain is modulated by cognitive processes: “if we pick up a hot cup of tea in an expensive cup we are not likely to simply drop the cup, but jerkily put it back on the table, and then nurse our hand” (Melzack & Wall, 1996, p. 193).

Pain is often discussed on a temporal scale and divided into acute and chronic dimensions. “Acute pain is characterized by a well-defined temporal pattern of pain onset, accompanied by signs of hyperactivity in the autonomic nervous system, such as sweating and vasoconstriction, and is usually responsive to analgesic therapy (Hawthorn & Redmond, 1998, p.41). Chronic pain has been defined variously, as pain that lasts more than 6 weeks, to pain that lasts longer than 6 months (Bates 1996; Hawthorn & Redmond, 1998; Horn &
Specifically in relation to back pain, chronic pain is associated with psychological and social sequelae that may affect the person's ability to resume normal and work function (Bates 1996; Hays, Kraft, & Stolov, 1995; Hawthorn & Redmond, 1998; Horn & Munafo, 1997). In addition to the actual experience of pain and its meaning for individuals, the fear of increased pain that may result from participating in work tasks may further limit return to work. The Fear-Avoidance Model (FAM) proposed by Letham, Slade, Troup and Bentley (1983) demonstrates how 'pain experience' and 'pain behavior' become separated from the 'pain sensation' in some individuals. According to this model, a person confronted with pain may react in one of two ways: avoid the pain and the activities that are associated with it, or confront and work through the pain. Pain avoidance is associated with past stressful life, personal pain history, personal coping and response strategies, and characteristic behavior patterns that are influenced by personality traits. The Fear Avoidance Model has been used extensively for understanding decreased function in a population of individuals with back pain (Rose, Lenerman, Atchison, & Slade, 1992). The fear of pain would appear to be an important factor when considering individuals’ capacity to return to work.

Similarly, in a study of 87 individuals who experienced pain resulting from a work-related injury, Williams and Thorn (1989) examined the beliefs about pain in relation to work productivity. Their results suggest that believing that pain will be enduring is positively related to increased reports of pain intensity, and negative perceptions of self and one’s abilities. These findings have been further supported in studies conducted by Sandstrom and Esbjornsson (1986), Vendrig, (1999), and Lackner and Carosella (1999).
Efficacy and belief in one’s abilities greatly influence behavior. Bandura (1977) offers a theoretical framework to explain initiation and persistence of human action. Specifically, Bandura postulates that efficacy expectations influence choice of activities and effort expended on those activities. According to Bandura, efficacy expectations arise from four major sources: past performance accomplishments, vicarious experience, verbal persuasion, and physiological states such as emotional arousal. Bandura argues that in order to analyze the concept of self-efficacy and its consequent influence on behavior, the assessor must attend to the magnitude, generality, and strength of efficacy expectations. Bandura concludes that self-expectancy may account for the behavioral variations individuals exhibit following similar therapeutic treatments. In this study, self-efficacy will be considered in the process of return to work in terms of how individuals’ beliefs about themselves and their abilities influence successful resumption of work activities.

The Model of Human Occupation, proposed by Kielhofner (1995) conceptualizes important individual factors that can influence return to work within socio-cultural and economic environments. The focus of the Model of Human Occupation (MOHO) is “on the motivation for occupation, the patterning of occupational behavior into routines and lifestyles, the nature of skilled performance and the influence of the environment on occupational behavior” (Kielhofner, 1995, p.2.). Human occupation is defined as “doing culturally meaningful work, play, or daily living tasks in the stream of time and in the context of one’s physical and social world” (Kielhofner, p.3). Kielhofner proposes that the individual is an “open system”. That is, the individual is composed of elements that interact together to make a complex whole. In addition, the environment (both physical and social) acts on the individual to influence behavioral action.
The human system is made up of complex elements (subsystems) through which behavior and occupation is patterned and performed. The three subsystems are:

1. **Volitional subsystem** - "A system of dispositions and self knowledge that predisposes and enables persons to anticipate, choose, experience, and interpret occupational behavior" (p. 30).

2. **Habitual subsystem** - Habituation refers to patterns of behavior that modulate a person's lifestyle. It is composed of two elements: roles (identities which are based on repeated actions/behaviors e.g. mother or worker) and habits (acts to regulate routines).

3. **Performance Capacity** - The performance components refer to the mind-body performance subsystem. These are an organization of physical and mental constituents that together make up the capacity to carry out occupational performance. (Kielhofner, 1996).

The MOHO represents a useful model for understanding individual factors involved in the return to work process. In this model, the multidimensional elements of values, habits, and physical and mental abilities reflect the personal motivation and abilities to return to work. A disturbance in one or all three subsystems is likely to impact return to work.

The review of the literature with respect to individual factors that affect return to work demonstrates that personal factors will indeed influence work re-integration. However, caution must be taken to not rely solely on individual factors in mediating the return to work process. A more holistic approach warrants an analysis of the environmental and occupational influences on return to work.

**Environmental Factors that Affect Return to Work.**

Environmental factors which have been suggested to affect return to work include social, cultural, political, and economic influences. Social and cultural environments refer to family of origin, the role of spouses, and the larger cultural influences that impact on health and work beliefs. Block, Kremer, and Gaylor (1980) examined the influence of spouse
behavior on pain complaints of individuals with pain. Twenty-two couples, of which one partner had chronic pain, participated in the study. The individual with chronic pain was asked to respond to two questions, which were audio taped: “how responsive is your partner to your pain” and “how much pain do you feel now?” Study respondents were required to answer these two questions under one of two conditions: 1. observed (behind a one-way mirror) by the their spouse or 2. observed by another health professional that the respondent did not know. Study results indicate that if the respondent perceived their spouse to be solicitous to their pain, they rated their current pain as higher when observed by the spouse than a non-related health care professional. When the respondents identified that their spouse did not empathize with their pain they reported their current pain rating to be higher when observed by a health care professional than when observed by the spouse. This study suggests that attention to pain by others contributes to increased pain complaints and reported pain intensity. The reaction of family members may therefore influence and perpetuate pain behaviors. Rael et al. (1995) also examined the effects of emotional support on occupational behavior. In their study examining return to work patterns of British 10,308 civil servants, these researchers found that high levels of emotional support were associated with more frequent absences from work, but lack of emotional support also jeopardized health and increased sickness absences.

The role of the family of origin in the development and support of illness behaviors must also be acknowledged. Fordyce (1991) argues that individuals with a long-standing disability are more likely to have had a family member with a long history of illness, since the norms of tolerance and acceptable sick role behavior established in that milieu may perpetuate the sick role of the injured individual. According to Fordyce, individuals in pain
assume verbal and non-verbal behaviors to demonstrate incapacity due to illness or injury thus pain behaviors are more likely to occur when the injury is invisible and when justification of pain may be required. Tarasuk and Eakin (1995) and Reid, Ewan, and Lowy (1991) have likewise argued that disability may result from the need to legitimize pain to others. Consequently, emphasis must be placed on the individuals’ learned and conditioned responses to pain as these responses may interfere more with return to work than the pain itself.

Critics of this behavioral model argue that it neglects cognitive responses (perception, health beliefs, and locus of control), as they may influence chronic pain behaviors. However, proponents of the behavioral model would point out that one’s perception, health beliefs, and locus of control are learned on the basis of social and cultural interactions and are time dependent.

Culture likewise affects health beliefs, which may in turn influence return to work. Kirmayer and Young (1998) found in their study involving 2246 multicultural residents in Canada, that somatization is common in all ethnocultural groups and serves psychological and social functions. Shorter (1997) argues that physical symptoms are affected by culture and society as much as by personality and physiology, since functional symptoms can change from time to time and place to place, depending on patients’ larger ideas of what represents legitimate illness. Likewise, patients’ interpretation of their symptoms can change as well, depending on the kind of behaviors that the wider culture expects of men and women. Shorter (1997) cites a Canadian study (King & Coles, 1992) in which children of various ages and nationalities were asked whether they had various symptoms of pain. The authors of the study found that the experience of physical symptoms varied among age groups,
countries, and gender. While complaints about physical symptoms may be culturally learned and reinforced, an interesting finding in that study, one that contradicts the notion that health beliefs are time and place specific, concerns back pain. King and Coles found that back pain complaints, regardless of the cultural background, began, as early as age 11 with no gender differences. By age 15 the gender difference in back pain is much less than for any other complaint. These findings indicate that back pain is a legitimate male and female complaint that is reinforced by cultural and societal environments regardless of nationality (King & Coles, 1992).

In summary, social, cultural, and familial ties evidently play powerful roles in the acceptance, maintenance, and eradication of pain behaviors and disability. Undoubtedly, these influences also affect individuals with back pain in their process to return to work. The influence of the family, as well as cultural and social norms on a person’s ability to cope with pain and thus resume work activity, are therefore of great significance to this study.

Political and economic environments may be considered at macro and micro levels with respect to work time lost to back pain. Brooker, Frank, and Tarasuk (1997) found that workers’ compensation claims for back pain increased during boom economic cycles and decreased during recession cycles. The influence of compensation on return to work has also been investigated at a micro level. In their comprehensive review of workers’ compensation systems, Plumb and Cowell (1998) found that as benefit levels increase, so do the frequency and duration of claims:

Increases in benefit levels reduce the amount of income workers forego by being absent from work, thus creating incentives for workers to take fewer safety precautions, remain away from the job on disability for long times, reduce the probability of return to work following the accident, and report claims that they might not have had were the benefits less generous. At the same time, increases in benefits increase employer costs and the financial consequence of workplace accidents, thus
creating incentives for employers to increase safety measures and to work to reduce the frequency, duration, and possibility the reporting of workplace accidents. In effect, workers and employers tend to work in opposite directions when benefit levels increase” (Plumb and Cowell, 1998, p. 259).

Similarly, Atlas et al. (2000), in their study of 326 patients with back related pathology, concluded that patients on workers’ compensation were less likely to report relief symptoms and improvement in quality of life than patients who had not been receiving compensation. In their study of the effect of economic and social support on work disability in 75 individuals, Ciccone, Just, and Bandilla (1999) concluded that work disability and depression were associated with economic and social rewards. Thus, there is substantial evidence to support that current compensation policies may have a negative affect on timely return to work.

**Occupational Factors that Affect Return to Work.**

This section will describe physical as well as psychological work demands with respect to return to work. Both the psychosocial and physical aspects of work contribute to workers’ health (Karasak & Theorell, 1990). Ahlber-Hulten, Theorell, and Sigalla (1995) found that increased job strain, and poor relationships with and support from co-workers increased the incidence of back, upper extremity and neck pain a population of 90 registered nurses. Similarly, in their study 10-year retrospective study of 902 blue and white collar employees, Leino, Hanninen, and LicSocSci (1995) found that work related psychosocial factors were most strongly related to the occurrence of musculoskeletal disorders. However, the measurement of psychosocial strain can not be reliably evaluated even by “expert” assessors, since its cognitive and emotional evaluation is specific to the subjective experience of the individual (Ostry et al., 1999).
Physical work demands likewise affect return to work. Dasinger, Krause, Deegan, Brand, and Rudolph (2000) found that the duration of work disability is influenced by the amount of time a worker is required to bend, lift, and push and pull heavy objects at work. The combination of psychosocial and physical work factors is important for understanding return to and absence from work. For example, Woo, Yap, Oh, and Long (1999) found that both psychological and physical stresses affected absence from and return to work. In their study, psychosocial stresses in the work environment were related to self-evaluated illnesses and absences from work. In contrast, physical work stresses were related to medically prescribed leaves of absence. The combined role of physical and psychological demands has been emphasized in studies by Burdoff, Rossignol, Fathallah, Snook, and Herrick (1997), and Kerr et al. (1998). These researchers point to multi-factorial variables associated with work related pain and work absence. Johasoon and Rubenowitz (1994) summarized the work-related factors that affected return to work:

1. Influence on and control over work: Influence on the rate of work; influence on the working method; influence on the allocation of tasks; influence on rules and regulations.

2. Supervisor climate: Contact with immediate supervisor; immediate supervisor considering viewpoints; communication climate within the organization.

3. Stimulus from the work itself: Is work stimulating and interesting?; Is the work varied and diversified?; Are there opportunity provided to use talents and skills, and to learn new things at work.

4. Relations with fellow workers: Relationships and contacts with fellow workers; Talking with fellow workers about the job; The extent of experiencing a cheerful atmosphere; Discussion of work-related problems.

5. Psychological workload: Stress at work; workload; Extent of feeling tired and exhausted after work; mental strain.

6. Physical workload: High risk job tasks and positions; Bending, static postures, vibration, prolonged sitting, lifting, carrying, twisting (from Johasoon & Rubenowitz, 1994).
While the importance of work and return to work for health and well-being is strongly supported in literature, return to work of individuals with back pain appears to be problematic. The rate of return to work following back pain lasting more than one month is low, and the anticipated rate of return to work decreases exponentially with increased time off work (Workplace Safety and Insurance Board, 1998; Hagen & Thune, 1998). Ellis argues that for individuals with low back pain of six months duration, there is only a 50% chance of return to work (in Hawthorn & Redmond, 1998, p.63).

Many individuals who return to work continue to report residual disability. For example, Pransky et al. (2000), in a study of 169 workers who have returned to work with back pain, documented that participants of the study continue to experience persistent pain and related anxiety. The researchers found that those with back pain had higher levels of residual disability than participants with upper extremity pain. According to McGorry, Webster, Snook, and Hsiang (2000), this residual disability associated with back pain is due to the episodic nature of back pain.

Psychological and physical work tasks specific to the nursing profession predispose nurses to back pain. Lagerstrom, Hansson, and Hagberg (1998) conducted an analysis of 42 studies on nursing work and back pain published between 1988-1998. According to this meta-analysis, factors affecting back pain in nursing include: lifts and transfers; awkward work postures associated with crammed work spaces; clinical areas of practice (orthopedic, geriatric, and rehabilitation wards put nurses at higher risk for work related back pain); organizational factors such as low staff density; and mode of nursing care (team versus individual nursing care). Psychological factors that predispose nurses to back pain include lack of social support at work and poor job satisfaction. These researchers found no
conclusive individual factors that influenced return to work in the context of back pain (Lagerstrom, Hansson, & Hagberg 1998).

The heavy physical work demands associated with nursing are thought to be particularly hazardous to health. A 1995 study supports that lifting is one of the most prevalent tasks associated with back injuries in a population of nurses (Owen, 1999). Lifting specifically related to patient handling is predominately responsible for back pain and strain (Harber et al., 1985; Cheung, 1999).

Organizational work place factors further contribute to back pain and injury. For example, in a one-year follow up study of 469 nurses, 57.9% had suffered from back pain within that year. Heavy workload was one of the most significant factors responsible for this pain, as cited by study participants (Niedhammer, Lert, & Marne, 1994). Helmlinger (1997) argues that hospital shortages translate into increased physical workloads for nurses causing increased incidents of back injuries. This further decreases the number of working nurses within hospital settings, and the remaining nurses are left to carry out lifts and other heavy demands of their jobs without adequate physical support from co-workers. While nursing predisposes nurses to back injuries, their heavy work tasks also likely contribute to pain and fear of re-injury upon return to work.

The work of nurses appears to be both psychologically and physically demanding. The nursing profession correlates to “active jobs” described by Karasek and Theorell (1990). These are jobs associated with the highest levels of psychological stress. The physical demands of nursing tend to predispose nurses to back pain. Returning to such a job with back pain would be clearly problematic.
The PEO model provides a structure for the synthesis of this broad and diverse body of literature. Within the PEO model, occupational performance may be regarded as successful performance in the capacity of nurse. Occupational performance is composed of a transaction between personal, environmental, and occupational components. The reviewed literature indicates that the consideration of each of the personal (demographic, psychological, diagnostic, pain and fear of pain, self-efficacy, volition, habituation, and physical capacity), environmental (social, cultural, organizational, and economic), and occupational (nursing tasks and duties) components is essential when evaluating experiences of nurses returning to work with back pain. In this study each of the personal, environmental, and occupational components will be considered and reflected upon in the course of the analysis of nurses’ interviews.

In applying the PEO model, a high level of confluence between the nurses’ personal and occupational capacities and the demands of their social and occupational environments will indicate a high level of occupational performance in the job of nursing (please refer to Figure 1, p. 5). A deficit in any one or combination of the three components will indicate a reduced potential for optimum occupational performance (please refer to Figure 2, p. 5).

While there have been many studies examining the factors that impeded return to work, relatively little research has explored the experience of those who successfully negotiated return to work. Bowman (1994) examined the meaning of chronic back pain in a sample of 15 injured individuals using a phenomenological approach. Of the study 15 participants, only one individual was employed and six were unemployed as a result of disability. The main barrier to the resumption of activities of daily living and work, as described by study subjects, was pain. Unfortunately, the perspectives of the one participant
who did return to work were not reported. Seers (1996) explored the experiences of chronic pain in a sample of 75 individuals. Participants were interviewed as a qualitative portion of a predominately quantitative study to examine the effects of a previously administered relaxation program. As noted by the authors, their intent was to use qualitative data to illuminate the quantitative results. Issues of employment arose mainly as the study participants reflected on their financial loss, and did not address issues or concerns associated with returning to work. The themes of importance as identified by the participants of this study involved their experiences with regard to health care, employment/finance, psychological state, physical state, and lack of personal control. As this study was primarily descriptive, relationships between the aforementioned concepts were not explored. Gard and Sandberg (1998) explored motivating factors for return to work using a phenomenological approach to analyze interviews with ten study participants. Gard and Sandberg found that return to work was motivated by the desire to participate in the work environment, re-engage in relationships with co-workers, provide service to patients and clients, the ability to carry out work tasks, and job control. While this study provided a structured framework for identifying motivating and de-motivating factors to return to work, the study also contained some limitations. First, the study’s intent was to evaluate a pain reduction program rather than investigate return to work. Participants’ reported “motivation” to return to work may have been influenced by the conditions of the program rather than their intrinsic interest in returning to their jobs. Second, motivation to return to work is not the same as returning to work. Last, study participants had different medical conditions that imposed specific limitations to work. Related to this latter concept, Thomas (1996) used a phenomenological approach to explore twelve individuals’ experiences of returning to work following liver
transplants. The author found that those who did not return to work were those individuals who were afraid of losing health insurance benefits and who had activity intolerance. Those individuals who did return to work cited returning to work as a possible way of ‘repaying’ for the gift of the liver transplant, a factor specific to the nature of the participants’ medical condition.

Despite the relative paucity of qualitative studies that have explored issues relating to return to work, the studies referred to in this review make several contributions. These studies have attempted to take a multidimensional approach in the examination of the various and complex issues related in returning to work in the context of pain and disability. As Holman (1993) suggests “when variables are diverse, only some variables are known to the investigator or are measurable, and heterogeneous subjects are actively pursuing their lives in a changing environment while the study proceeds…qualitative research methods, by providing access to potentially crucial information which otherwise may be surmised by the investigator, can yield the essential understanding” (p. 34). These studies offer the perspectives of individuals who are affected by pain and provide important and relevant data that are usually inaccessible through quantitative methods. The insights derived through qualitative studies move research further toward understanding of complex issues such as returning to work with back pain, by allowing deeper exploration into inter-related phenomena that affect participants.

