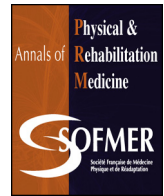




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Original article

Workers' perspectives on return to work after total knee arthroplasty

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ABSTRACT

Objectives: Total knee arthroplasty is an effective intervention for people with osteoarthritis. However, 15 to 30% of patients do not return to work, and studies frequently fail to provide an explanation of what may lead to work disability from workers' perspectives of the biopsychosocial factors. This study aimed to document workers' representations or understanding of work disability after total knee arthroplasty. **Method:** We adopted a qualitative approach with a narrative inquiry method. A convenience sample of partially and fully disabled workers was interviewed 6 to 12 months after surgery with use of a semi-structured interview guide and questionnaires on physical work demands and pain. Interviews were audiotaped, transcribed verbatim, and anonymized. Consensus was reached on coding, and multidisciplinary content analysis was performed. **Results:** Among the 8 workers interviewed, all were formally employed before surgery, half were men, and the mean age was 55 years. Half were not back at work when interviewed and felt they had received little support from their workplace, were struggling to adapt to their new condition, and had very few adaptive strategies for trying to get better (other than waiting), which did not make sense to them. By contrast, the other half felt they had experienced greater improvement after surgery and received concrete support from their workplace, which facilitated their return to work in their view. **Conclusion:** A work disability paradigm, based on a biopsychosocial approach, should be considered in rehabilitation when workers experience difficulty returning to work after total knee arthroplasty, because other factors besides the patient's condition may be involved.

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1. Introduction

Total knee arthroplasty (TKA) is an effective intervention for reducing pain, improving function, and enhancing quality-of-life for people with osteoarthritis (OA) [1,2]. An increase in the volume of TKAs performed, particularly among working patients [3], is likely due to improved surgical techniques, delayed retirement, an aging workforce, and OA prevalence [4–6]. TKA allows most OA patients to return to work (RTW), which is beneficial for working patients [7–13]. However, from 15 to 30% of patients are still partially (working but with limitations) or fully (on sick leave) disabled 6 months after surgery [14].

A recent systematic review reported factors affecting RTW after TKA, such as age, patient motivation, employment before surgery, and level of physical work. However, these factors do not fully explain why some patients still have work disability after TKA. Malviya et al. [15] emphasized the need for further qualitative

studies on this subject. The researchers conducted a qualitative study in a single site with 10 TKA patients who had returned to work and had mainly non-manual jobs. Three themes appeared to affect the RTW. First, most patients reported delays in surgical interventions and a worsening of their health conditions because they were seen as too young to undergo TKA surgery. Second, they mentioned receiving limited or inconsistent advice from health-care professionals regarding the RTW. Lastly, rehabilitation efforts mainly targeted mobility and range of motion but included very few interventions promoting a safe RTW. This pioneer study highlights, from both a personal and a health perspective, important barriers seen by workers who were successful in returning to work. The next step would be to document TKA patient experiences from a biopsychosocial perspective [16].

Musculoskeletal disorder studies show that the biopsychosocial perspective helps to explain work disability [17]. Indeed, workers' characteristics and interactions with their work, social, and medical environments play a role in the development and persistence of work disability. In the work disability paradigm, these environmental systems consist of the work environment, healthcare environment, and insurer environment, all of which

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interact with workers' personal characteristics [18]. Workers' characteristics include their representations or understanding of their disability integrated with their interaction with the environment, which is known to impact the RTW process by affecting coping behaviours [19]. Representations are the logic behind the action taken by patients. They are defined as personal thoughts, beliefs, and attitudes [20] concerning the nature of their illness. Representations do not necessarily reflect medical reality, because the whole process is idiosyncratic and guided by the patient's need to maintain a certain degree of coherence. Representations are a central part of Leventhal's Common-Sense Model (CSM) [21], which helps explain how patients adapt to an illness or a new health condition. First, patients construct illness representations by gathering information from different sources (i.e., environment, significant people, or personal experiences). From their interpretation of this information (their representation), they develop an action plan and evaluation criteria to reduce the gap between their actual situation (i.e., work disability after TKA) and their goals (i.e., to RTW).

