Congratulations but no congratulations: should physicians do more to support their patients at work?

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Clin Med 2004;**4**:102–4

A second edition of a book is usually a cause for congratulation. But is the second edition of a highly acclaimed but critical report the cause for similar rejoicing?

The question arises in relation to a report first published in 2000 by the British Society of Rehabilitation Medicine (BSRM) entitled *Vocational rehabilitation: the way forward*.[1] The report found a receptive audience. The Trades Union Congress (TUC) had described rehabilitation in the NHS as 'lamentable',[2] and the Association of British Insurers (ABI), in its second bodily injury award study, recognised the 'UK's poor record on rehabilitation [related to work]'.[3] More recently, the TUC stated: 'there was a growing acceptance that greater effort is needed to retain employees who have been affected by poor health, injury or disability in paid employment'.[4] The Third UK bodily injury awards study noted that 'there is still the need to promote rehabilitation and to encourage the use of rehabilitation services'.[5] And yet, according to one analysis, the escalation in disability benefits in the UK could reflect the decline in medical rehabilitation services.[6]

The government's response

The government, however, has been active in the field of vocational rehabilitation, partly by restructuring the Departments of Education and Employment and Social Security. Their employment functions were combined within the new Department for Work and Pensions (DWP), thus linking the worlds of work and benefits. The DWP has a clear view of the problem and is piloting several new initiatives designed to address the situation, including controlled trials of collaborative ventures between the NHS and the DWP on job retention and the rehabilitation of those on long-term benefits back into work.[7,8]

The background to the government's response is the fact that there are about one million unemployed people and 2.7 million on incapacity benefits, a figure which is climbing and which contrasts with the 3.7 million people who are disabled but employed. The majority of those who are disabled have musculoskeletal or psychological diagnoses.[8,9] Many believe that a sizeable number of those on incapacity benefits have treatable conditions, so why had they not received treatment?

There has also been a remarkable consensus from professionals and groups of and for those with disabilities that NHS services were too slow to respond.[1] The window of opportunity for intervention before considering a patient for incapacity benefits is only six months from the start of sickness, and many patients will not have completed the consultation, investigation and treatment process within that time.[1,10] Once a person is receiving incapacity benefits, it is hard to give them up and move on. Philip Sawney, from the DWP, commented in his recent presentation that the likelihood of leaving benefits decreases rapidly with the duration of receipt of benefits.[11] Those who are on incapacity benefits for 12 months stay on them for an average of eight years, and are more likely to die or retire than leave for any other reason.[11]

It was acknowledged, too, that certification of illness in the UK by general practitioners (GPs) is not linked to the rehabilitation process, as in some parts of Europe. The Organisation for Economic Co-operation and Development (OECD) recognised that there are major differences across western societies in the relationships between benefits and vocational rehabilitation.[12,13] Expertise in all parts of the NHS in terms of active management of the illness in order to get people to work speedily has been lost.[1] Where vocational rehabilitation was considered, it was usually as a 'bolt-on' after treatment and medical rehabilitation, even though best practice demands that the two processes are simultaneous.[1]

After the report

The second edition of the report, *Vocational rehabilitation – the way forward*,[14] summarises a number of conferences, documents and some initiatives that have followed from the publication of the first edition.[14] Specifically, the Royal College of Psychiatrists emphasised the importance of vocational rehabilitation within psychiatric rehabilitation and recommended 'vocational and welfare specialists in community mental health teams'.[15] Their recommendations were in broad agreement with *The way forward*.[14]

There was a conference on vocational rehabilitation organised by the College of Occupational Therapists and the insurers Swiss Re Life & Health who, like other insurers, recognise the huge economic consequences of poor vocational management and avoidable early retirement.[16] A group of interested occupational therapists is very active (Occupational Therapy in Work, Practice and Productivity) as is a group of chartered physiotherapists (Occupational Health and Ergonomics). The Case Management Association of the UK (CMSUK) is newly established and seeking charitable status. Finally, at the end of 2003, there was a lively conference at the Royal College of Physicians on work and musculoskeletal conditions, where the relationships of occupation to the presentation of musculoskeletal disease were discussed, together with how to help sufferers of these disorders remain in work.[11]

International perspectives

The OECD organised a conference on 'Transforming disability into ability'. Its report recommended flexibility in policies aimed at providing cash benefits, and that individuals should receive work/benefit packages that facilitated employment. For health professionals, the key feature was the recognition that the most effective measure against long-term ill-health was early intervention.[12,13]

Demographic changes in virtually all industrialised societies show that the numbers of the population working to support those who are not working (including children and elderly people) are falling.[9] The shedding by many companies of responsibilities to provide pensions for their employees confirms this.