Summary and Research Question

Most of the research on return to work has been conducted with the use of positivistic research methods and has been etiological, prognostic, and epidemiological in nature (Elders, van der Beck, & Burdorff, 2000; Dorceel & DuBois, 1999; Burton, Polatin, & Gatchel, 1997;
Klenerman et al., 1995; Rose et al., 1992). These studies identify one or more factors that influence return to work, and enhance our understanding of the process of returning to work related to personal, environmental, and occupational components. However, a more integrated view of how personal, environmental and occupational components interact is required in order to understand the complex and multidimensional processes involved in returning to work with back pain (Hudak, Cole, & Frank, 1998; Feurstein, Berkowitz, & Huang, 1999; Pransky et. al., 2000). Hignett (1996), Frank, Pulcins, Kerr, Shannon, and Stansfield (1995), and Mergler (1999) argue that qualitative studies are required in order to better understand the multifaceted dimensions of disability following back pain and the processes involved in returning to work with back pain.

The processes involved in returning to work following back pain in the nursing population have not been adequately examined. The studies that have addressed return to work in the nursing population have been largely descriptive (Hull, 1999; Shepherd, 1999). To date, there has been no analytic research grounded in the subjective experience of nurses who have returned to work following back pain. The current study differs from the studies that have been reviewed in that it analyzes and interprets the qualities of nurses’ experiences as they return to work with back pain. The PEO model provides as framework for an integrated examination of the confluence of factors that facilitate or deter injured nurses’ work re-integration.

Given the importance of work to health and well-being, the high economic and financial costs associated with absence from work due to back pain, and the high incidence of back pain in the nursing profession, research examining the experiences of those nurses who successfully returned to work with back pain is badly needed. As encouraged by Weiser and
Cedraschi (1992) “It would be instructive to study individuals who suffer chronic back pain and remain vital, if they exist. Lessons learned from their experiences could help others” (p. 667). Gaining an understanding of the processes involved in nurses’ successful return to work with back pain would suggest directions for research on new approaches or strategies for nurses with back pain, for rehabilitation professionals, and for nursing administrations to facilitate return to work.

The objective of this study is to investigate the experiences of nurses with back pain in their return to work process. This study describes and analyzes nurses’ experiences upon returning to work and answers the research question “What is involved in the process of returning to work for nurses with back pain?”
CHAPTER 2

Methodology

Theoretical and Methodological Approach

Research strategies are tools used to understand phenomena (Morse, in Denzin & Lincoln, 1994). The objectives and research questions guide the methods employed in conducting research. While back pain has been extensively studied with the use of quantitative methods, fewer studies have explored the issue of back pain and return to work using a qualitative methodological approach. The majority of the studies examining the sequelae of back pain in a population of nurses have been quantitative in nature (Mitchelmore, 1996). Frank, Pulcins, Kerr, Shannon, and Stansfield (1995) proposed directions for future research of occupational back pain: “Without the insights provided by preliminary qualitative work, there is little hope of appropriately modeling the development of ill health when large numbers of social and psychological variables are used that are frequently collinear, as in the case of occupational back pain” (p.10). Holman (1993) postulated, “…an explanation of events can almost certainly not be obtained without inquiry into the perceptions, attitudes and behaviors of those who are involved” (p.33).

Back pain, which consists of plethora of physiological, psychological, and social constituents, is particularly amenable to qualitative research methods. Holman (1993) argues that,

There should be no doubt about the enormous accomplishments of reductionism strategies and methods in modern biomedicine. They have provided penetrating information about the fundamental components of biological systems and their functional potentials. They have also yielded important diagnostic and therapeutic tools. But it should also be undeniable that conventional biomedical research has not provided decisive information about the origins or management of the most prevalent contemporary medical problems, namely chronic illness (p.30).
Holman (1993) suggests that "... qualitative research methods, by providing access to potentially crucial information which may not otherwise may be surmised by the investigator, can yield the essential understanding" (p.34).

The paradigm of qualitative inquiry rests on a distinctive set of beliefs (Creswell, 1998; Denzin & Lincoln, 1994; Bowman, 1996). First, the researcher places emphasis on the meaning of experience of individuals. These individuals are the experts of their life experiences. Second, exploration of respondents' motivations behind the behaviors takes place within the contextual environments in which respondents carry out the activities of their daily living. Thus, the environment is seen as a guide to social behavior. Third, the researcher interprets actions and words of respondents. The importance of situations is dictated and underscored by respondents. Emphasis is placed on the narrative of the personal life/event stories that participants share with the researcher. Fourth, research is conducted inductively. That is, assumptions and theory derive from the data rather than preceding it.

Qualitative research embraces many traditions of inquiry that provide the researcher with methods to investigate social phenomena. One of those methods is grounded theory. Grounded theory is a method "designed to aid in the systematic collection and analysis of data and the construction of a theoretical model" (Morrow & Smith as cited in Creswell, 1998, p.299). It is "a general methodology for developing theory that is grounded in data systematically gathered and analyzed" (Strauss & Corbin, in Denzin & Lincoln, 1994). The intent of a study using the grounded theory method is to "generate or discover a theory, an abstract analytical schema or a phenomenon that relates to a particular situation. This situation is one in which individuals interact, take actions, or engage in processes in response
to a phenomenon.” (Creswell, 1998, p. 56). Grounded theory as described by Corbin and Strauss (1990) and Corbin and Strauss in Denzin and Lincoln (1994), guided this research. Specifically, data collection and analysis were interrelated processes in which simultaneous analyses of incoming data allowed me to guide future interviews and assist in the interpretations of participants’ stories. Concepts were developed by identifying and grouping like data. Coding, a discussion of which will follow in the Data Analysis section of this thesis, was the method used to group and to interrelate concepts. Constant comparison was used to examine new data with respect to data already obtained, so that emerging hypotheses about relationships between concepts were repeatedly analyzed. Broader structural conditions were analyzed, such as social and occupational environments, to provide context to the processes involved in nurses’ returning to work. By using grounded theory to identify, group, interrelate, and contextually place data, the framework for a model of Occupational Reintegration was developed (Chapter 5).

Symbolic interactionism is the paradigm through which I chose to analyze the return to work experiences of injured nurses. Symbolic interactionism involves exploring meanings that people attribute to everyday interactions and objects. The meanings tend to symbolize emotions, beliefs, and shared social understandings. An important theme in symbolic interactionism is that of “becoming” (Plummer, 1996). The self is constantly evolving and changing based on situations and interactions with others. An individual’s behavior is seen as consciously directed and based on ideas about the self. Self-identity is produced in interaction with self (self-talk) and significant others. The perception of others’ judgement will regulate the roles people choose to take on. “People are reflexive, capable of standing back and reflecting on the social forces in the environment which impinge upon them
Behavioral action is the result of the individual's definition and analysis of the situation. For example, in examining return to work through the perspective of symbolic interactionism, the effects of the family's attitudes toward returning to work, on how the individual defines him/herself, and on the meaning and symbolic representation that work and disability have for this individual, may be considered.

The choice to study the experiences of nurses with back pain in relation to processes involved in returning to work using grounded theory as the guiding methodological approach and symbolic interactionism as the analytic method is consistent with the approach suggested by Morse (in Denzin & Lincoln, 1994). Grounded theory as strategy encourages the study of action and process. This relates to my interest in examining the processes involved in returning to work. The paradigm of symbolic interactionism connects 'who the person is' and 'what the person does' within a given contextual environment. The symbolic interactionism perspective was used to guide the analysis of self-reports of nurses with back pain regarding their negotiation of the process of return to work.

**Entry into the field**

My previous role as occupational therapist in the field of vocational rehabilitation and assessment, and my current roles as a research associate and consultant at Mount Sinai Hospital have afforded me access to a population of nurses within this hospital. Approval for this project was received from the Director of the Rehabilitation Department, Sharon Currie, and the hospital Vice-President, Jeanine Pearlman. Mount Sinai Hospital has no formal hospital research advisory committee and utilizes the University of Toronto Human Subjects Review Committee to approve research projects. This study also underwent a 'feasibility review' by the hospital's Nurses' Research Utilization Committee. This is a committee
composed of nurses employed at Mount Sinai Hospital. The intent of this review was to evaluate the demands required of nursing staff to participate in the proposed study. The Ontario Nurses' Association (ONA) was made aware of the proposed project and had no objections to the proposal or its procedures.

Participants

Sampling Strategy

Mays and Pope (1995) suggest that heterogeneous and purposeful sampling is ideal for the study of social phenomena. These authors note that "statistical representativeness is not a prime requirement when the objective is to understand social process" (p.110). The aim of purposeful sampling is not to identify a sample representative of the general population, but rather to identify a sample of individuals who have experienced a particular phenomena that is relevant to the purpose of the inquiry. In purposeful sampling, participants are specifically identified because they can enlighten a situation through an experience that has occurred in their lives. A heterogeneous sample is favored because "it increases the scope or range of data, as well as the likelihood that the full array of multiple realities will be uncovered" (Lincoln & Guba, 1985). "Heterogeneous" in this context may be defined as a group of individuals who may be unlike in all aspects (demographically, socially, culturally, etc.) but who have all experienced the phenomena of interest to the research study. A heterogeneous and purposeful sample would therefore have the greatest potential to reveal the personal, environmental, and occupational factors and their inter-relationships as they affect the return to work process. If the phenomena under study were experienced similarly in a sample of unlike individuals, there would be increased support for the importance of the phenomena to the object of study.
The chosen sampling strategy is likewise influenced by my research question and theoretical stance. For the purposes of this study, the type, extent, or date of injury is less important than the lived experiences of nurses who successfully returned to work with back pain. A 25-year-old nurse may recover more quickly physiologically than a 45-year-old nurse, and a person that has been injured 6 months ago might remember the details of their injury better than an individual who was injured a year or more ago. However, for this study I am concerned with individuals' feelings, emotions, and the recollection of factors that have assisted their return to work. For the purposes of this research, it was important to interview nurses who had returned to work despite their back pain. Other criteria, which are temporal and physical in nature, were of less importance. In this study, the nurses had one common experience that I wished to examine; they had all returned to work in spite of back pain. However, they had different personal and medical histories that allowed for a range of experiences and perceptions.

Participant Recruitment

The recruitment process was four pronged and involved: (a) posting flyers throughout the hospital and nursing stations (please refer to Appendix A), (b) sending an Information Sheet (please refer to Appendix B) to all nurses working at Mount Sinai Hospital, (c) making brief presentations about the project during nursing and nurse unit managers meetings, and (d) advertising the study in the hospital newspaper. Potential participants interested in participating in this project contacted this researcher through a contact number provided on all recruitment material. Nurses from the 17th floor of Mount Sinai hospital were excluded from this project in light of this researcher's consultative role on that floor. The recruitment process spanned three months, during which time ten participants contacted this researcher.
All nurses who expressed interest in participating were interviewed. The sample size is consistent with the suggested sample size for a qualitative research project. The suggested sample size ranges from 6-30 participants (Creswell, 1998; Denzin & Lincoln, 1994; Bowman, 1994) as this is usually the number at which theme saturation, the point at which variations regarding the phenomena of inquiry are exhausted (Creswell, 1998; Corbin & Strauss, 1987).

The initial plan was to interview nurses only from the Mount Sinai Hospital as this was a site that was known to this researcher, and entry, for the purposes of conducting research, would have been convenient. However, due to recruitment challenges (a discussion of which will follow), the ten participants who volunteered to be interviewed were drawn from the larger University Health Network which is an aggregate of three teaching hospitals in the downtown core in the city of Toronto. It is composed of Mount Sinai Hospital, Princess Margaret Hospital, and Toronto Hospital (General and Western sites).

The recruitment process was lengthy and difficult for several reasons. First, nurses expressed anxiety over confidentiality issues. Even though I stressed that the information obtained for the purposes of this project would not be shared with the hospitals’ administrations, many nurses expressed concern regarding confidentiality during nurse information meetings and during the interviews. The first three participants who volunteered for the study were themselves completing Masters theses and were involved with their own research processes. Interestingly, these three nurses were not concerned with confidentiality but suggested that other nurses may find this an issue. These three participants volunteered to refer others to my study, thus “chain-like” recruiting occurred (Miles & Huberman, in Creswell, 1998, p.119). Another factor affecting recruitment at Mount Sinai Hospital is that
Mount Sinai does not have an "in-house" research department, consequently employees may not be as accustomed to hospital research endeavors. The referred nurses were friends or co-workers of the first three volunteers, and the referred participants all worked for the University Health Network at the time of their injury.

The second reason that may account for the difficulty in recruiting nurses to participate in the study was that nursing unit managers were hesitant to promote my study to staff nurses. During a nursing unit manager meeting, six out of 10 managers noted that there were no nurses on their floors who met my eligibility criteria. Nevertheless, I interviewed nurses from those floors. These injured nurses confided that they did not disclose their back pain to their managers. When these nurses needed to take time off, they cited reasons other than back pain for their absences. In further discussions with nurses, and informal discussions with nurse unit managers, it appears that there is intense pressure on nurse unit managers to contain disability costs by decreasing the numbers of work-related injuries. Therefore, a nurse who is in pain or was previously injured may be asked by her manager to perform lighter duties, take time off, or even switch departments to avoid the risk of having further (more expensive) injuries in the process of work. To avoid these consequences, nurses in this study gave alternative reasons for being off work, such as being sick with a cold, when experiencing work related or work induced back pain.
Characteristics of Participants

Participant descriptions are written in such a way as to maintain confidentiality of participating nurses. Particular precautions were taken because of the close physical proximity in which all the nurses worked. Nurses were invited to the study by friends and co-workers thus increasing the possibility of recognition among participants and other nurses within the University Health Network. For this reason, the nurses’ physical work demands are summarized as heavy, medium, or light. For similar reasons, nurses’ ages and the dates of injury are approximated. The location and nature of participants’ injuries are summarized as work or non-work related.

All of the study participants had returned to work at the time of the interview. Their time off work as a result of back pain ranged between 0-8 weeks. Eight of the ten participants were employed on a full time basis. The participants were employed as nurses between 8 to 25 years, but not all of the employed years were spent working in one department. The nurses worked in one department for a range of 0-15 consecutive years. The participants were between the ages of 30 and 50 years. The injuries or trauma associated with back pain occurred two months to ten years from the date of the interviews. All of the participants worked in departments with medically compromised patients, and therefore their jobs involved heavy physical demands. Six out of the ten participants injured their backs in the process of patient care. Two of the four participants attributed their back pain to cumulative damage associated with their jobs. Two other participants sustained back trauma as a result of injuries unrelated to their work, however, work activities tended to exacerbate their pain. Seven out of the ten participants returned to work on a modified work schedule. All participants, at least initially, returned to the jobs they held at the time of their injuries or
at the time of onset of back pain. The Occupational Health and Safety Department formally set work modifications, but not all participants underwent a formal rehabilitation program. The over-representation of females in this sample is consistent with the proportion of females to males in the nursing profession.

Originally, I asked nurses to provide code names for themselves. Under these code names I briefly described the nurses in terms of their personalities in order to give the reader greater insight into their stories. However, it became apparent that even these brief descriptions could allow for deductive identification of the participants in their relatively small work milieu. Therefore I simply refer to the participants by numbers 1-10.

**Risks and Benefits to the Participants**

Participants of the study expressed concern that disclosing personal information about their return to work experience may adversely affect their work prospects and relations with their boss and co-workers. Several procedural steps ensuring confidentiality within the study design were aimed to decrease participants’ anxiety and ensure confidentiality: (a) the concepts of confidentiality and anonymity were stressed in the information sheet and the consent form and were again repeated at the onset of the interviews, (b) participants were ensured that no information, such as age, name, or department of work, that would identify participants would be published or disclosed to any parties, (c) to ensure that the study was being carried out for the purposes of a university level graduate project, all written correspondence was communicated on Graduate Department of Rehabilitation Science, University of Toronto letterhead, (d) all study information was stored in a locked filing cabinet to which only this author had the key (d) and finally, the participants had this student
researcher's supervisor's phone number and were able to verify the authenticity of the project. Interestingly, while all participants expressed concerns over confidentiality, all agreed, noting convenience, to be interviewed at Mount Sinai Hospital, either during, before, or after their work shifts. Interviews were conducted in a private room on an outpatient wing of the hospital where no nurses are employed.

Study participants received a $50.00 honorarium for their time and contribution to this project. An honorarium of $50.00 for a 60-90 minute interview is consistent with an hourly wage for a nurse (C. Zettler, nurse manager, personal communication, September 15, 1999). While this study will not likely benefit the study participants in any other direct way, participants may have benefited from the knowledge that they contributed to a scientific study that is aimed at assisting the return to work goals of other workers.

Analytic Orientation

Bourdieu (1996) writes that the interviewer begins the play of interaction during an interview, but that respondents hold the power of self-representation in the way they imagine and cognitively choose to represent themselves to the interviewer. Pamphilon (1999) suggests that participants construct and reconstruct their life stories based on who they think they are, who they think they should be, and who they think the researcher is. As noted by Clandinin and Connelly (in Denzin & Lincoln, 1994), depending on the given situation “people live stories, and in telling of them reaffirm them, modify them, and create new ones” (p. 415). Thus, life stories are not only descriptive but also constitutive. According to Strauss and Corbin (in Denzin & Lincoln, 1994) “[participants] have perspectives on and interpretations of their own and other actors' actions. As researchers, we are required to learn what we can of their interpretations and perspectives” (p. 280).
In this study there are several factors that may have influenced the interviews and stories that the participants shared with me. First, some participants expressed anxiety that interview information might be disclosed to the administrators of the hospitals. This anxiety, despite my reassurances, likely influenced their accounts. Other participants, who were themselves conducting research and were more familiar with confidentiality issues involved in research, did not express concerns and their speech pattern and body language appeared easier and more open. Second, my past role as an occupational therapist and my current role as a research assistant and consultant in the same hospital where many of the participants worked may have been seen as authoritative, despite the fact that I had no prior personal relationship with these nurses at Mount Sinai. While employed as an occupational therapist at Mount Sinai Hospital from 1997-1998 I worked on an outpatient wing of a floor where nurses were not employed. However, at the time of collecting these data I was providing consultative services to evaluate the work risks associated with the jobs of nurses on the 17th floor of Mount Sinai Hospital. For this reason nurses from the 17th floor were excluded from this study. Third, medical knowledge afforded to nurses as part of their professions likely influenced their accounts. For example, numerous participants referred to knowledge of back pain as “long lasting”. Interestingly, the participants vehemently stated, even though they were never asked, that they were non-malingeringers. The awareness of possible prognosis and the discourse around back pain likely influenced this justification that nurses felt they needed to share with me. During interviews it appeared that participants were not just sharing their experiences of returning to work with me, but also convincing me of their integrity as individuals. Participants would exhibit pain behaviors, pull out bottles of their medication, and even medical records to demonstrate the authenticity of their injury.
While I presented myself as a student researcher by wearing casual clothing, not wearing a Mount Sinai Hospital name badge, and repeating my affiliation with the University of Toronto, it is possible that my perceived role in the hospital (which afforded me the use of Mount Sinai facilities) and the sensitive nature of the study influenced the stories that participants shared with me.

I also acknowledge that my own stance as a researcher and person must be reflected in this study. As Pamphilon (1999) writes, “the writer/interpreter cannot be truly objective in the analysis of narrative. Almost certainly our feelings, emotions, past experiences, and life schemas will inevitably influence analysis” (p. 406). I must, therefore, acknowledge my own bias and expectations because, as Cladinin and Connelly (1994) point out,

“our experiences as researchers are clearly intermingled here, if not for the participants, at least for you as reader because you know only what we have chosen to tell that is a highly selective constructive act on our part, depending on the stories we wish to convey about our participants, ourselves as researchers, and ourselves as methodologists writing to other researchers” (p. 414).