Research into the factors leading to work disability after TKA is scarce. To explore this issue, we documented workers' representations of their work disability after TKA (including their perception of their various environments) in accordance with the work disability paradigm.

2. Method

We conducted a qualitative study based on a narrative approach to capture details of patients' experiences by considering the whole biopsychosocial context [22]. Convenience sampling was used to recruit approximately 10 participants, as this number would allow for an in-depth understanding of each case [23]. Inclusion criteria were:

- 6 to 12 months post-TKA;
- experiencing limitations while at work (partially disabled) or on sick leave (fully disabled);
- between 18 and 64 years old;
- formally employed before surgery;
- fluent in French.

To promote explicit and comprehensive reporting of information regarding the study, we used the CONSolidated criteria for REporting Qualitative research (COREQ) for qualitative studies [24].

2.1. Recruitment

Participants were recruited by using 2 approaches:

- referral from an orthopedic department in the Greater Montreal Area, in Quebec, Canada;
- screening a database of patients who initially gave their informed consent to be contacted in a hospital situated in a semi-rural area in Quebec's Eastern Townships.

One of the researchers (PM) identified eligible patients, contacted them by telephone, and assessed them according to the inclusion criteria. Patients were recruited between March 2014 and February 2015 in 2 university hospitals so as to have access to patients with different surgeons.

2.2. Data collection

All the semi-structured interviews were audiotaped and conducted by 2 female researchers (PM and MFC). MFC is a health psychologist, has extensive interview skills, and trained PM

(kinesiology) during her master-degree studies. The guide was used in a previous study [25] and was adapted for work disability patients; it included open-ended questions based on the CSM model [21] (see Appendix 1). Participants were asked about their symptoms and functional limitations, the medical and rehabilitation interventions they received, the RTW process, and their relationships with stakeholders (e.g., employer, union, insurer). They were asked to describe what they saw as their "problem" in order to avoid influencing their responses to questions specific to their condition. Aside from the telephone contact made to recruit participants, no other prior relationship existed, and participants' knowledge of the interviewers was limited to the information provided in the consent form (study goal, rationale, and information on the interview process).

Data on occupation, pain intensity (at home and at work), and self-reported level of physical work demands were collected. According to the Hébert et al. [26] classification, occupation was identified as manual, non-manual or mixed manual and non-manual. Pain intensity was measured on a visual analog scale (VAS) from 0 to 10 ("no pain" to "pain as bad as it could be") [27]. Several studies support the reliability and validity of the VAS across many populations [28]. The level of physical work demands was described with selected tasks involving the knee, such as handling objects, squatting, or walking long distances [29], to allow for an exploratory description of working tasks as perceived by participants.

2.3. Analysis

We used an iterative process that alternated between recruitment, data collection, and analysis. This method allowed us to refine the data by adding, if necessary, new questions to the interview guide to clarify emerging themes. We repeated these steps until the main components of the CSM [21] were covered. This stage occurred when no new information emerged from our analysis of the latest interviews, which would justify adding new data [30,31]. Interviews were transcribed verbatim and anonymized. We followed the Landry [32] coding method. First, we used a mixed coding method with codes established *a priori* by using the CSM [21], with a possibility for emerging codes. Second, two researchers (PM and MFC) independently coded all the interviews by using Atlas-Ti software and discussed diverging results until consensus was reached. Third, 3 multidisciplinary researchers (psychologist, physical therapist, kinesiologist) performed the content analysis, and discussed each interview to compare the analysis and obtain consensus [33].

The project protocol was approved by the research ethics committees at 2 hospitals: Hôpital Charles-Le Moyne (Longueuil, Quebec, Canada) and Centre Hospitalier Universitaire de Sherbrooke (Sherbrooke, Quebec, Canada).

3. Results

3.1. Participant characteristics

Overall, 31 patients were initially contacted by telephone to assess their eligibility (Fig. 1). Eight workers signed an informed consent form regarding experimentation with human subjects in which privacy rights were mentioned. After interviewing 6 workers, our analysis revealed that almost all CSM components [21] were covered. By adding 2 more workers, we were confident about the credibility of our results and data saturation on the main themes.

We met participants individually for interviews (average length 59 min, range 33 to 83 min) at their convenience, in their home ($n = 5$), in a university setting ($n = 2$), or by telephone ($n = 1$). The

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