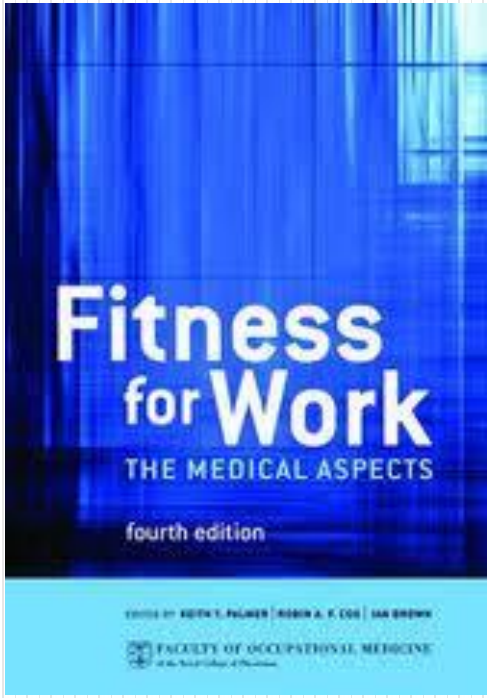
Fitness for Work: the medical aspects *2013*



Musculoskeletal disorders and return to work

Kim Burton **OBE, PhD, Hon FFOM**

University of Huddersfield, UK

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Work is what defines us:

“..... and what is it you do?”

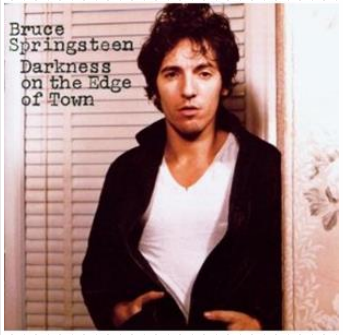
The WORK ⟷ HEALTH double act

I see my daddy walking
through them factory gates
in the rain

Factory takes his hearing,
factory gives him life

The working, the working,
just the working life

Bruce Springsteen, 1978



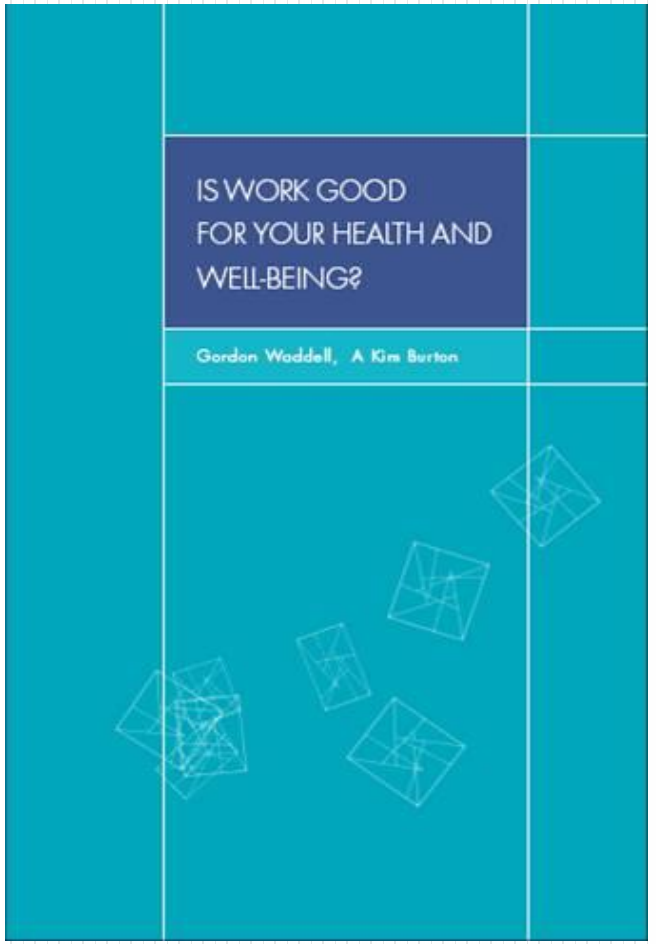
"Work is life, you know,
and without it, there's
nothing but fear and
insecurity."

John Lennon, 1969

But, is work healthy?