While I, very likely, brought my own expectations to this research, I am not aware of any biases that may have influenced the interview processes or analyses of interview data. I attempted to treat all interviews and data in an objective and non-judgmental manner. My training as an occupational therapist did not include training in qualitative research. I learned from courses and readings in the process of conducting this research. My research question—examining the process to return to work—evolved in my own process of evolution as a qualitative researcher. My acknowledgement of my positivistic beginnings and my assessment of their impact on my research (assessed in the section titled Data Analysis) provides the reader with insight that will assist in the understanding of my interpretation of stories injured nurses shared with me in their process of returning to work.
Data Collection and Management

Potential participants contacted me through a contact number. I reviewed the details of the information sheet with potential participants over the telephone. A convenient time and place for an interview was arranged for eligible and willing respondents. Respondents who agreed to be interviewed for this study were asked to read and sign a consent form (please refer to Appendix C). The consent form outlines the intent and procedures of the study, stresses anonymity, and the opportunity to terminate the interview at any time. A copy of the consent form was provided to all study participants. One-on-one interviews commenced only after respondents read and signed the consent form. All interview questions were open-ended and followed the interview protocol (please refer to Appendix D). Interviews lasted between 60-90 minutes. The interview process was led by one main question, “Some people have an easy time returning to work, for others it is more difficult. Would you tell me what it was like for you to return to work?” Additional questions were used as probes to examine the personal, environmental, and occupational influences on return to work. The interview questions were structured with reference to guides outlined by Benjamin (1981) and Britten (1995). Audiotapes of interviews were transcribed and the transcripts were edited for accuracy. Audio recorded and transcribed interview data, and field-notes data obtained from interviews with study participants were stored in a locked filing cabinet. Only this author had the key to the filing cabinet for the duration of the study. Personal identities of participants were coded and kept in a codebook in a separate locked cabinet.
Data Analysis

The data were first coded by categories identified by the literature review. Specifically, the literature points to pain, self-efficacy, volition, habituation, physical capacity, the social/cultural environment, and the demands of the job as determining the success of return to work of injured workers. Although these codes provided a concrete template, I felt that I was ‘describing’ rather than ‘analyzing’ data. That is, my coding grouped the participants’ words into predetermined categories that were based on literature that was often medical in nature. To more accurately “listen” to what the participants said, I summarized the data into more general codes. By collapsing the passages of transcripts into a sentence or two, I more accurately captured the gist of the participants’ meanings. In an effort to provide a context to the interviews I created a face sheet for each study participant. This face sheet provided yet another summary of the interviewee’s basic biographical data, as well as notes on factors which participants reported as facilitating their return to work. I repeated this procedure for all ten participants and found that particular themes emerged from the data.

First, being a professional nurse appeared to influence the way that participants tended to react and treat their pain. Because the profession of nursing and the process of helping others (patients) appeared to be of great personal value to the nurses, they often placed themselves at risk by returning to work despite pain. Second, all interviewed nurses described their parents as being stoic in spite of pain or disease. Last, it appeared that there was an attitude of reciprocal assistance within the nurses’ workplace. As nursing is a very physically demanding profession, many nurses have experienced injuries or pain as a consequence of their jobs. Thus, co-workers of injured nurses tended to assist each other
with the physical demands of certain procedures with the implicit understanding that one day such a favor may be returned to them.

As intriguing as these findings may have been I was hesitant about reporting them. I did not have confidence in my coding. The coding key I developed was ‘borrowed’ from the literature and was descriptive in nature. The codes did not emerge from the data; rather the data was slotted or was required to ‘fit’ with the codes. I felt that by only applying the literature derived codes to the data I was possibly missing important trends and relationships that may not be represented in the literature. In this case, the coding and the analysis were very separate processes. Re-assessing and re-evaluating my interest in keeping the data grounded in the participants’ perceptions of their experiences was the first step to re-analyzing the data. Reading and re-re-reading the text, keeping this in mind, was the next step in the analysis. I relied on the writing of Mauther and Doucet (1998) to assist in the numerous readings of the transcribed interviews. These authors provide a guideline to assist researchers in reading and comprehending qualitative interview texts. Pamphilon’s (1999) "Zoom" model further assisted my comprehension. The Zoom model invites the researcher to focus on four levels of narrative text-macro-zoom, meso-zoom, micro-zoom, and interactional zoom. Pamphilon compares the zoom model to a photographer’s lens. Different zooms concentrate the focus on different aspects of a story.

Mauther and Doucet (1998) suggest reading an interview passage four times. In the first reading close attention is paid to 1. the plot of the overall narrative and 2. the researcher’s (analyst’s) own feelings in response to the participant and the participant’s story. These parallel Pamphilon’s meso-zoom and interactional-zoom levels of analysis. In the first I reading I looked for the general stories that participants conveyed. What was important to
them in the return to work process? What was most influential? What was most helpful?

What were their general experiences?

Reflexivity in relation to the text is the second phase of the first reading and is labeled as the interactional-zoom by Pamphilon. At this stage the researcher must reflect on his/her own feelings toward the subject and the presented story. As Pamphilon writes, the writer/interpreter cannot be truly objective in the analysis of narrative. Almost certainly our feelings, emotions, past experiences, and life schemas will invariably influence analysis. Pamphilon writes that strong feelings toward participants are “... crucial moments for reflection as they pointedly show different landscapes and challenge the researcher to think through the implications of living in a place of the world that makes that way of thinking possible” (p. 406). Thus, I attempted to take into account my own feelings about the interviews, participants, and the interaction in the interview process. I also took into account how my role as an occupational therapist may have influenced the interviews and be reflected in the data and its analysis. Likewise, the issues of confidentiality, already expressed as worrisome by some participants, were likely magnified by the fact that the interviews, by the participants’ choice, were conducted at Mount Sinai Hospital. The participants’ insistence that they were “not malingerers” was likely influenced by my role as an occupational therapist and interviewer. The participants wanted to leave me with a lasting impression of them, one that would not include the idea of malingering.

In the second reading of the text, as suggested by Mauther and Doucet, I read for the participants’ references to self. Specifically, I read for “how the respondent experiences, feels, and speaks about herself” (p. 128). I read for patterns that participants used to describe themselves in the process of return to work. For example, a certain pattern arose with regard
to the participants' identities as nurses. Nursing, as a profession, was all consuming for most participants. Participants identified having early childhood caring experiences that defined their professional path. The nursing profession defined many of the participants. Nurses referred to their work as "life" and source of "self-esteem" and "self-worth". Many participants were zealous in their return to work. They either quickly returned to work or gave up modified duties in order to continue nursing.

In the third reading I examined the participants' relationship to others, specifically parents, spouses, bosses, and co-workers. While parents influenced participants' responses to pain and the mode in which they related to their work (see the analysis of the fourth reading), they were not directly influential in the current return to work process. At times the parents of participants were not aware of the injuries. These interviews suggested that having a supportive spouse did not influence return to work patterns of nurses. All interviewed nurses returned to work, regardless of having a spouse, not having a spouse, or whether the spouse was supportive or not.

In this reading it was evident that nurse unit managers were generally not aware of the participants' back pain. The staff chose not to share their feelings of pain with their bosses for fear that the bosses would reduce their work hours, modify work duties, or demand that they switch departments to areas that require fewer physical demands in order to reduce departmental disability costs. As a result, participants spoke of relying on the assistance of co-workers in order carry out nursing duties despite back pain. The relationship with co-workers was repeatedly presented as one of the most important reasons participants were able to return to work.
Reading number four allowed me to relate the central phenomenon, the process of return to work, to cultural, structural, and ideological contexts. Contextual environments may be "constraining or enabling" (Mauther & Doucet, p. 132). The cultural and social contexts relate to Pamphilon's (1998) macro-zoom. Within macro-zoom, the dominant social discourse and the cohort effect influence the actions and ideologies of participants. The cohort effect refers to the events of childhood/adolescents and their impact on values, behaviors, and choices in adulthood. "In adolescents/early childhood, effects will be seen as opportunity, life choice awareness and identity choices, such as vocations" (Pamphilon, 1998, p. 399).

For all participants the choice to return to work appeared to be influenced by the context in which nurses grew up. Participants spoke of parents who remained stoic despite illness. The participants' parents, despite disabling conditions, tended not to display pain behaviors and continued working. Likewise, nearly all participants had early childhood caring experiences that had an effect on their choice of an adult career of nursing. Finances appeared to affect some but not all nurses' choices to return to work. Financial need was an individual motivator to return to work that did not appear to be associated with marital or parental status in this sample.

The dominant discourse in terms of low back pain and disability played an important role in the return to work process. First, low back pain was seen as a long term and expensive disability and consequently nurse unit managers may have been hesitant to have participants return to work because of their potential financial "liability" to the department. Consequently, nurses within their departments managed themselves in terms of giving one another assistance and/or time off without the involvement of management. Second, back
pain is often a perplexing diagnosis that cannot be verified by objective medical tests. Thus, low back pain is reported and evaluated by subjective complaints. All of the nurses spoke of ways of legitimizing their pain: by their use of medication; exhibiting pain behaviors; and having medical documentation to prove the legitimacy of their pain. Likely their repeated claim of “not malingering” stems from the negative discourse surrounding back pain.

Multiple and directed readings of the text allowed me to understand the data from different perspectives - from the perspective of the narrator, from the perspective of the interpreter, as well as from a cultural/social perspective. With my new understandings, the data were then re-coded using approaches outlined by Corbin and Strauss (1990) and Corbin and Strauss in Denzin and Lincoln (1994). The following coding system is used in grounded theory studies to manage vast amounts of data and at the same time to link and combine data in order to make a coherent story and/or produce a substantive theory. This coding system allows the researcher to describe, label, and inter-relate data in the process of developing a theoretical framework. I chose to apply the coding method proposed by Corbin and Strauss (1990), which proceeds from “open coding (identifying categories, properties, and dimensions) through to axial coding (examining conditions, strategies, and consequences), to selective coding around an emerging story line” (Dey, 1999).

Open coding is a system of placing conceptual labels on events and the duration of these events of the given phenomena. During axial coding the researcher aims to distinguish the relationships between the events of a phenomena. That is, in what context and under what conditions did events occur? Selective coding is the stage where theory development takes place. The researcher integrates all selected categories into a unified theory that explains the phenomena and its conditions from the words of the involved participants. As
the last stage of data analysis, selective coding is the culmination of the refinement of the research question, readings of text, and the literature within a general theoretical framework.

To summarize the analysis process, I was dissatisfied in the application of my original coding key to my data. The codes were descriptive rather than analytic. This time, I began open coding by labeling the text, focusing on action, interaction, and process within the narrative. From the numerous readings of the text I knew that certain themes were repeating themselves and I began labeling them. The first main theme was derived from the nurses’ descriptions of their working styles prior to back pain, which told of early childhood caring, nursing as life enriching, their great commitment to their work and patients, as well as the injuries that they sustained while in the process of nursing. I asked myself such questions as 1. *What is happening?* and, 2. *What are these actions, interactions and processes representing?* I then collapsed these data under the broader label of “Going Beyond the Call of Duty” because the nursing styles described by participants represented, to me as the researcher, instances of going beyond the regular requirements of their jobs. “Going beyond the call of duty” tended to predispose nurses to back injury or to exacerbate existing pain.

The second important emergent theme includes the instances where participants discuss the change in their working styles following back pain or trauma. It appeared that back pain, particularly the belief that back pain is chronic in nature, motivated participants to take better care of their health. “The Cherished Back” represents instances where participants shared how they have realized that they, in fact, must take care of themselves - the caregiver. In order to take better care of themselves, participants placed parameters on themselves and their bodies.
The last major theme emerging from the data was participants’ need of physical assistance from co-workers in order to continue to nurse. However, in order to receive assistance from co-workers the participants who were experiencing pain had to prove to their co-workers that their pain was indeed legitimate. In addition to the issue of legitimacy, it was apparent that participants who received the most help were those who made past contributions to their co-workers. These contributions were made possible if the nurses had a long work history within the department, if they had built up social ties with other nurses, and had previously helped other nurses.

In labeling these instances within text, the notion of a point system arose. That is, participants who made past work contributions were able to ask for and receive assistance from other nurses. Participants that did not have an opportunity to make these contributions, as a result of a short work history, casual work, or frequent absences due to illnesses, did not receive sufficient assistance from co-workers in order to carry out heavy nursing care. In reference to the point system as a method of rationing assistance, the aforementioned data were labeled “Assistance Requires Membership-The Bank of Goodwill”.

These new codes are not merely descriptive but were derived from analysis. They summarized and elaborated the data.

Axial coding was the next stage of data analysis. At this stage I attempted to draw connections between data within the three themes—”Going Beyond the Call of Duty”, “The Cherished Back”, and “Assistance Requires Membership-The Bank of Goodwill”. I used the Paradigm Model (Corbin & Strauss, 1990) to illustrate the connections. Please refer to Figure # 3.
Figure 3. Paradigm Model

Causal condition $\Rightarrow$ Phenomenon $\Rightarrow$ Intervening Conditions $\Rightarrow$ Action $\Rightarrow$ Consequence

(Corbin and Strauss, 1990, p.99)

Relating this model to the interview data of injured nurses I drew the following connections:

**Causal Condition** = work tasks, nursing commitment and style as a contributor to increased back injury and/or pain

**Phenomenon** = back injury/pain

**Intervening conditions** = assistance provided by co-workers as evaluated by past contributions to the department

**Action** = re-negotiation of identity by placing parameters on the self and on the body

**Consequence** = return to work (nursing/non-nursing/physically less demanding job)

Axial coding, as accomplished through the use of the Paradigm Model, provided insight into the movement and evolution of the relationships in the process of return to work. While within their initial working styles, labeled in this research as “Going Beyond the Call of Duty”, participants injured their backs or exacerbated existing back pain. In order to continue working participants negotiated a new working style, labeled “The Cherished Back”, by setting limits on their bodies and on their identities as nurses. Their ability to continue working in physically demanding jobs also depended on assistance that nurses were able to receive from their co-workers. The amount and the type of assistance that nurses received from co-workers depended on the participants’ past work contributions to the “Bank of Goodwill”. While all of the nurses in this study returned to work, those who did not receive significant assistance from co-workers either changed professions or changed nursing jobs to those that required fewer physical demands.
Selective coding is the next and final stage of analysis. Selective coding, as per Corbin and Strauss (1990) is described as "a descriptive narrative about the central phenomenon of the study" (p. 116). This narrative is meant to be an integration of all the categories earlier described. Selective coding was the last stage of data management in parlaying concepts into a theoretical framework, guided by the method of grounded theory (Corbin & Strauss, 1999). The relationships that were suggested in the process of selective coding were used in the conceptualization of the framework of Occupational Reintegration (Chapter 5). Occupational re-integration (OR) is theorized to be the transaction between the Person (the successful shift in the nursing identity), Environment (negotiation of support from co-workers), and Occupation (ability to negotiate a graded workload). In summary, the method of grounded theory provided a systematic approach to the data analysis, through three coding processes, to interrelate concepts and to build an integrative and explanatory narrative that offers insight into the processes involved in nurses returning to work with back pain. The end stage of the coding process is described in Chapter 5, where occupational reintegration is presented in a theoretical framework that takes into account personal, environmental, and occupational influences on return to work.

This section summarized the methodological approach taken in order to understand, interpret, and represent data collected from nurses with back pain in their process of returning to work. The methodological approach followed from the nature of research question and the analytical stance of this researcher.
Presentation of Results

Presentation of this thesis is organized by the three themes that emerged from the data. A detailed report of the findings are presented in Chapters 3 and 4. In these two chapters the common themes, which were drawn from the analysis of interviews with participants, are represented by discussions of the negotiation of self and the negotiation of work duties in the process of return to work. These negotiations involve: 1. The re-negotiation in identity as 'nurse' subsequent to back pain, and 2. The assistance required of co-workers in mediating this change in identity in relation to work tasks. The chapters are therefore entitled 'Re-Negotiating Nurse Identity-From Beyond the Call of Duty to the Cherished Back' (Chapter 3) and 'Re-Negotiating Work: The Price of Assistance is Membership-The Bank of Goodwill' (Chapter 4). 'From Beyond the Call of Duty to the Cherished Back' illustrates the way in which nurses re-conceptualize their physical abilities in order to continue nursing. 'The Price of Assistance is Membership-The Bank of Goodwill' demonstrates the importance of co-workers in allowing nurses to behaviorally change their working styles in congruence with their re-conception of their physical abilities. Participant quotes will be used to illustrate and illuminate important themes within the data, as well as to provide validity to my interpretation. Discussion of these themes with respect to existing literature, the limitations of the study, practice and policy implications of this study and suggestions for future research in the area of back pain and return to work are discussed in Chapter 5.
CHAPTER 3

Dimensions of the Return to Work Process, Part I

Re-Negotiating Nurse Identity: From “Beyond the Call of Duty” to “The Cherished Back”

From ‘Beyond the Call of Duty to the Cherished Back’ describes the shift in the orientation of the commitment to nursing that participants in this study experienced toward their jobs during the process of their return to work. Their pre-injury work orientation seemed to be grounded in their observations of their parents and early childhood experiences of caring. The role and activities involved in nursing provided self-esteem and a sense of self-worth for participants. Their commitment to nursing, combined with the heavy work tasks and quick work pace required to carry out the role of nurse, predisposed nurses to back pain. Continued back pain and the belief that back pain is chronic, motivated participants to re-conceptualize their nurse identity. The nurses participating in this study began to “cherish their back” by setting limits on their bodies and on their work.

Precursors to Initial Nurse Identity “Beyond the Call of Duty”

Pre-injury Work Orientation-Parental Modeling.

All of the study participants, without exception, reported having parents who remained stoic despite substantial physical limitations. In addition, all study participants noted that their parents’ reactions to pain influenced their reactions to their back pain as well as to other illnesses. For example, Participant #8’s father lost a leg in an accident that required one year of hospitalization. Despite this injury he returned to work. The participant described her father’s return to work:
After his injury he went back to the railway and went to full-time work. He really tried to function independently. You know when you see someone, you know, with one leg crawling up a train like a monkey it makes you realize like gees, people can be rehabilitated to go back. You know. So I think that—I think your background maybe dictates with how you cope with injury and how you deal with it for sure. What you see your parents do.

Participant # 9 also found her mother to be stoic with regard to pain. She told how her mother fell and broke her jaw,

... she tripped and fell and bashed her jaw ...broke her jaw but did not tell anybody. Went to the pharmacist and said ‘Do do you have anything for this bruising?’ And he knew her from going there regularly. He said, ‘ think you need to go the emergency (laugh) department’.

This participant also felt that her own “very high pain threshold” is influenced by her mother’s general conduct toward pain.

Not all of the respondents’ parents had such sensational tales of pain tolerance, but all study participants noted that parents did not display pain behaviors. Participant # 7 noted that her father, “sick or not, always showed up to work”. Participant # 3’s father “stays in bed until he feels better, but he doesn’t complain or anything, he just sort of, you know, just doesn’t talk to too many people until he feels better”. Consequently, this participant felt that her return to work was influenced by her parents. She states, “I guess that it is a function of the of the way my parents raised me. I just wanted to get back to work, really, there’s just no—there’s really no other reason than that”.