So conferences and resolutions have abounded and new groups of interested professionals continue to emerge, there has been little change in the NHS, so we remain unsure whether the production of a second edition is a cause for congratulation. Particularly, there has been no specific allocation of resources to vocational rehabilitation, no recognition of the importance of local links between vocational therapists and the employment services, as we suggested, and no new models of service apart from those being piloted by the DWP. No budget for research has been established, nor has funding been offered for a research programme to provide the evidence base for better practice, other than that commissioned by the DWP. There has also been no plan to develop the expertise needed by the NHS and by the mushrooming private sector. Accreditation for vocational rehabilitation for any discipline is the subject of ongoing work by the National Vocational Rehabilitation Association but there is no specific provision for doctors.

What do doctors need to know and when? Some may say they need neither awareness nor expertise in this area. The conference at this College, however, indicates its recognition that this is an important issue for health professionals. The capacity attendance indicated that there is a substantial body, particularly in the fields of rehabilitation medicine, rheumatology and occupational medicine, who share the College's view.[11] Quality of life is closely related to one's view of oneself as a useful participant in society (which does not exclude those who participate but are not paid for so doing). Numerous studies have shown that depression and suicide are more common in unemployed individuals. Also, income is not unrelated to autonomy, and disabled people are known to have less income (and less employment).

Education and training

The advent of the Postgraduate Medical Education and Training Board, and a re-examination of postgraduate medical education (including discussions about length of training and its content), is perhaps a good time to consider what physicians need in their training to help their patients to retain or regain a full life.

The undergraduate training curriculum is full and all specialties are aware of the difficulty of adding more facts to the students' workload. The information that needs to be conveyed during training is relatively simple:

- a patient's medical history must include their occupational history
- the relation of symptoms to the working day needs exploration
- the NHS must respond quickly to illness causing sickness absence in order to preserve jobs
- help is available from the DWP.

The full range of services offered by the DWP to facilitate job retention or for returning to a new job is given in Appendix 4 of the second edition of the BSRM report.[14] The knowledge that this information is available and how it can be obtained needs to go into core teaching, perhaps as a vignette in the musculoskeletal or primary care attachments.

It is unrealistic to expect that doctors in their foundation years will fully graps these relationships. It is therefore vital that senior members of medical teams have this knowledge, or employ a team member with appropriate skills and an understanding of both best practice and the evidence base for returning those with common conditions, like backache, to work. It has been shown that interventions focussing on returning to work and implemented in the subacute stage of low back pain can reduce time lost from work by 30–50%.[17] Frequently, simple modifications to equipment or hours at work are all that is required to facilitate the return to work, often starting with shorter hours and gradually building them up to a normal working day.[4]

Doctors also need to be able to tease out the occupational component of a disease or disability. Attitudes to patients' work should be more positive and health professionals need to be encouraged to communicate better with those able to help the patient.[18] Doctors and employers should encourage early return to work, modified if necessary, *before 100% fitness is attained.*

Communication/certification

Beaumont drew attention to current poor communications, not least between general practice and occupational health services.[18] He noted that sickness absence is not well managed

by some GPs, and that the myth that referral to an occupational health service implies early retirement should be dispelled. Maybe GPs should regard themselves as the gateway to rapid rehabilitation.

The current situation relating to sickness absence certification is summarised in Appendix 7 of the second edition,[14] and the complexities of the task in primary care have been reviewed recently.[19] GPs will thus need the knowledge and desire to improve their patients' work situation, using certification as an opportunity to intervene. The certifying doctor can always use the 'Doctor's remarks' section to record, for example, that rehabilitation or workplace adjustments may be appropriate (see Appendix 7[14]).

A cadre of physicians will need a vocational rehabilitation module in their training (though all physicians need some knowledge). It is encouraging that the dialogue has begun.

Improving medical practice

There needs to be a greater sense of urgency in outpatient consultations. It is unacceptable to see a patient, for example with potential nerve root compression, to send them for investigations, arrange to 'see in two months' and only then put them on the physiotherapist's waiting list. The introduction of targets that will speed up this process is good, but the resources must also be available to ensure that this happens. Some good triage schemes are currently suspended through lack of resources! For an individual with potential nerve root compression, which is not deemed clinically 'urgent' but nevertheless threatens their ability to work, to wait up to eight months for magnetic resonance imaging (MRI) (known to occur in some trusts) is unacceptable. Such poor care may result in long-term withdrawal from the job market with losses to the individual, their family and society at large.

Doctors may be unable to effect improvement (eg to shorten the waiting time for a 'routine MRI') but we can review our practice, which may not have changed for many years. The overriding need of trusts to respond to government targets concerned with waiting lists and accident and emergency often mean that the parts of the service which should respond rapidly to the needs of the workforce (which would help not only the individual but the country's economy) are often starved of the required resources. As Disler and Palant point out, 'whilst this [rehabilitation] is not a cheap option, a community with unemployed, disabled ex-workers is likely to be even more costly'.[10]

Thus we need some targets or clinical guidelines that relate closely to getting people with medical problems back to work or, better, keeping them at work.[20–22] This will not be easy to achieve. Resources will have to be found inside the NHS and somehow ring-fenced. It also requires a committed sustained thrust from a knowledgeable medical profession that has put its house in order, in terms of its own practice and training.

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