As I suspect many colleagues also do, I find myself increasingly describing our speciality as concerned with the effects of work on health and of health on work. The second part of this definition, usually tagged on as something of a conforming phrase to demonstrate how we have modernized beyond the ‘industrial physician’ label, seems now to be the main focus of practice. In making judgements on the latter point, we are often confronted with how little we know, or can predict, in how individuals will respond to a return to work. The range of possible factors may go beyond those we have traditionally assumed would predict a successful return to the workforce, and in many cases involve the combination of social and other personal factors with the strictly medical assessment of function. In this issue, several articles address the identification of predictors of return to work (RTW), and again serve to let us know that our evaluations of physiologic functioning or the adequacy of illness treatment may not go far enough in assuring us that our patients will successfully negotiate a return to the workforce.

Moshe and colleagues [1] assessed the records of 52 patients with upper limb disorders and their RTW history. Their results indicate that the sole predictor of RTW was the patient’s score on the DASH questionnaire; neither physiologic measures of function such as grip strength nor job characteristics such as physical demand level of the work proved useful. While limited by the lack of detail on some individual socioeconomic factors and work organization, this paper clearly indicates a strong role for the perception of disability in the return to function.

Along the same lines, van Muijen et al. [2] convened focus groups of insurance physicians to evaluate criteria for return to work after cancer diagnosis and treatment. As might be expected, they find considerable difficulty in decision making, and not only because of the heterogeneity of cancer types and stages. While these physicians clearly put considerable weight on individual medical factors in their assessments, they also clearly note the significance of personal and environmental factors, including social functioning and the provision of societal support systems. The relative importance of these non-medical factors remains to be determined, but, as in the article by Moshe et al., it seems clear that personal determinants and the patient’s self-assessed capacity for work must be recognized as strong predictors of the RTW mechanism. Finally, Nimmo [3] reminds us of a subset of diverse patients in whom social and societal factors operate at their most maladaptive. Taken as a whole, these articles remind us that our work is by nature widely encompassing and that, as Nimmo points out, ‘the main role of the occupational physician is to identify bio-psycho-social barriers to work and suggest strategies to address them’.

Looking prospectively at work, Dunn and colleagues [4] report on the requirements and needs for guidance in the deployment of diplomats, many in high-threat postings. They find little consensus on measures for the psychosocial risk of these postings and suggest that organizations look to the available evidence when making judgements about tour length and mechanisms of support. Post-tour decompression can be clearly recommended, as in the military setting, and may serve to ensure that personnel are in better health for their next tour. As do the other papers discussed here, they serve to remind us that the evidence base we use remains incomplete and requires expansion if we are to best support the decisions we make on both placement and return to the workplace.

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References