Participant # 1 related her reaction to pain to the manner in which her mother experienced chronic back pain,

I would use my Mum as an example, and as I say, she’s got this chronic back, and she’s phenomenal; she knows her limitations, we try and help her out where she can—where we can. She likes to do things on her own so I sort of see it in me, you know where that part came from...my Mum is really independent too, and she still likes to do all her own things and it frustrates her, for example, you know, when my Dad has to help her with the laundry and do the vacuuming if she can’t do it.
Similarly, in the latter portions of the interview this participant described her frustration with her own limitations. She became tearful when she related that she was unable to participate in grocery shopping with her husband.

According to the participants in this study, parental responses to pain influenced their reactions toward their own pain and the process of their subsequent return to work. The participants' parents demonstrated few ill behaviors when coping with illness and pain. Furthermore, the parents modeled a behavior pattern for their children that reinforced the continuation of activities of daily living, such as returning to work, despite injury, pain, or illness.

**Pre-Injury Work Orientation- Early Childhood Nursing.**

The career of 'nurse' was chosen early in the study participants' lives. Most described early childhood experiences of caring for others. It appears that these early childhood experiences influenced the choice of career for the nurses. Participant # 3 said, “I always wanted to go into nursing. I ALWAYS wanted to nurse, I love looking after people, I just always wanted to nurse. All my life.” She described her early childhood and caring for her dolls, “I used to put all my dolls under the bed in boxes and put little plaster [band aid] on their foreheads and take off the plaster and think they’re all better”.

According to respondents, early ‘nursing’ experiences seemed to contribute to their feelings of self-esteem, and these feelings, as will be discussed later, continued to be one of the main driving forces for nursing in adult life. Participant # 6 discussed her feelings of self-esteem as she assisted her brother following an accident:

And I remember one day my brother was hit by a car and he had broken his arm and I remember giving a blanket and helping him drink some juice and feeling really good about that. Helping someone...So it was this sort of feeling that—like feeling sorry
for people but yet being able to do something for them. That sort of directed me to go into the profession.

Participant # 4 discussed how the experience of caring for her alcoholic father established her choice of nursing as a career:

My...my father when he was ill liked to be cared for. And he was an alcoholic, and there's a lot to be said for people that grow up in an alcoholic family because a lot of the children, there's been a lot of studies done and the children of alcoholics tend to end up being care-givers...so I cared for him a lot.

For these study participants, early childhood 'nursing' served to draw them to the profession of nursing. The following section describes the deeply-rooted commitment nurses feel toward their jobs. At times, there appeared to be a lack of boundaries between the professional (nursing) and the private home life lives of the participants.

**Nursing as Life Enriching.**

Participants in this study not only liked and enjoyed their jobs, but the job of nursing became an integral part of who they were as people in their private, non-working lives. When Participant # 2 was asked what her job meant to her she very quickly responded, "Yeah, it [work] has been my entire life until I was off injured". It is interesting that she placed work so high in the hierarchy of her life, despite the fact that she has two children and was previously married to their father.

I need my work to sort of validate my existence. I think you'll find that a very common vein in caregivers, that we need to be caring for somebody in some way to make ourselves seem worthwhile or real. I don't know [if] it's sort of a deficit in our personalities. The majority of people that I work with feel along similar lines. When I was off work when my back wouldn't allow me to work I found that my sense of self-worth really was eroded.

Participant # 10 also found a great sense of self-worth in her work. She discussed her feelings about work when she is nursing, "And I think I also miss the—the feeling of self worth, of going to work...um, it means, um, helping others. And feeling good about it". 
Participant # 7, who currently holds a part-time managerial position, noted that she missed patient contact. She said, “I think that’s why we go into health care, you know, we want to care for people.” Despite having a husband and two young children she later made a reference to nursing being similar to “family”.

I love everything about the job. I love the patients, um, interaction. The family interaction. I love the people I work with. I mean this was my life kind of thing. Yeah. This is all I know how to do”.

Participant # 4, who worked as a hospital volunteer early in her life, noted that she liked the feeling it gave her to help other people. She noted that “helping others” was one of the motivating factors for her to return to work. She said, “By helping somebody else, I felt I could really contribute”. She spoke of the spill-over of work into her personal life. “And one other thing, I’m not sure if that would work for everybody—anybody else but, by helping other people, sometimes you help yourself. You forget about your own situation”. ‘Nursing’ others provided an escape for this participant.

The theme of nursing as life enriching was evident in the interview with Participant # 6:

...I always liked Dr. Kildare [a doctor on a TV show], you know as a child of an alcoholic, you know, [I went] into nursing, [to] take care of other people, I guess. There’s always something lacking, always, always, always.

She noted that nursing is a way of avoiding the tribulations of her own life.

Similarly, Participant # 5 said,

I get involved with my clients and I want to do the best for them or I want, you know, I go that extra mile. But it’s a good way of not looking at your own problems, looking at someone else’s you know.

According to these participants, nursing enriches their lives in two ways. First, participants seem gain a great deal of self-worth and esteem from helping others. Second,
the act of nursing others appears to fill participants' lives so that they have less time and energy to devote to their private lives, where they seem to feel that they may have less control.

**Nursing Style-The Commitment to Work and Patients.**

Caring for others in early life and the positive feelings that participants developed during the process of nursing directly related to the care participants reported extending to their patients. The participants in this study described a tremendous commitment to their work and patients. The devotion to their work frequently went above and beyond the job requirements. Their commitment to patients was one of the reasons some participants returned to work following their back injuries. For example, Participant # 6 said that when she is ill, one motivator to return to work is the way she feels toward her patients.

“Commitment is a definite issue with me, I feel commit—you, I'm committed to people...to my clients now, you know. So that definitely has a bearing.”

According to the participants, patient contact was one of the most important aspects in the job of nursing. For example, Participant # 7, upon her initial return to work from a back injury, refused light job duties because these did not allow her to provide direct care to patients. Despite the fact that light work duties would have allowed this participant to gradually enter the work force following her back injury, she declined the light position in favor of full duties that would involve patient care. She noted“... [by]Occupational Health suggestion, you know, doing some of the stuff at the desk and I think I did that for one day; like I just missed being around the patients”.

Participant # 2, who also commenced her return to work on modified duties, was frustrated when these modified duties did not involve direct patient care. She stated,
Because almost I felt singled out. People would get me to do very mundane tasks that—and dirty. go and test this urine and do this bed pan, things like that that you didn’t need to be a registered nurse to do. And it made it very difficult to go into work in the mornings.

The intriguing part of this quote is that registered nurses do indeed test urine for sugars and do provide bedpans for patients. She performed some but not all of the tasks of registered nursing. Nevertheless, those tasks without the provision of full patient care made it difficult for her “to go into work every morning”. Participant # 5 described the need for and the importance of the emotional and physical contact with patients,

The least stressful part [of my job] is when I can pull up a chair and talk to a patient about, you know, how things are going. And, you know, ‘How you are feeling’, and so on. You know, talk about meds or whatever. So that to me I like. That’s the easiest part. And it’s what—You know that’s the most rewarding part for me.

This description is interesting because she described “being” with a patient rather than “doing”, as in providing nursing care, for the patient. It is this part of the job, patient contact, that was missing from Participant’s # 2 modified duties, the “doing” bed pans and specimens testing which she found “dirty”, without the personal interaction of “being” with patients.

When the participants described the nursing care that they provided, they again discussed “being with” patients. The commitment to patients and patient care carried over to the type of care that nurses provided to their patients. Participant # 5 discussed her commitment to her patients and ‘going beyond the call of duty’.

As work goes, I think I’m a good nurse, my patients like me even though we don’t have time, believe you me I spend time. And the doctors would be there ranting and raving and doing whatever they want behind my back, I really—that’s not my concern. My concern is the poor unfortunate person laying on the table...So, that’s my priority, is to look after the patient, not just the little squares that they’re being
operated on. Hold their hand and make sure they are comfortable. nobody can be comfortable going to sleep. but to be as comfortable as is possible to be....

This quote is intriguing for two reasons. First, even though this nurse is an operating room nurse she also saw part of her role as being outside the operating room where the patient is conscious and not under anesthesia, where she has an opportunity “to be” with the patient. Second, it is intriguing that having a good working relationship with surgeons, her co-workers, is not her “concern”. Her main concern, above and beyond other nursing duties, is caring for the patient.

Caring appears to be one of the most important aspects of nursing. When asked what she liked best about nursing Participant # 10 replied,

The caring part of it. I’m a caring person. And, ah, you’re here to help. That helps a lot. I like that. And I like to share with a patient. I like to see, like we get—we receive a lot of sick patients like pre-op and like to see the changes post-op and what we’ve done for them. How well they’ve, you know, moved through the system.

Participant # 4, who previously described deriving a sense of contribution in taking care of patients, had tremendous feelings of guilt when she was injured by a patient while providing care. She admitted,

…I was very, very upset, very afraid, hum...at the same time it left a lot of feelings because this person was dying (chuckles), you couldn’t feel angry at him, hum, although I WAS angry but it was like an ambivalent feeling.

The ambivalence that she described may have arisen from having to divide herself into a nurse and a private individual. As a nurse she could not allow herself to get angry with the man who required her help and who was on the receiving end of her care. Yet, as a private person this participant was very angry as this man caused her a great deal of physical and emotional pain. To resolve these incongruent feelings she sought counseling to “allow”
her to get angry. It appears that "anger" is not an emotion that she had previously experienced toward her patients. The reasons she went into and continued in the nursing profession is to assist others-to make them feel better. Anger, likely a natural emotion in her private life, did not have a place in her nursing role. Thus, this participant required the assistance of a counselor to flush these angry feelings.

This section reports on participants’ descriptions of their deeply-rooted professional commitments, which are linked to their high regard for patient contact. The opportunity to have patient contact was one of their main motivating reasons to nurse and return to work. As described in the next section, this commitment to work predisposed nurses to work related injuries or exacerbated existing pain.

The Injury and Insights Gained

Injured in the Line of Duty.

The mental and physical dedication that participants felt toward their very demanding profession took a toll on the nurses’ health. Six out of ten participants were injured while caring for patients (and another two attributed their back pain to long term nursing). For example, Participant # 4 was injured when a patient attacked her. Participants #10 and #2 were injured during patient lifts; Participants # 7, 8, 9 were injured as they broke their patients’ falls. None of the nurses injured in the process of patient care felt that their injuries were unusual. According to them, to use their bodies to assist or shield patients is a part of the job. Also intriguing is the fact that all of the nurses who were injured at work finished their work shift before addressing their own pain. All said that they did not feel that their pain was significant enough to warrant attention. Only at the end of their shifts, while at home or on their way home, did they feel the significance of their pain.
These nurses' lack of attention to their pain while working may be compared to the adrenaline rush athletes feel during an athletic event. Where the athletes are engrossed in the moment of athletic glory, the nurses are engrossed in the midst of patient care. In the process of their jobs they ignored warning signals that may have indicated the onset of further bodily damage. Work and caring took precedence. For example, although Participant #7, who injured her back while breaking a patient's fall, felt tremendous pain upon the injury, she nevertheless finished her shift. The next morning, despite pain, she returned to work. She said,

...the next morning I really felt like I almost couldn’t stand, and I didn’t call in sick. I mean I remember it because I remember the situation. I could tell you the patient’s name even, I remember it very clearly. Ahm, I didn’t call in sick because I just said, ‘oh, it’s just gonna go’ and I mean sometimes these things happen but I don’t think I did myself any favors by going into work. I mean it was pretty—that part was pretty challenging. And I ended up leaving halfway through the day, because I was pretty much in agony...

This endurance to keep working despite pain is repeated numerous times in the stories of study participants. For example, Participant #2 was twice injured in the process of patient care. She admitted that the injuries occurred because she did not give herself enough time to recover. She discussed her back surgery, “So I ended up having to have a very large fusion, because to ignore things and probably not giving myself enough chance to recover, I made things so much more worse”. She noted that despite knowing that the heavy physical demands of her job were detrimental to her health, she continued to provide patient care. “Even to just—sit up, to turn over, to get out of bed, and you would take half their weight, and nobody that has a back problem should be doing that kind of thing, but I would be attempting to do that anyway”. It is interesting that this participant noted that “nobody should be doing” the heavy physical demands of nursing in her condition yet despite this she
almost proudly attested that she would be “attempting... anyway”. This participant didn’t even take medication to decrease her pain at work because she was fearful that the medication would sedate her. She responded, “I suffered in silence”. By the time she came back to work following her third time on disability leave her co-workers delegated to this nurse “non-patient” work.

Not taking care of the caregiver.

Many of the nurses indicated that they had not extended the care they provided to their patients to themselves. For example, Participant #8 talked about the prevalence of nurses not taking the time to care for themselves,

Um, I would think as nurses I—I think we’re so caught up in looking after others that we don’t really take some time—the time we need for ourselves. To do on-site prevention. Or taking enough time off to heal. And I don’t know if that’s because we’re women and we’re caregivers. That’s a --there’s a syndrome that they call, when you always look after others but you don’t look after yourself, I can’t think of that word right now. But I think nurses need to be more in tune with their health because even though we’re looking after—we’re health professionals and we’re looking after unhealthy individuals we need to—to be more in tune with what our feelings are and what our limitation are. And I still sort of see that. People working sixteen hours. People not taking breaks. And—I look at that in a sad way and I think, you know, some day we’re gonna be the unwell ones.

The nurses wield a power to make others feel better, yet they rarely took an opportunity to reflect on their own health - until it failed them. Participant #4 noted her frustration over her own rehabilitation process,

I just wanted the pain to go away (laughs) I didn’t know—and I didn’t know how I was going to make it go away. And it was really sort of frustrating because, a lot of the things that... I guess being a nurse, you thought you knew what to do to make everything get better.

She experienced a frustration with herself because she was unable to do for herself what she was able to do for others. The reason why nurses may experience such high
degrees of pain is because they generally wait until their pain, as Participant # 8 described, is “debilitating” before they stop working. Many nurses expressed surprise and helplessness at their pain. For example, Participant # 1 described her reaction to her injury, “I just couldn’t believe that this was happening to me, I couldn’t stand or sit. It was awful”. Likely the participants’ surprise at the extent of their disability came from the fact that for nine out of ten participants this was the first major injury to their bodies. The extent of the pain and their inability to perform activities of daily living encouraged the participants to re-evaluate their working styles and make a shift in their professional orientation.

“Beyond the Call of Duty” described the commitment nurses in this study had toward their jobs. “The Cherished Back” describes how nurses re-conceptualized their identity as nurses, by placing limits on their bodies and their work.

Nurses’ Shifting Identities: The Cherished Back

Following back pain, the nurses in this study began to re-evaluate their physical abilities and their working styles. In this re-evaluation the nurses spoke of the perceived longevity of their pain and the change in their nursing style since the injury.

Placement of Restrictions on the Body.

In order to continue working over the long term, in contrast to the initial stages of returning to work, nurses within this sample re-evaluated their physical abilities. Many of the nurses put restrictions on themselves and their bodies. That is, the nurses stopped viewing their bodies and themselves as limitless sources of “giving”.

Participant # 8 discussed her personal “limits” in relation to work,

Like, I’ll stay an hour [extra] to help out but that—that’s it. I’ve put my day in and that’s it. You know, I mean, if I’m gonna keep nursing for another five years I—I don’t want to burn the candle too-too short now.
It appears that she is pacing herself and her body for work. She noted some specific changes that she has made since her injury in order to promote her ability to continue working over the long term,

If I—if I feel overtired and I don’t feel a hundred percent I don’t go into work now. That’s something I never used to do. I used to go there and give it my best but now I listen to my body. Um, so that now I’m more in tune with my body. More so than ever before.

This quote is intriguing for numerous reasons. The injury and the vulnerability of her health have forced this nurse to assess her body and her abilities. She had not made this assessment before her back injury, she admitted. She has now learned to pace and “listen” to her body. Despite the pressures associated with caring for sick patients she has made her health an increased priority after her injury. While the pressures of her work remain the same, Participant #5 chose to take a more preventative approach to her health.

The pressure of the system forces you to work quickly and sometimes you have to really stop and—and I think I am doing something that’s gonna endanger my nursing license or my health. And that’s after being a nurse for fifteen years. It’s sort of the first time when I’ve slowed down. And I thought ‘I’m not gonna let these people intimidate me to rush because now I know what happens when you rush and you don’t wait’.

This nurse has learned to place limits on her body since her back injury. She noted, “I’m just aware of everything now where I wasn’t before. I just used to take everything for granted. Because I never had any pain - ‘Oh, no problem.’ But now I’m aware of it, you know, I really take care that I don’t mess up my back any more”.

The newly recognized need to take care of one’s back and the vulnerability that all the participants felt in the context of their jobs are associated with the fact that all of the nurses in the study continued to experience back pain. Their continued back pain served as a reminder to place physical restrictions on themselves. Participants referred to their pain as
“chronic”, “long term”, and “continuously excruciating”. For example, Participant # 10 stated that “…the pain will never go away”. As a result she is acutely aware of how work activities will impact her pain and back,

You have to protect, you know. You’ve got to be careful how you do things. How you can’t reach and grab something, you know. You know every time you do something you got to think about your back. So that kind of bothers me a little bit. You know you can’t just be yourself anymore.

Like others, this participant noted that she is approaching her work life differently. And like others, she found this approach to nursing novel. She refers to “not being herself”.

The notion of changing working styles and approaches to one’s health in relation to the back injury and back pain was dominant in all of the participants’ stories. The ‘before me’ ‘and the ‘current me’ is echoed in each of their interviews. It seems that the back injuries served as a kind of awakening for the participants. As Participant # 3 suggested when discussing her changed work attitude, “Cause right now I’m thinking about the present, I’m thinking about me. How I’m feeling”.

The types of restrictions participants placed on themselves depended on the participants’ consideration of ‘working’ (long term) versus ‘returning to work’ (short term). For example, participants placed more stringent parameters on themselves in the context of long-term work. Participant # 6 described having placed loose parameters on herself during her initial return to work, “I did too much too soon.” When asked about her current work, this participant described more protective parameters,

Ahm, I’m learning to take care of myself because no one else will. No one, (chuckle) you know...so you, you know, things take longer, and they do take longer, but you know, you’ve got to protect yourself. Because I know now what causes me more pain, so I really try and avoid it.
It appears that she, through experience and continued pain, has re-conceptualized her limits by placing her own health as a high priority.

The re-conception of one’s abilities was a difficult task for participants, likely because the participants in this study worked in self-disregarding capacities for many years. For Participant #2, two earlier back injuries did little to deter her nursing style. Only when the continued abuse to her back (from too little time spent recuperating before returning to work,) resulted in spinal surgery, did this participant reconsider her capabilities. She noted the changes in her work style since her surgery,

And even when I’m [I was] sick myself, I will [would] drag myself to work generally until I’m [I was] told to go home, which isn’t a good thing to do; you’re just spreading your germs around. But even when...when I’m at home I find it difficult just to relax, let myself recuperate. And it wasn’t until I had the...the big spinal surgery that I was able to realize that I was not invincible. And it gave me a bit more insight.

In this section, nurses described the re-conceptualization of themselves since their back traumas. The nurses spoke of taking care of themselves, both to continue working in their jobs but also in consideration of their general health. It appears that continued back pain, discussed by all nurses, served as a constant reminder of the pain and disability that nurses experienced as a result of their injuries.

**Placement of Restrictions on Work.**

The participants’ re-conception of themselves as assailable to injury led the nurses within this study to re-conceptualize their method of nursing. Their previous working style, described as “beyond the call of duty”, was modified by placing limits on their working styles. The restrictions on their work paralleled the restrictions the nurses placed on themselves and their bodies. The nurses in this study identified methods of modifying their work in order to reduce further back injury and pain. Work modification became necessary.
for the purposes of "working" long term. Adapting the tasks of "nursing" to their physical tolerances was a novel concept for the participants - previously the nurses adapted themselves to the rigor of work. Participant # 4 noted,

My biggest perception in the last year and a half is that... each person who has to live with a back injury has to learn to adapt with whatever the pain, the discomfort, adapt to their environment, whatever kind of nursing... job you have. Uhm, if you need to go and sit down or go and lie down, just do it on your break no matter what other people think.

Fear of re-injury was an important motivator in changing the participants' working styles and was congruous with the notion of protecting the self and one's body for long term work.

When Participant # 10 was asked how she changed her nursing style she noted,

'Cause I did it in the sense that I was concerned that I would do another injury, you know, re-injure myself. I didn't want to end up, you know, quite crippled up. Oh yeah it was always in the back of my mind. Prevention.

Another change in the nursing style was to involve patients with their own care. The nurses asked and expected patients to assist them with transfers and dressing. The nurses saw this as a way of decreasing the physical demands of their work. Participant # 8 noted, "I guess I used to do too much for them [patients]". Some nurses began to involve their patients more in their own care. Participant # 10 described her way of modifying her nursing lifestyle, "I was very careful making patients do a lot more for themselves in terms of getting out of bed, doing things like that". A nurse described one incident that almost jeopardized her recovery,

As I said I was careful with the patient. Because I do remember there was a - a not particularly nice patient who, um, I—I guess she'd just had the baby whatever probably had just, um, wanted to get up. And without allowing me to take her by the arm and help her get up she—she yanked me and pulled me and I—I remember getting quiet angry with her. You know because all I could think of was 'back'. You know, and she was quiet upset. But I was also quite upset because of my back.
This participant’s reaction to her patient is novel in the sense that nurses in this sample reported that they had, prior to their injury, compromised their own health for the sake of their patients. As noted earlier, one nurse had a great difficulty being upset with a patient that had injured her and required the services of a counselor to diffuse those feelings. It appeared as if the nurses began to reclaim their bodies—back pain appeared to have served as an impetus for this.

Another method of modifying work was to ask and wait for assistance from co-workers. Participant # 3 noted that assistance is essential for preventing further injury to her back,

I’m trying to stop the damage occurring any more. Like if this is the worst that my spine can be, I’d be—I can almost live with it. But the problem is it’s getting more a curvature where I’ll have to put rods in or take it further. That scares me. That’s enough to stop me from, ahm, and (chuckle) from lifting as much as I am. That’s why I’m to do it, that’s why I am asking other people to help me, that’s why I’m trying to, ah, move the cases differently.

Participant # 8, who was injured specifically because she did not wait for assistance from co-worker during a heavy patient lift, noted how she has learned to be more patient. She discussed how she has changed the way that she nurses, “I learned to take that as a—good lead that I must just wait”.

Participant # 5 discussed how she has learned to refuse to do certain tasks that may potentially cause her further injury,

You have to speak up and ask for help. That was sort of what I learned. Because if you try and be, you know, strong, they think you are strong. So I learned to be a little more assertive in asking for help. Just saying ‘no’ I can’t do that.

Participant # 3 also found that she has learned to speak up for her ‘health’ by limiting work tasks that may be particularly painful for her to perform. She discussed her interaction
with a surgeon who had booked numerous heavy surgeries in one day. "I sat down and I said, 'I can't take so many, can you not spread these patients', you know, over the list?'

Four nurses have elected not only to change their working styles but also to change jobs in order to continue working. All of these nurses noted that they wanted to work in jobs that have lighter work duties due to their back pain, which they consider enduring. One was looking to leave the hospital environment to find a job that is less physically demanding, "Uhm, but um, it's something I'm going to have to deal with probably for a long time. And like I said, I'm looking probably at finding a different type of nursing job where it's going to be more, uh, not doing those things, so something in home care". Another participant had already left her hospital job to work in home care. Another has undertaken graduate studies in order to leave bedside nursing. One nurse chose to leave nursing all together and is now in an administrative role.

During their return to work, participants changed their working styles to suit their re-conception of their physical abilities, in order to continue their careers. The participants viewed their back pain and injuries as chronic in nature and therefore made modifications to their working styles. It appeared that their injuries have made the nurses aware of the vulnerability of their own bodies. All nurses noted that they have taken care to protect their backs in work situations since their injuries, in order to decrease work-related pain. The nurses have modified their working styles by taking breaks, asking the patients to participate more in patient care, and asking for assistance from other co-workers. Some nurses have elected to leave hospital nursing for other less physically demanding jobs.
Chapter 4
Dimensions of the Return to Work Process, Part II

Re-negotiating Work: "The Price of Assistance is Membership" - "The Bank of Good Will"

This chapter describes the role of co-workers in allowing participants to change their working styles in order to accommodate their injured backs. The nurses in this study work in hospital departments with very medically and physically challenging patients. Thus, nurses rely on co-workers for physical assistance during such heavy tasks as patient lifts and transfers. The nurses described in this study have, as a result of back trauma and pain, re-conceptualized their role as nurse and their physical abilities for the purpose of nursing. As a result, the nurses have made personal decisions to modify their working styles in order to protect their backs from further injury. However, because heavy nursing requires co-worker assistance, the participants' ability to modify their work duties depends on the amount of support and assistance available from their co-workers. The role of co-workers in mediating the participants' return to work is of great significance partly, because of the relative absence of the role of the nurse unit manager in the process of return to work, and partly due to the heavy work tasks involved in the profession of nursing.

This chapter begins by describing the heavy occupational demands of nursing and the relatively absent role of the nurse unit manager. The combination of these two factors necessitated that participants with back pain rely on co-workers in order to complete work tasks. The discourse regarding back pain within nursing departments required nurses to justify their pain. Co-workers provided assistance if their pain was seen as legitimate, and if
the nurses with back pain had a work history that demonstrated previous contributions to the department.

**Occupational Demands**

All participating nurses described the occupational demands of their jobs as heavy. Each of them worked in departments (surgical, palliative, emergency, etc.) that required direct patient care. One nurse who worked in a neo-natal unit, which would seemingly require light physical duties, injured her back as she broke a fall of a new mother. All of the participants were responsible for feeding, bathing, and dressing their patients. In addition, these nurses were also responsible for medical procedures such as monitoring vital signs, dispensing oral and intravenous medication, and dressing wounds. The heavy job tasks that were performed regularly included lifting patients (during transfers), and pushing/pulling patients on wheelchairs, surgical beds, and/or stretchers. Walking, standing, and bending were performed on a frequent to constant basis. Each of these nurses was responsible for the care of three to four patients during a day shift and four to five patient during a night shift. Often the tasks were performed in a hurried manner due to the heavy and medically compromised patient caseload. The participants were, in principle, able to access assistance from their co-workers for the heavy tasks such as patient transfers, but this assistance, which was absolutely necessary for heavy patient care, depended on the availability and workload of other nurses.

The participants noted that the easiest parts of their jobs included, "going home" and "sitting to talk to patients". In terms of returning to work, all of the participants noted that despite the best intentions of their Department of Occupational Health and Safety, and the limitations suggested by physicians, modified return to work existed only in terms of number.
of hours worked but not the quality of their duties. Participant # 5 noted, “There are no modified duties in patient care. If a patient needs you, we [as nurses] have to be there for them”. Participant # 1 discussed the expectations of her co-workers upon her “modified return to work”, “…The staff had the expectation on my first day back that I was coming back to work, so I was working, and that was fine”. The lack of modified duties is, according to participants, related to nursing shortages. All participants, without exception, reasoned that decreased monetary resources within hospital departments resulted in a shortage of working nurses. Participant # 7 noted how staff shortage affected her return to work,

At that point after I’d come back after that two-week period I was scheduled as a staff person, so there was…there was nobody there to sort of back me up or to work beside me, so I just went back to full capacity.

In the perception of these nurses, the heavy work tasks, the repetition of work duties, the hurried pace of the work, and the lack of assistance was associated with frequent work injuries amongst nurses. Participant # 4 commented on the frequency of injuries in her department, “I am just one of the nurses [injured at work]. There was, actually in the last year and a half, there have been five of us.” Participant # 10, when discussing the heavy physical demands of the nursing profession, pointed out that “in our unit at least every day one or two people are ill”. She noted that her own back injury may have been avoided had there been extra staff to assist her, “’Cause maybe, if someone would have been holding this other man’s [patient’s] arm, the weight would have been equally distributed”.

All of the participants described physically demanding work tasks that are consistent with the description of the occupation of ‘nurse’ in the National Occupational Classification (Ministry of Supply and Services Canada, 1993). These work demands predisposed nurses to injury.
Nurse shortages resulting in scarcity of available assistance on the job heightened this predisposition.

**Self-Management**

Based on the reports of participants in this study, it appeared that the great influence that co-workers had in mediating an injured nurse’s return to work, by providing or withholding assistance, was a function of the relative absence of the nurse unit manager role in the return to work process. The nurses within a nursing unit seem to assist or hinder (through the lack of provision of physical support) the injured nurse’s return to work.

Significantly, five of the participants reported that their nurse unit manager was not aware of their injuries. For example, Participant # 6, who was not a full time member of the nurse unit team, did not let her boss know of her back surgery. She noted, “I never really had a relationship with the boss. I never discussed it [surgery] with her”...I think she knew later on, I just didn’t tell everybody”. Participant # 3 did not tell her boss of the pain she was experiencing as a result of a back condition, because she felt that such a disclosure would jeopardize her job,

I, this may be mean to say, but I’ve seen her lay the boots to other people. And it’s ahm, its something that I..., as a mother can’t afford to do. I cannot lose my job, or be restricted, or have something written that may say I’m not...I’m not capable to perform my duties.

She continued to say, “...but the feeling from management was …'cope'! And we [referring to other nurses] 'coped'”. Participant # 8’s experience with her nurse unit manager was similar. In referring to her boss’s awareness of her injury,

...she [her boss] did not know about it until about day or two after I called...My manager, I don’t really trust because I’ve heard stories where people have phoned her and another colleague’s been watching her on the phone. And she’s on the phone, “Oh don’t worry. Take as much time as you need”. And at the same time she’s giving her secretary a very offensive finger gesture. Like, yeah, right.
Participant # 7 spoke of her boss as taking a "hands off approach" with respect to her return to work.

"But you know, I guess to be honest I don’t want—this is going to sound crass - but I don't think she really cared...[she] stepped back. Stepped back. She didn’t really, like, she was never that type to come and sit and dictate to you, you must do this”.

Because the nurse unit managers of the nurses in this study were not very involved in their return to work, the co-workers assumed responsibility for assisting work reintegration.

"Back Injury Discourse" in the Nursing Departments

Despite the understanding that nursing is a highly demanding job, co-workers appeared to resent those nurses who called in sick. This resentment stemmed from the apparent shortage of nurses in the hospital environment. This nursing shortage translated into additional work for those nurses who needed to pick up the caseload of the sick or injured nurses. This resentment was widely acknowledged by all study participants.

Participant # 4 reported that in the past year at least five other nurses on her floor sustained work injuries that required time off work. Yet in spite of the prevalence of work injuries there was, at times, a lack of empathy between nurses. She rooted the lack of empathy in the shortage of nurses. She explained what happens when a nurse is off sick, “...you have to do twice as much work. So it's like pitting one against the other.” She noted that to avoid the resentment that is built up toward those individuals who are sick, the injured nurses are motivated to return to work, at times with detrimental consequences. This nurse stated, “Because that’s why I think more people end up coming back, then being off again, because either they re-hurt themselves, or, they just aren’t able to [perform work tasks], so then they have to be off longer".
Participant #3 admitted that when people return to work from an illness or an injury, co-workers make snide remarks such as “how was your vacation, most of us are slaving, how are you doing? She discussed the reasons for such sentiment,

Yes they tell people take—‘if you’re sick, you’re sick, you can take time off’. But then, you can’t help but to get angry because there’s no lunch break, there’s no breaks, there’s no help, there’s no...there’s no back up if your patients get sick. There’s no resources, and you are still expected to carry the workload. And we all know that that’s what we have to do, but it still doesn’t make you less resentful or angry that the person did call in sick.

Participant #5 found that the commitment to her work and co-workers was major factor to her return to work. She stated, “You know, the longer you stay off, they’re [management] not gonna get somebody to replace you, so the longer you stay off, the more work somebody else has got to do, right. To me it’s not fair!”

All study participants cited examples of co-workers’ resentment toward those nurses who were on sick leave. This resentment primarily stemmed from a nursing shortage that occurred when a nurse called in sick and other co-workers were required to pick up the patient assignments of the sick nurse. In order to decrease this resentment and to increase co-workers’ belief that injured nurses were not on “vacation”, each of the participating nurses felt the need to legitimize their injuries to their co-workers.

Making the Invisible Visible—the Issues of Legitimacy

As health care professionals, nurses are aware of the general medical discourse regarding back pain. For example, Participant #1 pointed out that back pain has “a dubious prognosis”. Participant #6 suggested that “back pain is invisible” and difficult to diagnose and treat. Thus, nurses felt that they required factual proof, such as physicians’ reports, to substantiate their injuries, or felt that they needed to exhibit overt pain behaviors to demonstrate the severity of their disability. The study participants’ perceptions were that
acceptance of the legitimacy of the injury by co-workers granted injured nurses physical and emotional support. Consequently, study participants found ways to legitimate their injuries by ‘making the invisible visible’.

Participant #5 reported that her co-workers knew that her injury was legitimate and subsequently they bonded as a unit to allow her to attend therapy during her work shift.

Well I think co-workers tend to be resentful if they have to pick up slack if they know people are slacking off. Okay? But I mean like everybody knows what happened. It’s not something that like I’m faking or, you know, something; they knew what happened, they knew I was in an accident, they could see me walking around...you know, in pain like that, they said “Don’t worry about it”. They said, ‘you—let’s organize it and you go’, and I went.

This nurse demonstrated her “legitimacy” because her injury was serious and known to her co-workers - and she also displayed her pain in her walk.

Participant #8 also used a dual method to prove the legitimacy of her injury and the need for modified work duties:

It definitely [medical documentation] validated my injury for sure because, it was, you know, I’d had a physical assessment. And, you know, I was in pain and couldn’t really sit. So it was—it was a valid injury. But I think it supported me because here—here’s medical documentation.

Participant #3, who experienced severe pain as a result of a back condition, noted that only her immediate co-worker knew of her pain. She said that her co-worker could pick up on her physical state, “Like she [the co-worker] can look at me and she knows that I’m sore...I know that she would pick up my slack. But if I knew that someone else was coming into the department who I’m not as familiar with, sore or not I’m there”. This nurse established a solid working relationship with her immediate co-worker—they had an understanding that went beyond the spoken word. Her co-worker could anticipate her pain “just by looking”. However, this nurse had not established a similar relationship of trust and
understanding with other co-workers. Consequently she performed all work duties, regardless of pain, when not with her immediate co-worker. She noted that if other co-workers were to know of her pain and her inability to perform certain work duties, that knowledge may jeopardize her job. She had legitimized her need for help with her immediate but not other co-workers.

The issues of documented legitimacy around pain and disability are not all that is required to receive assistance from co-workers. For example, Participant #4 noted that “there wasn’t even a question of...how the injury had come about or what was there. But there’s always the...the part that I was interested in, but the thing is...the question is, ‘how much pain you’re having’?” She was convinced that others doubted her pain because she was not taking pain medication. She said, “...probably I shouldn’t have been maybe as honest, as peoples’ perception—I can’t take pain killers, I never did even after I’d had two surgeries before, and I think I did say that...when I was there. So then it was like, ‘oh, if you don’t even need pain killers, how much pain can you really be in?’” So while the injury was legitimate and was not questioned (as this participant was injured at work) the severity of disability was an issue for her co-workers because she was not taking medication.

Participant #2 reported “feeling guilty about not looking sick but having this problem [back pain]”. She noted that she did not receive a lot of peer support because “people that have had back injuries don’t look sick. And unless you’re in excruciating pain you don’t really look like you’re in pain anyway”. Since her injury was not perceived to be legitimate, she did not garner a lot of physical and emotional support from co-workers. All nurses felt the need to have their injuries believed. The nurses used another method to assure their co-
workers, and this researcher, that their injuries were legitimately disabling. The nurses presented themselves as “non-malingers”.

“Not a Malingerer”.

Another main sub-theme that emerged from the data was the “not” representation of self. That is, repeatedly participants asserted what they were not, in this instance “malingers”. The need to be perceived as ‘not malingering’ seemed to provide a major impetus to return to work for all of the study participants. It should be noted that none of the participants were asked about their ideas on “malingering” since malingering was not a concept that I originally set out to explore in this study. Nevertheless, references to non-malingering were voluntarily and repeatedly made by study participants, apparently as one way to ensure that their pain was perceived to be real. That is, if the nurses had high personal integrity, their injuries would be likewise “honest”.

Participant # 3, who had assistance from her immediate co-worker, spoke of why she has avoided being called “lazy” by others,

Regardless of being sick, regardless of when I was pregnant. I … worked. And I was very fortunate that way. Even this time, I never once made them [co-workers] say that I was lazy, or you know, ‘I don’t know why she is here, she is feeling miserable’.

Participant # 10, who was off work for 6 weeks with a back injury she sustained while caring for a patient, noted that she would have liked to taken more time off work but did not want to appear as a malinger. She explained, “Malingerer. So I guess I didn’t want to seem like that, ‘cause I’ve come across enough people who have done that”. This example illustrates how she separated herself from those who are perceived to be malingers. The differentiation between those who are working with pain and those who choose to take time off was further reinforced by Participant # 5. “… You have one or two of what you call
malingers that, right, you know, as soon as they sneeze they’re off sick. But you know, you have that everywhere”. This quote is interesting for two reasons. One, this participant was in a major accident, significant enough that she required a lengthy course of therapy and medication. Despite the significance of her injury she elected to only take one day off work. Likely, her reference to what constitutes a “malingerer” - a few sneezes - is based on the way she managed her own health and her conception of what allowances can be made in case of sickness. Second, she assumed that I would “know” about malingers. It seemed like “malingerers” and ideas about malingering are common and shared knowledge. This nurse set up a dichotomy between them, “malingers”, and the two of us in the interview situation. Her identification as a “non-malingerer” acts as yet another method to legitimize both her injury and her integrity.

When participants had to take time off to recuperate from their injuries, there was a potential for others to perceive them as malingerers. Consequently, these nurses developed ways of narrating their stories that separated them from their “failed” back. For example, Participant #2 had two back injuries and one back surgery in her lengthy career of nursing. She attributed the repetitious nature of her injuries to the fact that she tended to ignore her pain, “…probably not giving myself enough chance to recover, I made things so much worse…” Because of her injuries, she now modifies her activities to avoid re-injury. Yet when she spoke of these modifications she detached herself from her back,

And if it’s the weekend, and the weather is bad, I won’t go out. Not because I don’t like bad weather but because I’m so afraid of falling and that wasn’t—fear wasn’t part of my personality, wasn’t part of my regular life, but my back has done that to me as well. My injury to my back.
The modifications that she made on her life are not perceived as being self-imposed but are rather imposed by her ‘back’. The reason for this disassociation may be found in the feelings she revealed about herself when she took the responsibility for modifying her activities.

And after just a couple of days I felt very...lazy trying to avoid doing things, so I just threw myself right back into my work, and was still getting back pain, was taking, ahm, anti-inflammatory pills to control this pain and just carried on with it.

It is interesting to contrast two of these passages. This nurse felt guilty for self imposed rest and carried on with work despite pain; however, when she had to modify her activity level she disowned her role in managing her activities and allowed her “back” to dictate her activity level.

The disassociation of self from the body is also evidenced in the narrative of Participant #8 as she described the rest she needed following her injury.

I—depending what kind of illness it is, I know to really lie low. Like, um, whether it may be flu or this particular back injury, my body demanded that I lay low. So I didn’t really do any cooking. My husband either cooked or we ordered in. Um, my child was taken to day care by my husband so I really—I—really took it easy. I just tried not to look around at the room at the mess or the untidiness ‘cause I just—my body dictated I couldn’t.

In summary, the presentation of self as a non-malingering may be viewed as another way that these nurses chose to legitimize their injuries and themselves in the eyes of the researcher and their co-workers. When the potential existed that such a label would be attributed, such as following long absences from work, participants separated themselves from their bodies. That is, participants disassociated themselves from the “failed” back that limited their activity and ability to work. Legitimacy surrounding the validity of the injury and inability to work involved all participants regardless of how or where their injuries occurred. All participants seemed to believe that they were required to prove the authenticity
of their injury before co-workers would contemplate extending physical assistance to them. Based on their reports, once co-workers believed that the need for their help was genuine, the amount of assistance provided related to the worker’s past contribution to the department.

The participating nurses’ previous contributions to their departments appeared to be measured by three categories: 1. The number of years that a nurse worked on a given unit. The longer a nurse worked on a unit the greater the opportunity she had to contribute to the “Bank of Good Will” in the next two categories. 2. Social ties developed within the department and 3. Reciprocal assistance.

**Years on the Job.**

The number of years on the job and within the same department provided an opportunity for nurses to build social ties within departments and to demonstrate reciprocity in terms of physical assistance, to co-workers. All of the nurses that described receiving a tremendous amount of assistance from their co-workers had long, non-sporadic, work histories within one department. All of these nurses worked between zero and fifteen years on the same nursing unit. Longevity appeared to offer these nurses formal and informal ranks of seniority and entrenched their status in the culture of the floor. Participant # 5 spoke of her co-workers: “They are willing to sacrifice for me to go [for therapy]”. Participant # 10 noted that her past work record, recognized by other co-workers, afforded her to take it easier on her return to work. She stated, “I’m always a helper. If I said I couldn’t do that everybody knew that I couldn’t do it. So, ah, I think they were supportive”. Participant # 7 also pointed to her history on the unit as the reason why co-workers were willing to assist her in her initial return to work. She said, “Because quite—like I’ve helped them, you know. I mean I try to make it a, I’m going to say win-win”.

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Nurses who have spent less time working in a particular department or who worked on a part-time or casual basis developed fewer ties to their co-workers and had less opportunity to offer assistance to others. Participant # 9, for example, was working in her job for only one year when she was injured. She worked in the post-natal unit where assistance from other nurses was not required due to the light physical demands of her job. As a result she had little opportunity to develop reciprocal working relationship with her co-workers. While she noted that she liked her co-workers, when she was injured, it was her personal friends rather than her work friends who provided physical and emotional support.

Participant # 6 worked in her department on a part-time basis. When she returned to work following back surgery she did not tell her boss or her co-workers about her pain,

She [the boss] didn’t really know. I think she knew later on, I just didn’t tell everybody. I didn’t—a lot of my work mates didn’t know until I needed help, so it wasn’t a general—I was kinda out of the picture, I was over at another site all of the time so I was kind of, a, out of view for a while. So I didn’t broadcast it. Maybe I should have told, I’d get more assistance.

According to the participants’ accounts, physical presence seemed to create social ties between nurses. These ties in turn created a network of social and emotional support between nurses. Participant # 4 was a casual worker, that is, she worked whenever the administration determined there was a shortage of nurses on the unit. She noted that co-workers were sympathetic to her following her injury, but later viewed her as a liability because of the extra work they were required to pick up from the workload she was unable to complete. Possibly this feeling of resentment came about because she, as a casual worker, was supposed to assist them with their workload. That is, this nurse was not one of the permanent “team members” on the unit, and should have been there to provide assistance to them. The nurses on the unit provided help to the “in-group”. This participant, as a casual
worker, was part of the “out-group”. She noted, “Uhm, they were sympathetic in one form, but in the other form it’s like you’re a liability...you have to do twice as much work. So it’s like pitting one against the other”.

Re-Negotiating Work: “All for One and One for All”-The Price of Assistance is Membership.

Working together over the years seemed to allow nurses to build social ties with each other. For example, Participant #7 described how the social aspects of nursing were one of the motivating factors to return to work. She says, “I missed the work, I missed the work, I missed—work is very social; you know, I missed joking around with people, ahm, so yeah, there was that part of it too”. Participant #1 drew references to “family” when describing work,

And we also have a lot of fun after we get over, sort of, the intense piece of getting started, and I mean it’s not that we forget about the patients, but we do—you know, there’s—again, the social aspect there’s opportunity to sort of chat and, you know, sort of sitting around a table.

It is interesting to note that this nurse was describing the atmosphere around the operating table, yet in her description and out of the context of the interview the connotation of a gathering around a dining room table is conjured. Participant #10 makes a more specific reference to family. She said,

It’s a social environment; we spend more time at work almost more than we do at home, so it tends to become family. So I really missed having the co-worker, ah, contact. So, I was anxious to get back to work.

For this nurse, “missing contact with people” was a great motivator to return to work.

In contrast, Participant #2 did not have an opportunity to develop strong social ties to her co-workers due to a sporadic work history resulting from repeated absences related to her
injuries. She implied that she has closer ties to friends in her private life. She felt that her co-workers replaced her.

It’s more that my personal friends work outside of the hospital—these are the people that would come and spend time with me when I was at home when my back was injured, and didn’t sort of see me as somebody that was being replaced because of sick time, because I was off sick.

According to the participating nurses, social ties built with co-workers in the process of prolonged presence on the unit produce a sense of family and comraderie on the unit. This sense of family contributed to a work atmosphere in which the nurses assisted one another, not only out of professional duty but also out of “familial” duty.

Reciprocal Assistance: The Bank of Goodwill.

Despite the participating nurses’ back pain, each of these nurses, upon return to work, felt an obligation to continue to contribute to the unit. Interview accounts suggest that this obligation resulted from two factors. First, all of the participants’ work units experienced staff shortages. Therefore, the return to work of injured nurses was necessary for the functioning of the unit. Second, many injured nurses felt an obligation to reduce the workload for other co-workers. This self-imposed obligation was mostly experienced by nurses with a long work history on the unit. The injured nurses’ contributions to the department, despite their injuries, fostered feelings that promoted reciprocity of assistance. The notions of “deposit” and “withdrawal” into a ‘Bank of Good Will’ seemed fitting here. That is, the more injured nurses had contributed to the department, the more their co-workers provided physical assistance.

The longer the period of time an injured nurse worked modified duties, the longer co-workers needed to pick up “the slack” of the workload, thus there seemed to be an
understanding that without the contribution of the injured nurses, the good will of their co-workers would be limited. Participant # 5 discussed this reciprocity.

You know what, the more people are off sick the more work my co-workers had to do. Right? Now I’m not going to be a martyr and go to work if I’m at the death’s door; but at the same point I’m not gonna have a headache or I’m just not gonna get up and say I don’t feel like going to work. To me it’s not fair. It’s like I’m not pulling my weight, you know. If you’re there, you’re there to work and you have a responsibility and a commitment to your patients, and you should be there to help if you can possibly be there.

This participant discussed a responsibility to her patients but also the responsibility to her co-workers. She showed an understanding and empathy, possibly gained through many years of nursing, towards her co-workers, as they may need to work extra to cover her patient assignments. She returned to work only one day after her accident. She noted, “So as long as it [the pain] wasn’t excruciating, I could work. So I did”. She felt her co-workers picked up her sentiment regarding her return to work and reciprocated with assistance. She noted of them,

Well, ahm, my co-workers at work were really good. Like they knew what happened and they knew I had just come back to work so, you know, I’d sit down whenever possible, right, and they were very good, they wouldn’t—I wouldn’t lift anything heavy.

Participant # 7, who was also off for a short period of time reported that she asked co-workers for assistance, but was understanding when that assistance is minimal. She said,

When I went back, again because I wasn’t off for that long, it wasn’t like it was a big deal, to be honest with you. I mean, and yeah, I…I told people, like I said I’d been off and you know, try to…try to be easy with me or whatever; not easy, that’s not the right word, but you know, try to give me a bit of a break. But quite frankly its’ difficult; you really—I mean if you have fourteen heavy patients in there you’re not gonna be really able to get a break.

For this nurse, there was a professional understanding of the type of help one can ask for and the type of help one can receive. She noted, “…it’s just kind of the way it is”. This
respondent also brought up the issue of reciprocity. "So I said, you know, can you just give me a hand; and most them, by and large most of them were fine. Because quite—like I’ve, ah like I’ve helped them, you know. I mean I try to make it, I’m going to say win-win”.

It appears that there is an implicit awareness amongst nurses regarding the difficulty of their job. Thus, all participants attempted to protect their own health and 'backs'. Participant # 10 discussed her perception of her co-workers' reactions when she was not able to provide assistance to them,

They are unhappy at times, but initially supportive. And everybody knows you have back problems, so it becomes difficult for them too. I am going to say they were supportive but you know they can’t help the feelings that they have when there’s nobody to help them either. ‘Cause then the burden’s on them and then everybody wants to protect their back.

Teamwork is integral to the promotion of every nurse’s health on the unit but, as just noted, teamwork meant not putting other nurses at risk of injury. Participant # 5 put this sentiment forth, “There’s not enough staff. There’s nobody to replace…so you’re —ahm, everybody has a responsibility—feels a sense of responsibility of getting work done”.

Participant # 1 further acknowledged the effects of the staff shortage on her unit. As noted earlier, even though she returned to work on modified duties she said, “the staff had the expectation on my first day back that I was coming to work, so I was working and that was fine.” This nurse “met” the expectation of other nurses - she took the responsibility for her patient case load so that she required minimal assistance from other nurses.

The shared understanding and solidarity concerning the difficult work involved in nursing is vividly illustrated by this excerpt from the interview with Participant # 8. This nurse came back to work on modified duties, and even though she felt that she could use an
extended period of modified duties. She gave these up because she felt that there were other injured nurses who could benefit even more from a modified work schedule. She notes,

And I—I think I could have benefited from another week or two but at the time there were other individuals that required the modified program because of their illness...I sort of felt, well, I don’t want to hog this area [modified work].

The nurses within the unit, not the nurse unit manager, appeared to be responsible for the success of nurses’ re-integration in the workplace following an injury. The provision of physical assistance appeared essential for the injured nurses’ successful return to work. Assistance appeared to be a currency that was earned and traded. Nurses could ‘trade’ workloads by varying the amount each nurse would do, depending on her physical state. In this study, a successful trade was usually dependent upon the recognition by others of the injured nurse’s past work history. Sharing the normative standard of “pulling one’s weight” symbolized a ‘good’ work history. Participant # 5 may serve as an example of a nurse with a good past work history in the sense that she worked with the recognition that her contribution to the department had eased the work of other nurses. She noted, “the more people are off sick the more work my co-workers have to do”. The idiom of reciprocity is well represented by Participant # 7 when she spoke of other nurses who provided her with physical assistance to achieve a “win-win”, that is, they know that she would provide them with assistance should they require it. She noted that co-workers know “I would be there to help them if they needed help”.

However, Participant # 2 did not have “one for all - all for one” type of past work history, and had not cultivated working relations for the reciprocity of assistance. The injuries that this nurse sustained in the process of patient care represented her sacrifices to the patients - not to her co-workers. That is, this nurse’s zest to “care” resulted in extra work that
her co-workers were required to do in her absence. In terms of reciprocity, this nurse, unfortunately, could not offer much. First, she had not been able to reciprocate the past assistance provided to her by her co-workers as a result of her work-related injuries. Second, she was fairly explicit with her co-workers regarding tasks that she would and would not do. She had told them that she would not participate in a lot of heavy physical demands, and unfortunately, it is in the heavy work tasks that nurses provide assistance to one another. In turn, this nurse reported that she felt the resentment of her co-workers build throughout her series of injuries. She noted that the return to work from her last absence was the most difficult. She felt she was perceived as a liability. She noted that she felt “singled out” by her co-workers, who made her do “dirty” patient care tasks such as specimen collection. She said of her co-workers,

And although nobody really said anything, I go the impression from my co-workers that they sort of perceived me as sort of being there for an easy ride and getting paid for doing very little. Didn’t get a lot of peer support because people who have back injuries don’t look sick.

It appeared as if her co-workers excluded this nurse from the circle of “help”. She was on her own. To exclude her from the circle of shared assistance, this nurse was delegated patient tasks that required no assistance from other nurses. It is interesting to note that her co-workers, not the nurse unit manager, delegated these tasks. Staff had the power to broker assistance and delegate tasks. Without her co-workers’ co-operation she was not able to thrive in the department and took a job in a different department. In fact all three nurses who did not have strong support from their co-workers as a result of weak social ties and a poor history of reciprocity, both of which were a factor of their sporadic and short work histories, changed jobs to different work settings.
According to the participants' accounts, nurses, following a back injury or back-related pathology, required the assistance of their co-workers to successfully integrate into the pre-injury work setting. In order to receive assistance, co-workers must first believe the veracity of the injured nurses' pain. The nurses requiring assistance used several methods, including, demonstrating pain behaviors, using medical reports to prove legitimacy, presenting themselves as non-malingers, and disassociating self from the injured body, to persuade co-workers that their pain was indeed legitimate. Second, in order to receive assistance, a nurse experiencing pain must have had a work history that demonstrates past contributions to the department. A model of metaphorical 'bank of good will' was used to demonstrate this evaluation by co-workers. It appeared that a nurse, during her nursing career, may accumulate 'credit' among her peers, so that when a nurse requires the assistance of her co-workers to perform work duties, she may make a 'withdrawal' from the 'bank of good will'. The amount and type of assistance appeared to correlate with the level of credit that a nurse accumulated in the process of her nursing career within a given department. This credit seemed to be based on the number of years a nurse worked in the department and was related to the other two credit building components - the building of social ties within the department and past assistance to others. For example, a nurse who has had a long working history within a department and who has assisted other nurses during their injuries or illnesses will have a larger 'credit' account from which to withdraw assistance from others. This nurse is therefore more likely to be able to change her nursing style because other nurses provide physical support. On the other hand, a nurse who has a short nursing history within a department, during which she was unable to build up 'credit' for future assistance, may not receive physical support from co-workers. Because physical support from co-workers is
essential in the profession of nursing, the aforementioned nurse may need to switch nursing departments where her ‘credit’ rating is not established, or change nursing areas to a job with lighter nursing duties. Thus, the change in conception of one’s abilities may be understood as a personal decision, but one that may be realized only with the support of co-workers.
CHAPTER 5

Discussion

The Meaning of Returning to Work

In this study of the return process to work experienced by nurses with back pain, the main findings are:

1. Nurses participating in this study re-conceptualized their physical abilities and their abilities to nurse following back injuries and subsequent pain. The nurses’ initial working style was conceptualized as “Going Beyond the Call of Duty”. In this style of nursing, participants demonstrated a commitment to their work and their patients that placed their own health at risk. Data gathered in this study suggested that the self-esteem and self-worth gained in the process of nursing leads nurses to care for patients in ways that jeopardizes their own health. Following their injury, participating nurses re-evaluated their physical abilities and their working styles in order to take better care of their health and their backs. The concept of the “Cherished Back” represents a process by which participants came to realize the vulnerability of their bodies in the context of their work. They subsequently began to change their working style by placing limitations on themselves and their working styles. Their perception that their back pain was chronic appeared to motivate the aforementioned change in working style.

2. While all participating nurses re-conceptualized their nursing style, their behavioral manifestations in the course of their nursing activities were modulated by the availability of co-workers assistance. The role of co-workers’ assistance was integral to the successful return to work of participants, in part because of the limited role played by the nurse unit manager in the return to work process. Co-workers provided physical support to nurses with
back pain if two conditions were met: if their back pain was perceived to be legitimate; and, if nurses with back pain had work histories that demonstrated a contribution to the department or to co-workers.

This chapter discusses these findings in relation to the relevant literature. First, the results will be discussed in relationship to the literature reviewed in Chapter 1. Second, the relationships between the main themes resulting from this research will be interpreted within to the Symbolic Processual Analysis model described by Turner and Turner (1978). Last, occupational reintegration will be analyzed within the theoretical framework of the P-E-O model (Law et al., 1996).

Reflection on the literature

Throughout the interviews, participants cited back pain and the notion that pain is lasting as the predominant reasons to change their working style. Back pain was perceived as a 'call' to nurses that their health is assailable. The notion of pain as 'protector' and having a purpose is cited by Melzack and Wall (1996). Chronic pain in relation to the back has been medically defined as pain lasting from 6 weeks to 6 months (Bates, 1996; Horn & Munafo, 1997; Hawthorn & Redmond, 1998). In this sense all of the study participants experienced chronic pain, but without the severe functional implications evident in the chronic pain syndrome (Horn & Munafo, 1997). Instead, participants in the study continued to function in the context of their jobs but with limitations that they imposed on their bodies and their work. The self-reports of the nurse participants in this study suggest that the reason for this modification was their belief that their back pain is long lasting in nature. This finding is congruent with the work of Williams and Thorn (1989): their study supports the notion that belief in pain as long lasting is negatively associated with activity levels. Despite the belief
that pain is long lasting, the nurses continued to function effectively, albeit in a modified manner, in their home and work environments. The belief that back pain is long lasting in nature has been documented in other studies. For example, Tarasuk and Eakin's (1994) study of workers who were receiving treatment for back injuries, the fifteen participants also perceived their back pain to be permanent. Similarly, in a pre-and-post-intervention to decrease injured nurses perceptions of themselves as disabled Cooper, Tate, and Yassi (1998) found that although the participants reported a decrease in their overall perceptions of disability, they continued to see themselves as disabled with regard to work. Yet, the participants of the aforementioned study continued to participate in work activities. When considering the epidemiology of back pain, recurrence of back pain is not uncommon. In fact, "a previous history of back pain is known to be the most consistent predictor of future trouble [back pain]" (Burton, 1997, p. 2577). The Fear-Avoidance Model (FAM), is frequently applied to individuals with back pain who do not resume their past activities of daily living. However in this study, the FAM may explain changes in the nurse identities and working styles rather than failure to return to work. It is interesting to note that the FAM places emphasis on the psychological rather than the social influences responsible for pain perception and behavior. While individual influences are important in behavioral reactions to pain, in this study, social influences appear to have a greater effect on the nurses' return to work process.

The Model of Human Occupation (Kielhofner, 1995) can provide a fuller explanatory framework from which to examine the participants’ experiences in returning to work. The three subsystems inherent to the individual (volitional, habitual, and performance capacity) influence occupational performance depending on the perceived demands of the task. In the
case of the interviewed nurses, the initial back injury and subsequent pain compromised and inhibited the fulfillment of the volitional and habituational subsystems of nurses. However, despite the back pain, participants returned to work because of their strong will to nurse [volition] and the important [habitual] role nursing had in their lives. Participants’ viewed nursing as “life”, “family”, and “all I wanted to be”. Thus, while their performance capacity may have been limited as a result of pain, participants continued to work, albeit in a modified manner. Although their capacity to resume work appeared to be mainly due to the strength of their desire to nurse and the importance of nursing in their lives, the volitional, habituational, and performance capacity subsystems do not interact in a vacuum. The social and physical environments greatly influenced participants’ occupational performance.

Environmental influence, particularly that in early childhood, was strongly represented in the stories of return to work. Uniformly, participants cited examples of seeing their parents persevere through pain and continue working in the home and/or formal job settings. All participants noted that their parents remained stoic in the presence of pain. The participants used words such as “quiet”, “go away” and “close the door” when describing their parents’ reactions to pain. In addition, participants noted that their parents’ reactions to pain influenced their own current approach to return to work while experiencing back pain. This finding is consistent with Fordyce’s (1987) model of behavioral learning and imitation. Interestingly, the participants’ current family did not appear to influence participants’ experiences in returning to work. While studies suggest that spousal behaviors influence the prevalence of pain behavior and disability (Block, Kremer, & Gaylor, 1980; Flor, Turk, & Rudy, 1987), marital status or the absence or presence of children did not appear to influence return to work for the study’s participants. All participants who had spouses noted that while
their spouses were supportive, the decision to return to work was made independent of them. This may be explained by the strong commitment nurses felt toward their jobs. Some, but not all participants were motivated to return to work earlier than desirable by their economic situation. It is significant to note that all four of these women were single, and three out of the four were single mothers. Only one of these participants was not eligible for salary compensation. Nevertheless, not all single mothers returned to work for financial reasons. For example, one participant who had two small children at the time of her injury noted that money was not a factor that pressured her to return to work because she was always “financially savvy” and finances were “not a difficulty”. Thus, it may be interpreted that personal finances were a motivator to return to work for some, but not all, study participants. Financial need did not appear to be solely associated with marital status, children, or casual versus full time work in this small sample of women. Instead, financial need as a determinant for return to work was based upon highly personal and individual evaluations. Financial compensation did not deter participants from returning to work as suggested in some studies (Hadler, 1997; Sommer, 1998; Plumb & Cowell, 1998). All but one participant received financial compensation from the hospital in which they worked, yet despite receiving this compensation, all participants returned to work within two months of their injuries. The results of this study suggest that the importance of nursing as a career and as a central identity were some of the most salient factors driving the return to work process.

Psychosocial and physical work environments contribute to either worker health or illness, and the job of nursing falls into the ‘high strain’ category (Karasek & Theorell, 1990). Nursing is a job with both high psychological demands and low decision latitude. The work tasks of nursing predispose nurses to high levels of psychological and physical stress
Six out of ten nurses in this study injured their backs in the process of patient care. For the other four, back pain was exacerbated by work activities. The fast paced nature and unpredictably in the process of patient care appeared to have affected back pain in those nurses who have returned to work. Thus, the nurses in this study reported experiencing pain on a constant basis, and spoke of the longevity of their back pain.

The growing physical workload as a result of hospital shortages, as well as increasing injuries among nurses decreases the number of working nurses in departments (Helmlinger, 1997). Several participants in this study reported that their injuries occurred because they required assistance that was not readily available. Upon their return to work, all nurses in this study decided to increase their reliance on the physical assistance of their co-workers in order to decrease the possibility of further injury and to decrease their current back pain. However, physical support was not available for all nurses. As noted, nurses who were believed to have had a true injury as well as nurses who had the opportunity to contribute to their departments, garnered more support from fellow nurses than others. The findings of this study are consistent with the findings of Tarasuk and Eakin (1995), in that the issue of the legitimacy of the nurses' pain was central in the experiences of nurses in their return to work and in their inter-relationships with nurse co-workers. In this study, support from co-workers also depended on past contributions to the department. Nurses who had made the largest contributions to the department, and those who received the most support, were those nurses who had the opportunity to work in that department for many years. This finding is significant because physical and emotional supports in the workplace are important as they act to decrease work-related absenteeism (Metzger, 1985). According to Jennings (1987)
...support is typified by reciprocal interpersonal exchanges that enhance security, mutual respect and positive feelings. People who experience social support are better able to withstand the stresses of their environment (p. 64).

The use of support is particularly relevant in the job of nursing. Physical support and teamwork is essential in carrying out the heavy work demands associated with the job of nursing: “helping a colleague turn or ambulate a patient, assisting someone to make a bed, and answering call lights qualify as tangible support, as does adjusting one’s schedule to help a co-workers” (Jennings, 1987, p.64). Significantly, social support in nursing has been linked to a business exchange (MacPhee, 2000). Nurses having a short or sporadic work schedule may not have an opportunity to contribute to the departments in which they work, “because flex nurses are less rooted to particular units and staff, and fewer opportunities (or desire) may exist to engage in reciprocal social interactions” (MacPhee, 2000, p. 196). MacPhee found that nurses working full time and on traditional schedules had more emotional and physical support available to them. Nurses’ social networks at work are important for buffering emotional and physical stress: “When work-related networks were insuficiently supportive, individuals were forced to rely on individual coping strategies. Although personal coping strategies were helpful, they were not sufficient to buffer work-related stressors” (MacPhee, 2000, p. 192). McPhee postulates that nurses with non-traditional flexible schedules form fewer social attachments by moving among multiple units. Unfortunately, the nurses who have not had an opportunity to make a significant contribution to a department may receive little or no support, and nurses with low levels of social support from co-workers have the highest levels of reported back pain (Josephson, Vingard, &
Musci-Norralije Study Group, 1998). The latter study suggests "evidence for a direct association between insufficient social support and low-back pain" (p.69).

Attention must be given to the limited role played by the nurse unit manager in the return to work process of participating nurses. Although Shaughnessy (1996) argues that the role of the nurse unit manager is integral in facilitating the return to work of an injured nurse, most of the nurses in the current study did not notify their managers of the injuries they sustained or their subsequent pain. The fears that their employment status would be compromised and that their managers would make judgements regarding their pain were given as the reasons for not involving the manager in the return to work process. The under-reporting of injuries is found in other studies of nurses. For example, White (1999) discusses cost containment as one of the reasons for underreporting injury. According to White, managers attempt to save funds by reducing injuries and associated compensation payments. However, in the process of attempting to reduce costs "the unfortunate nurse is blamed, discriminated against, left to muddle through or even summarily dismissed" (p.56).

While the participants offered explanations of the limited involvement of nurse managers at one level, a brief analysis of the organizational structure of nursing units at that point in time offers an alternative perspective. Since the mid-1990's, hospitals in Ontario have undergone significant restructuring resulting in not only reduced nursing personnel, but a reduction in middle management nurses through the merging of nursing units. Thus, nurse managers became responsible for several units, and the routine tasks such as the daily division of workloads was delegated to unit nurses (Burke & Greenglass, 2000; Krampf, 1995). The process of decentralization of nursing power was also identified in a qualitative study that examined the roles of six nurse unit managers in Canadian hospital settings (King,
2000). King found that nurse unit managers no longer follow the traditional hierachial mode of management; instead nurse unit managers accomplish tasks by leading and advising nurses to lead themselves. Another study suggests that the main contributions of nurse unit managers include their focus on promoting change and improving the quality of professional practice (McGirr & Bakker, 2000). In McGirr and Bakker’s study, nurses were responsible for the tasks of social integration within the unit. With these shifts in the patterns of nursing, Manthey (1999) has argued that nurse unit managers are becoming “clinical advisors rather than controllers” (p.14). The documented leadership profiles of nurse unit managers as advisors is associated with promoting and encouraging increased responsibility for nurses within nursing units. In this study, both administrative restructuring of the context in which participants worked, as well as the evolving model of nursing management provide alternative explanations for the nurse unit manager’s limited role in the return to work process.

The under-reporting of back pain in the nursing population has been also identified by Collins (1990) (in Hignett, 1996). Collins (1990) suggests that the under-reporting of pain may be attributed to the underlying cultural within the nursing profession. Specifically, Collins points to: 1. The fear of reporting back pain as it may influence future employment; 2. The conditioning nurses undergo to ignore the existence of pain; and, 3. Pain being a common experience within the nursing profession (Collins, 1990 in Hignett, 1996). These reasons are all consistent with the findings in the current study. Certainly, the nurses in this study were fearful that reporting back pain would jeopardize their jobs. More significantly, these nurses ignored their pain even though some heard a “ripping sound coming from the
and they finished their work shift before attending to their own pain, risking further injury.

This section reviewed the study findings with respect to the literature, encompassing personal, environmental, and occupational factors involved in the experience of returning to work with back pain. The following section aims to synthesize the major findings within this study. The inter-relationship between nurse identity, negotiation of identity change with respect to limitations placed on body and work, and co-worker assistance will be presented.

Renegotiating the Nurse Identity

Participating nurses appeared to have enmeshed their personal and professional identities. Nursing was an extension of their personalities and lifestyles, not just their jobs. Nursing for many participants began in early childhood, before the beginning of their formal careers as nurse. Unlike Davis (1968), who suggested that nurses learn to function within the medical model by separating and alienating the self from the lay world, the nurses in this study integrated the role of “nurse” early in life. In fact, participants had difficulty separating from the nurse role. This finding is congruent with other studies examining personal and professional identities in nursing populations. Ohlen & Segesten (1998) examined nurse identity through the use of interviews and a theoretical literature review. Their study suggests that personal identity is highly connected with professional identity. “The professional identity of the nurse is conceptualized based on personal and interpersonal dimensions from a theoretical perspective focusing on interaction, growth, and maturity” (Ohlen & Segesten, 1998, p. 725). The participants in this study note that their style of nursing was much more developed as a result of personal experiences of caring than the expectations placed upon them by co-workers. While nurses developed their style of nursing in the process of
socialization with others. This socialization did not appear to arise solely from formal nursing experiences. Rather, working styles seemed to have been developed early in the nurses' caring careers, often in childhood. The feelings of self-worth and self-esteem they found in caring for others were replicated in formal nursing. The need to nurse others at times took precedence over the nurse's own health. The nurses in this study came into the nursing profession with engrained life experiences that emphasized the needs of others. It appears that these experiences may have influenced the nurses' "working styles". Feurstein, Grant, and Pransky (1999) describe working style as a "pattern of behaviors, thoughts, and physiological reactivity evoked in response to a set of work demands" (p. 178). These authors examined the prevalence of work-related upper extremity disorders in light of working styles. Similarly, in this study working styles appear to have contributed to work related back pain.

Fagermore (1997) analyzed surveys and interview data provided by working nurses to examine the values comprising the professional identity of nurses. The researcher found that caring for patients meets the nurses' "other oriented values" (upholding humanness, attending to the needs for protection, etc.) and "self-oriented values" (intellectual stimulation, personal stimulation, creativity). It is interesting to note that both other-oriented values and self-oriented values are "mediated through the actualization of the other oriented values and through nurses' engagement in her work-setting... hence, working as a nurse maintains and enhances their self-concept both as nurses and as persons" (Fagermore, 1997, p. 440). "Over caring" and self-less giving in the context of work and personal life result in emotional and physical burnout (Hall & Wray, 1989). This studies associate over-caring, self-less giving, and nurturing with symptoms of low self-esteem and self-worth. This finding seems
consistent with the data of this study. Participants spoke 'of work being their life', as a consequence of having "something missing" or "not addressing their own problems". Their back pain acted to focus participants' attention on their own health. Thus, back injuries and subsequent pain assisted nurses to place limits on their altruism and forced them to address their own physical needs. Following back injury, participants in this study re-negotiated their nursing identities by placing limits on their bodies and work.

The issue of identity change following a chronic or long-term illness has been widely studied (Bury, 1982; Karp, 1996; Charmaz 1987, 1990, 1995; Yoshida, 1993). This body of research suggests that during the process of chronic illness, individuals re-negotiate the presentation of self in a dynamic interaction with themselves and societal norms and expectations. The re-negotiation of self is a long-term and dynamic process consistent with the nature of chronic illness (Yoshida, 1993; Charmaz, 1987). For example, Charmaz (1987) discusses a hierarchy of identity change, mediated by the individual, in the course of increased dependence and loss of abilities. Yoshida (1993) uses the metaphor of a swinging pendulum to describe an individual’s changing view and presentation of self. The notion of the pendulum connotes identity as dynamic and taking multiple forms as the individual evaluates and represents him/herself to others. The influence of societal norms is important but not central to the identity change.

The identity change experienced by nurses within this study is similar to identity changes experienced by individuals with chronic illness. Their understanding of their back pain as chronic guided participants to monitor and “save” their backs in the fear of relapse. Fear of re-injury and the understanding that pain is enduring has been demonstrated to affect
occupational status in other studies (Letham et al., 1983; Lacrois et al., 1990; Rose et al., 1992).

Corbin and Strauss (1987) identify an important aspect of self-conception - the integration of various aspects into a sense of wholeness about who one is. “This [integration] is derived from the ability to carry out successfully the performances associated with the various aspects of self that make up identity” (p. 255). Back pain impedes the nurses’ ability to carry out nursing in the previous mode of their healthy selves. Back pain viewed as a life long condition motivated nurses to change their nursing identity and to modify their working styles. Back pain is seen as a chronic and long-term illness. The participating nurses’ change in self-identity, which is illustrated by the changes in nurses’ working styles from “Beyond the Call of Duty” to the “Cherished Back”, may be attributed to the nurses’ experience of back pain as a chronic condition.

According to Charmaz (1995) “identities bring commitments and responsibilities”. The changing of nursing identity in order to “cherish the back” brings forth a change in commitments and responsibilities in the job of nursing. Charmaz describes bodily change prompting identity goals. Thus, a bodily change such as back pain will influence identity goals of nurses, in this instance the method of providing nursing care. If body change is viewed as permanent, then the change in identity goals will be long standing. In the current study, the participants believed that their pain is of long duration and thus made, at times, long-term accommodations to their jobs, such as switching departments and even types of work to ensure lighter duties. Charmaz discusses the components involved in change of identity and identity goals: 1. The individual’s definition of their situation, 2. The significant others’ views, and, 3. The interactions and negotiations between them. The concepts are well
suited to illustrate the change in nursing identity experienced by this study's participants following their back trauma.

**The Individual's Definition of Their Situation.**

The nurses within this study defined their pain as chronic and long lasting. As one nurse noted, “back injuries in my estimation, as a nurse, they seem to last forever”. Perceived disability in a sample of nurses has been linked to time loss from work and disability in job related activities (Cooper, Tate, & Yassi, 1998; Tate, Yassi, & Cooper, 1999). Furthermore, prolonged back pain, particularly in the context of heavy patient care, serves as a reminder to nurses of their vulnerability in the work environment and contributes to their definition of their pain as long standing.

The uncertainty of the nurses’ pain may further contribute to the nurses’ caution in carrying out work activities. Additional assault to the back is unpredictable but highly possible in the job of nursing (Harber et al., 1985). The “Uncertainty in Illness Theory” (Michel, 1990) provides further support for the finding that participating nurses began to take precautions against further back injuries in the context of their jobs. The theory postulates that “if uncertainty is appraised as a danger there is an expectation of a harmful outcome, resulting in the [individual’s] activation of coping strategies to reduce the uncertainty” (Michel, 1990, p. 256). In this study, nurses appraised their jobs as “dangerous” to the future health of their backs. The nurses then used adaptation strategies such as taking breaks, avoiding heavy work tasks, and asking for assistance from their co-workers. When assistance was not available or not sufficient, nurses opted for less physically demanding careers within and outside of nursing. Nurses’ definition of their abilities, as suggested by Charmaz (1995) was central to the identity change within their nursing roles.
This concept of self-identity is derived from a symbolic interactionist perspective. The self and the chosen identity may be viewed as an object created by the individual and supported in the interaction with others. Within the perspective of symbolic interactionism, identity creation and change is based on an active assimilation and understanding of life situations. While emphasis is placed on how individuals, in interaction with themselves, assemble meaning about themselves, their behaviors and their world, human action is influenced [but not ruled] by transactions with others (Plummer, 1996). Self identity is chosen based on emotions, beliefs, and shared societal understandings that are likely gained in childhood and reinforced in adulthood. In the current study, the initial self-less presentation of nurses who went “beyond the call of duty” likely arose from the childhood feelings of self-esteem derived in the process of caring and the lack of parental modeling of illness behavior. Thus, “going beyond the call of duty” not only symbolized the attributes of a good nurse but also the attributes of a good person. In the narratives of many participants, nursing was described as “my entire life” and “the reason for being”. Nursing provided participants with self-esteem and fulfillment: in return nurses went “beyond the call of duty” in the process of their jobs. The self-less and the self-disregarding nursing identity appeared to have been created by nurses in the process of achieving personal self-esteem in their interaction with patients. The nurses’ current re-conception of self was a result of their definitions of back pain, their fear of re-injury, and the uncertainty of their illness. The change of identity, as suggested by Charmaz, is largely accounted for by the individual’s definitions. However, the nurses’ ability to act according to their new definition and “cherish” their backs was influenced by their co-workers’ views and the interactions and negotiations among them.

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Significant Others’ Views.

All participants re-evaluated their abilities to nurse and changed aspects of their nursing identities following back trauma. This re-evaluation appeared to be a personal choice but was enhanced or constrained by their co-workers’ influence. That is, not all nurses were able to work in the modified way that accommodated their new conception of themselves, as work modification was highly dependent on the co-workers’ assistance. This assistance was in turn determined by the co-workers’ informal evaluation of the injured nurses. Thus, while all participants experienced a personal re-conception of self and abilities, behavioral manifestations of these re-conceptions (taking breaks, refusing heavy work tasks, etc.) took place only if co-workers agreed that the disability was legitimate and that injured nurses had made past contributions to the department.

Interactions Between Changed Identities and Others’ Views.

These findings may be conceptualized within the framework for Symbolic Processual Analysis (Turner & Turner, 1978). While Turner and Turner’s work addressed the social process of the ritual, their main argument is taken from Van Gennep’s (1960) work on the process of passage. The process of passage has a three-phase structure. These have been summarized by Prout (1989)

...first, the initiate who is undergoing a change of status must be separated from his/her existing or initial role; second, following this separation, the initiate enters a threshold, or liminal stage, when neither the old nor the new status is occupied; and then, the initiate enters their new role (p.338).

This is represented in Figure 4.
Figure # 4. The process of change.

<table>
<thead>
<tr>
<th>Initial Status</th>
<th>( \Rightarrow )</th>
<th>“Liminal” phase</th>
<th>( \Rightarrow )</th>
<th>New Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>[\downarrow]</td>
<td>Rites of Separation</td>
<td>[\downarrow]</td>
<td>Rites of Aggregation</td>
<td></td>
</tr>
</tbody>
</table>


This conceptual model has been replicated by Prout (1989) in his study examining sickness as a cultural performance within life course transitions. In the current study this model may be used to illuminate the conceptual transition of nurses from “Beyond the Call of Duty” to “The Cherished Back”. This notion of the re-negotiation of self and work with assistance (or non-assistance) from co-workers has been conceptualized within a revised model of Symbolic Processual Analysis (Turner & Turner, 1978), entitled, for the purpose of this study, “Negotiating the Self and Work Tasks in the Process of Return to Work”. This model is represented in Figure 5.

Figure 5. Negotiating the Self and Work in the Process of Return to Work.

<table>
<thead>
<tr>
<th>Initial Status</th>
<th>( \Rightarrow )</th>
<th>“Liminal” Phase</th>
<th>( \Rightarrow )</th>
<th>New Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Going Beyond the Call of Duty”</td>
<td>[\downarrow]</td>
<td>“The Cherished Back”</td>
<td>[\downarrow]</td>
<td>New Working Style</td>
</tr>
<tr>
<td>[\downarrow]</td>
<td>Rites of Separation</td>
<td>[\downarrow]</td>
<td>Rites of Aggregation</td>
<td></td>
</tr>
<tr>
<td>[\downarrow]</td>
<td>Back Trauma or Pain</td>
<td>[\downarrow]</td>
<td>Evaluation by Co-workers</td>
<td></td>
</tr>
</tbody>
</table>

(Adapted from Turner and Turner, 1978, in Prout, 1989)

In this model, the initial status represents the nurses’ working style prior to back pain. Back trauma or pain represents the rite of separation from their initial “Beyond the Call of Duty” style of nursing. The liminal stage is the time of re-conceptualization of identity as nurse, labeled the “Cherished Back”. Rites of aggregation may be viewed as the evaluation
performed by co-workers to determine the legitimacy of participants' claims. Finally, the new status is the nurses' new nurse identity that is either supported or not supported by co-workers. If co-workers support the new status, participants continue to work in their pre-back pain departments with the assistance of co-workers. If co-workers do not support the new status, participants maintain their new identity but must change their jobs to those that require lighter physical duties. This conceptualization provides a developmental and evolving framework from which to examine the concept of occupational reintegration. It provides an explanation of phases of change and of the main factors influencing the return to work process.

**Occupational Reintegration**

The Occupational Reintegration framework is based on the theoretical model of Person, Environment, and Occupation (Law et al., 1996), introduced in Chapter 1. Occupational Reintegration represents successful return into the work environment. In this study, occupational reintegration depicts the extent of the successful transaction of the three components of person, environment, and occupation with respect to nurses' return to work. Occupational reintegration is defined as the ability to complete pre-injury work roles and tasks. Occupational reintegration occurs when there is a sufficient confluence between the physical and psychological attributes of the individual (person), the physical and psychological requirements of the occupation (occupation), and the context (environment) within which an occupation must take place. Alternatively, occupational reintegration is compromised by a poor fit between individual attributes, the context, and the required occupational tasks. A limitation of this conceptualization, as noted earlier in the review of
the PEO model (Law et al., 1996), is the difficulty in attributing the relative importance of each component as well as their collective balance. For example, it is unclear whether a lack of social support may be compensated for by an extraordinary favorable environment and unchallenging occupational demands.

In this study occupational re-integration may be viewed as the fit between: a successful shift in identity within the ‘Person’ component; the negotiation of physical support from co-workers within the ‘Environment’ component; and the ability to grade work tasks for successful work re-entry within the ‘Occupational’ component. In this framework, occupational reintegration occurred not only as a result of a successful transaction of the three components, but seemed to be carried out in a specific sequence. That is, occupational reintegration occurred only after nurses renegotiated their nursing identities and work styles, followed by the nurses’ attempt to garner physical support from co-workers which afforded the nurses the opportunity to grade their work tasks. Support from co-workers was contingent upon co-workers’ belief in the legitimacy of the participants’ pain, as well as co-workers’ evaluation of participants’ past contributions to the department. For example, Participant #5, in her belief that her back injury was long lasting, chose to modify her work style to decrease the risk of re-injury. In this modification she recruited assistance from her co-workers to help her with heavy work demands and to assist her with her patient caseload while she received therapy during a work shift. This participant’s co-workers readily provided assistance because she had demonstrated the legitimacy of her injury (she noted that co-workers could see that she was in pain), and because during her long work history on the nursing unit she had provided assistance to her co-workers (she described that her co-worker oriented ethic was appreciated by others). Thus, this participant reconceptualized her
working style and was able to grade her work tasks with the assistance provided by her co-workers. This participant’s successful reintegration into her pre-injury work is schematically demonstrated illustrated in Figure 6.

Figure 6. Optimal Occupational Reintegration the Case of Participant #5

![Venn Diagram](image)

OR - Occupational reintegration into the pre-injury job

Person-Shift in nursing identity

Environment-Negotiation of physical support from co-workers

Occupation-Ability to grade work tasks and change work style

(Adapted from Law et al., 1996)

In contrast, occupational re-integration may be strained or unsuccessful if the fit between Personal, Occupational, and Environmental components is compromised, for example, by limited support from co-workers. An example may be drawn from those nurses in this study who, as a result of a sporadic or short work history, have not made departmental contributions deemed as satisfactory by the co-workers. While these nurses may have renegotiated their work identities, they were not able to sufficiently modify their work tasks without the physical support of co-workers, and as a result these nurses were unable to achieve successful occupational reintegration into their pre-injury departments. As a result these nurses changed jobs to those with lighter work duties in order to promote performance within their new jobs.
The return to work process of Participant #2 illustrates this example. Following three major work absences related to back injury and pain, this participant redefined her work identity - she chose to take better care of her health in the context of her job. However, because of her three long work absences and modified return to work programs, she was not perceived to have made significant past work contributions by providing assistance to coworkers. Therefore, this participant's co-workers did not offer her physical support but instead, delegated light work tasks that had little patient contact. In the absence of physical support, this nurse was not able to grade her work duties. Thus, this nurse changed departments to work in a job that required light work duties. This case example is schematically demonstrated in Figure #7.

**Figure #7.** Compromised Occupational Reintegration the Case of Participant #2.

Please note that when the environmental component (representing limited support from co-workers) and occupational component (representing inability to grade work tasks) are pulled away from the personal (renegotiations of work style) component, the area that represents occupational reintegration (the confluence of the three) is smaller. The framework of Occupational Re-integration offers a schematic representation of those factors that
facilitate or hinder return to work. It also demonstrates the importance of the transaction between the person, environment, and occupation for achieving occupational reintegration. However, this framework does not provide guidance for the evaluation of the relative significance of each component in occupational reintegration, nor the modeling of the sequence of events in the return to work process experienced by participants in this study.

Summary and Conclusion

This study explored a sample of nurses' experiences in returning to work with back pain. The frequency of back injuries in the nursing population and the associated social and financial costs warranted this investigation. In contrast to other studies exploring return to work issues with back pain, this study explored this phenomenon using a qualitative research methodology in order to provide a more in-depth investigation of the subjective experiences associated with returning to work. The intent of the study was to learn about the personal, environmental, and occupational factors that facilitated nurses return to work, despite back pain. Ten nurses from the University Health Network were interviewed for the study. Three main themes emerged from the interview data. First, nurses' descriptions of their working styles prior to back pain told of early childhood caring, nursing as life enriching, and of their great commitment to their work and patients. This nursing style tended to predispose nurses to back pain and injury. Second, nurses changed their working styles following the onset of back pain—pain they believed to be chronic and long lasting. In order to take better care of themselves and their bodies, nurses set limits on their bodies and their work. For example, nurses experiencing back pain chose to take more frequent breaks, asked their patients to be more independent, and requested assistance from co-workers more frequently. Last, nurses were able to change their working styles only if: 1. Their co-workers believed in the
legitimacy of the nurses’ pain: and. 2. The nurses with back pain made past contributions to the department. In order to prove the legitimacy of their pain and to avoid being labeled as “malingering” nurses returned to work quickly after their injuries. Displaying overt pain behaviors, taking medications, and having medical documents to substantiate their claims assisted nurses in proving the veracity of their pain. In addition to proving the legitimacy of their pain, nurses were required to have made past work contributions in order to receive physical assistance from co-workers. These contributions were based on established social ties with co-workers and required reciprocal assistance when work peers required help. A metaphorical “Bank of Goodwill” was used to describe this evaluated point system. The physical support provided by work peers was essential to nurses’ ability to carry out work tasks for two reasons: 1. The work tasks in the nursing profession are physically demanding 2. The limited involvement of the nurse unit manager in the return to work process. While, all nurses in this study returned to work, those nurses who could not receive physical support to carry out their assigned work tasks changed departments or types of work in order to perform lighter work duties.

In summary, this study suggests that it is possible for nurses to return to work with back pain when nurses renegotiate their working styles by re-conceptualizing their physical abilities in relation to the heavy demands of their jobs, and when these renegotiations are supported by the physical assistance and social support from their co-workers.

Limitations of the Study

Several limitations of the study must be acknowledged. First, the limited sample size and scope of recruitment from three inter-related work sites does not provide results that can be generalized to other nursing environments or other workers. However, the concepts and
processes revealed through this research may be applicable in the development of research involving the return to work of other nurses or other injured workers. However, it may be that nurses are a unique population because, as revealed in this study and supported with literature (Fagermore, 1997; Pinch, 1996; Shires, 1989), nurses appear to gain tremendous self-esteem from caring and from the identity of nurse. In this study, their needs to care for others at times interfered with the nurses' capacity to care for their own health. Thus, the concepts and processes developed from this research may be most relevant to studies of other occupations in which members maintain strong personal attachments to their work or to studies of other health care professionals.

**Distinctive Contributions of the Study**

First, this study examined the return to work experience in a sample of nurses using qualitative research methodology. While other studies have made contributions to the return to work literature, they have mostly used quantitative research methods. Several researchers have recommended that return to work be investigated using qualitative research methods (Mithchelmore, 1996; Hignett, 1996; Holman, 1993; Weiser & Cedraschi, 1992). Qualitative studies reviewed in this thesis (Gard & Sandberg, 1998; Thomas, 1996; Seers & Fridli, 1996; Bowman, 1994) did not explore return to work in the context of back pain. This study of nurses returning to work with back pain has revealed processes and relationships that facilitated return to work, that have not previously been discussed in the literature.

Second, this study provided an evolving conceptualization of the return to work process that accounted for personal and social change. Studying the process as well as the content of phenomena is integral to the study of experience (Corbin & Strauss, 1990). By using the framework of Symbolic Processual Analysis (Turner & Turner, 1978), this study
demonstrated the phases of change and demonstrated factors influencing in the participants’ return to work process. This study took into account the change that participants underwent in their conception of themselves as nurses in order to continue working with back pain. The negotiation with co-workers influenced the participants’ ability to behaviorally enact their re-conception of self.

Third, this study, using a modified version of the Person, Environment, Occupation Model (Law et al., 1986), demonstrated the importance of the transaction between personal, environmental, and occupational components in occupational reintegration. Occupational reintegration was shown to be successful when participants were willing to shift their nursing identity, negotiate physical assistance from co-workers, and consequently grade work tasks and change their work style. Occupational reintegration into pre-injury jobs was unsuccessful when the transactions between personal, environmental, and occupational components were strained or insufficient, for example, when nurses were not able to garner support from co-workers.

Recommendations for Practice and Policy

As exploratory qualitative research, the recommendations resulting from this study are directed toward the applicability of the revealed themes and processes to other studies. These recommendations are provided to invite future research. The concepts and processes of occupational reintegration may be applied in research into: therapeutic interventions for return to work by rehabilitation specialists, educational strategies by nurse educators; and, policies for return to work by nurse unit managers, occupational health and safety practitioners, and hospital disability management programs.
Recommendations for future studies in rehabilitation:

In light of the results of this study, rehabilitation specialists involved in the return to work process of injured nurses and other workers are invited to examine:

- The applicability of the injured workers’ conceptualizations of themselves, in relation to their roles in their jobs, their capacity to grade work tasks, and their perceptions of the roles of their managers and co-workers in the return to work process. Research such as this may help to identify areas of potential difficulty for workers who hope to return to work.

- The sequential processes involved in returning to work, as well as the effect of varying levels of co-ordination of the return to work process with co-workers, managers, and the staffing needs of the work unit.

- Work identity, co-worker support, and the worker’s ability to grade tasks, in other populations of workers. Such an exploration may illuminate occupation specific or more global concepts that may facilitate or hinder return to work.

- Remodeling of Occupational Reintegration to highlight the relative importance, hierarchy, and temporal sequencing of the personal, environmental, and occupational components as they influence occupational reintegration. This remodeling is encouraged to enhance the explanatory potential of the model.

Recommendations for future studies in nurses’ practice and education:

- Explore the effects of nurses’ work identities on work styles and encourage nurses to lead healthy lives that emphasize the maintenance of their own health and well being within the context of nursing work. An increased emphasis on nurses’ health should
allow nurses to make greater long-term contributions to patients, co-workers, and departments, and reduce financial and social costs of disability.

**Recommendations for future studies of policies for return to work nursing unit managers and Occupational Health and Safety practitioners:**

- Explore implicit and explicit return to work policies and solicit feedback from unit nurses regarding their needs in the return to work process. As some nurses choose not to share information about back pain with nurse unit managers and Occupational Health and Safety Departments, an alternative system to assist nurses in their return to work may be relevant. A specific examination of the needs in the return to work process for nurses who work casual and flexible hours may be warranted as these are nurses who may have fewer emotional and physical supports available to them and thus may be at risk for increased injury and pain.

**Recommendations for research on hospital policy for disability management**

- Explore the focus of disability management in hospital policies to examine the nature of the working environments that facilitate nurses’ reporting of work-related pain. The results of this study suggest that increasing the focus on worker health and well being, and decreasing focus on cost containment may encourage nurses to report work-related pain. With an awareness of injuries and work-related pain, nurse unit managers and Occupational Health and Safety departments may take early and proactive measures to reduce risks of subsequent injury and disability. Hiding pain could lead to more severe injuries and lost time that may increase overall costs of disability management within hospitals.
References


Attention Nurses!!!

Have you successfully returned to work following back pain?

I am Anna Kaushansky, an Occupational Therapist and Graduate student in the Dept. of Rehabilitation Science at the University of Toronto. For my Master of Science thesis I am investigating the experiences of previously injured nurses in the return to work process. If you have successfully returned to work following back pain and would like to participate in a 60 minute interview that examines return to work issues contact me at:

(416) 707-9563

All information you contribute will be confidential and you may withdraw from the study at any time. Ethical approval has been granted for this study by University of Toronto Research Services. In order to recognize your time and contribution to this research you will receive a $50.00 honorarium.

<table>
<thead>
<tr>
<th>Return to work</th>
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Appendix B

Information Sheet
NEGOTIATING SUCCESSFUL RETURN TO WORK:
PERSPECTIVES OF NURSES WITH BACK PAIN

I am Anna Kaushansky, an Occupational Therapist and University of Toronto graduate student who is pursuing a Master of Science in the Department of Rehabilitation Science. Thank you for considering my invitation to participate in an interview to examine the perspectives of nurses in their process to return to work with back pain. The intent of the interview and of the study is to provide a forum for you, as a previously injured nurse, to offer insight into those factors that have assisted your return to work.

All information about you will be confidential. Your name or any identifying information will not appear in the study or in any academic papers or presentations stemming from it. You may withdraw from the study at any time without consequence. Any opinions or perspectives you offer will not, in any way, be used to influence your work environment. Your responses may be audio-taped or documented in handwriting as per your request. All interview data will be kept in a locked filing cabinet. The information provided during the interview will be used only for the study proposed by me and as approved by the University of Toronto Research Services.

Your involvement in this study will include a 60-90 minute interview that will be arranged at a time and place of convenience to you. In order to recognize your time and contribution to my research, I am offering a $50.00 honorarium for your participation in my study. If you would like to participate, please telephone me, Anna Kaushansky, (416) 707-9563 or my primary supervisor, Dr. Susan Rappolt, at (416) 946-3248 to clarify any information provided here or to ask more questions regarding the study.

Your involvement and opinions are important. Thank you very much for considering my request.

Sincerely,

Anna Kaushansky Hon. B.Sc. O.T., Master of Science Candidate
Appendix C

(GDRS University of Toronto Letterhead)

NEGOTIATING SUCCESSFUL RETURN TO WORK:
PERSPECTIVES OF NURSES WITH BACK PAIN

Consent Form

I am Anna Kaushansky, an Occupational Therapist and graduate student in the Department of Rehabilitation Science at the University of Toronto. I am studying the experiences of nurses with back pain who have successfully returned to work. There are no known risks to your involvement. All information is confidential and will not, in any way, be used to affect your work environment. No parts of your name or other identifying information will be included in the study or any publications or presentations that may stem from it. You will receive a $50.00 honorarium for your time and your contribution to my research. Your participation may contribute to the development of rehabilitation programs that will assist other injured workers to return to work sooner as well as assist health care professionals to assess and treat injured workers.

I will conduct the interview at a time and place of convenience to you. You will have opportunities to ask and respond to questions during the interview. The level of participation is entirely at your discretion and you may withdraw from the study at any time without any consequence. The interview will be audio-taped or hand written as per your request. All interview data will be kept in a locked filing cabinet. The information you provide during the interview will be used only for this study and as approved by the University of Toronto Research Services. You will be provided with a copy of this consent form.

Please sign below to indicate your consent:

_________________________  ____________
Print Name                date

_________________________  ____________
Anna Kaushansky            date

I agree to be audio-taped   YES       NO
Appendix D

Interview Guide
NEGOTIATING SUCCESSFUL RETURN TO WORK:
PERSPECTIVES OF NURSES WITH BACK PAIN

Date:
Time of Day:
Data collection method (hand-written/audio-tape):
Interviewer:
Interviewee (first name/code):

Questions:

"Some people have an easier time returning to work, for others it is more difficult, tell me about what it like for you to return to work?"

Probe Questions:

1. Describe your usual daily routine.

2. When you had back pain, how did your life change?

3. When did you decide to get back to work?

   What was happening in your life when you decided to go back to work?

   What was your financial situation when you decided to go back to work?

   Did your work contact you or did you contact your workplace for the purposes of going back to work?

4. How did you come to decide to go back to work?

   Did you want to return to full duties and hours or modified duties and hours? Why?

   What sequence of events in your life lead you to return to work?

   What was the deciding factor to return to work?

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How would you describe the injury you had?

How do you feel about yourself when you are sick?

5. What was your pain like when you returned to work?

How did your pain change over time?

What aggravated or decreased your pain?

Was pain a concern when you returned to work? How?

6. When you had back pain how did your family react?

Were family members supportive to you when you were not working as a result of back pain?

Were you responsible for completing daily household chores when you were off work as a result of your back pain?

How was your/your family’s financial situation when you were off work and on sick leave this time?

7. Describe your job to me.

How did you injure yourself?

Did you have any concerns about returning to work?

Were there specific tasks of your job that you were worried you may not be able to do as a result of your injury?

How did your co-workers and boss welcome you back into the job?

Have your workers and boss been supportive while you were ill?

Have you had any contact with your workers and boss while you were ill?

What is the best thing about your job? What is the worst?

Demographic data: (age, marital status, sick leave before treatment, type of employment, years at present employment, dependents at home)
Observations/Notes (written following the completion of the interview):