WORK ⟷ HEALTH

- Review for DWP
  - *G Waddell, K Burton (2006)*
- Work is generally good for physical and mental health and well-being; prolonged sickness absence is not
  - Work can contribute to better health outcomes
- Proviso: good jobs are good for health



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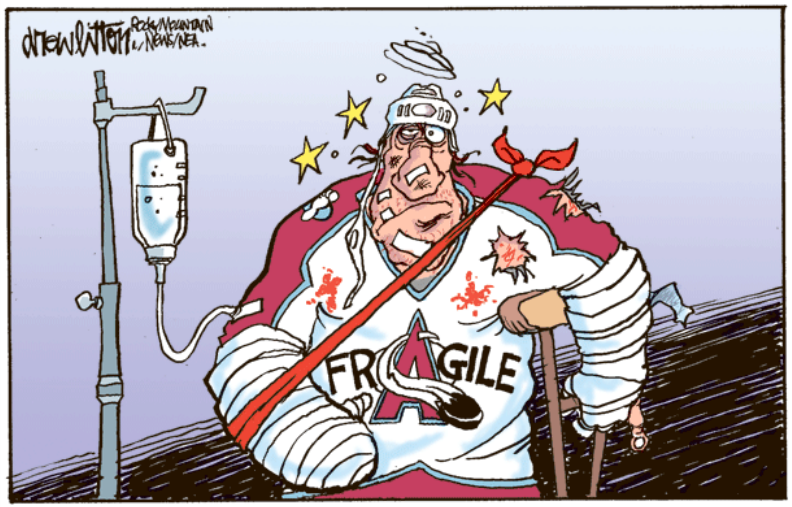
Work is an important health outcome

- Depends on who you are and where you are
  - Subjective reduction in symptoms
  - Improvement of functional limitation
  - Regain work participation
    - these are not equivalent and no linear path!



Huddersfield Dispensary and Infirmary

- model of charitable healthcare → OH

1814

1831

Traditional occupational health paradigm

Bernardino Ramazzini 1633-1714

Trauma → Injury / disease

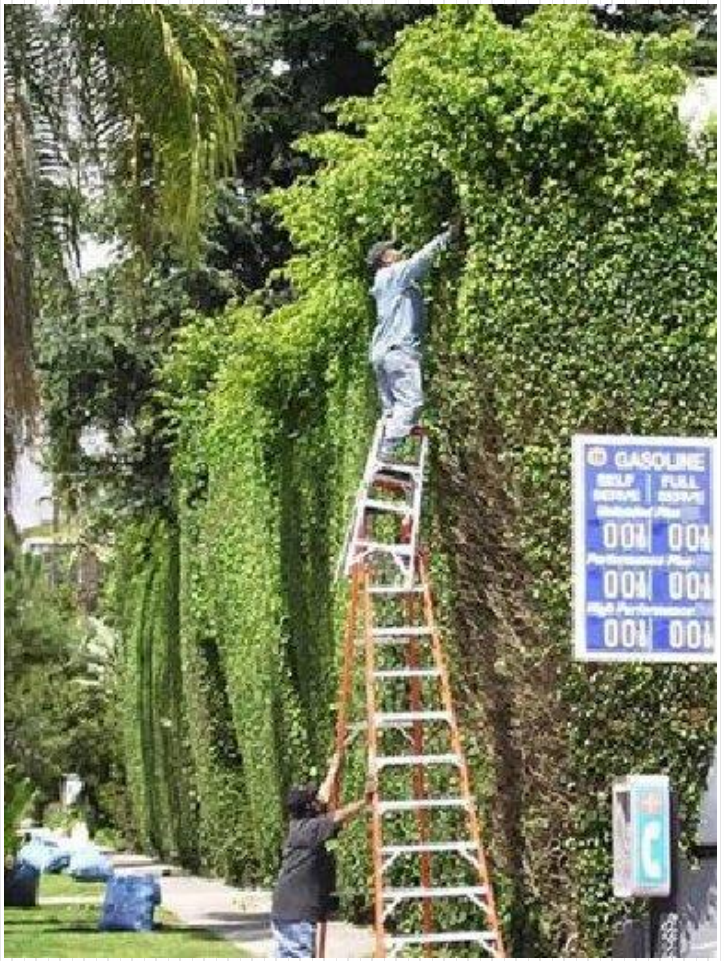
Hazard → Worker → Harm

→ Focus on causal relationship →

.... a reasonable concept, but over simplistic

Safety *v* Health – conflicting paradigms

- Reduce risks → primary prevention
  - paradigm works for safety
    - e.g. falls from height
  - paradigm works for occupational disease with clear cause-effect
    - e.g hazardous substances
- But, the paradigm does not work for most common health problems

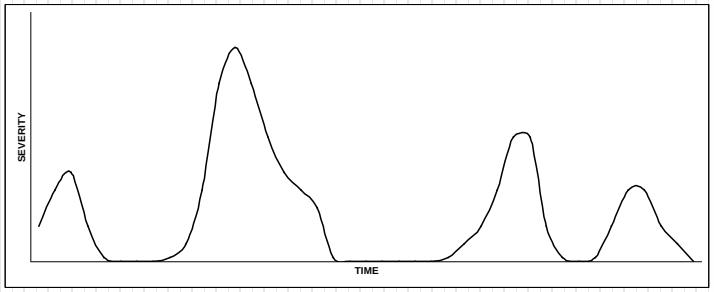


Common health problems

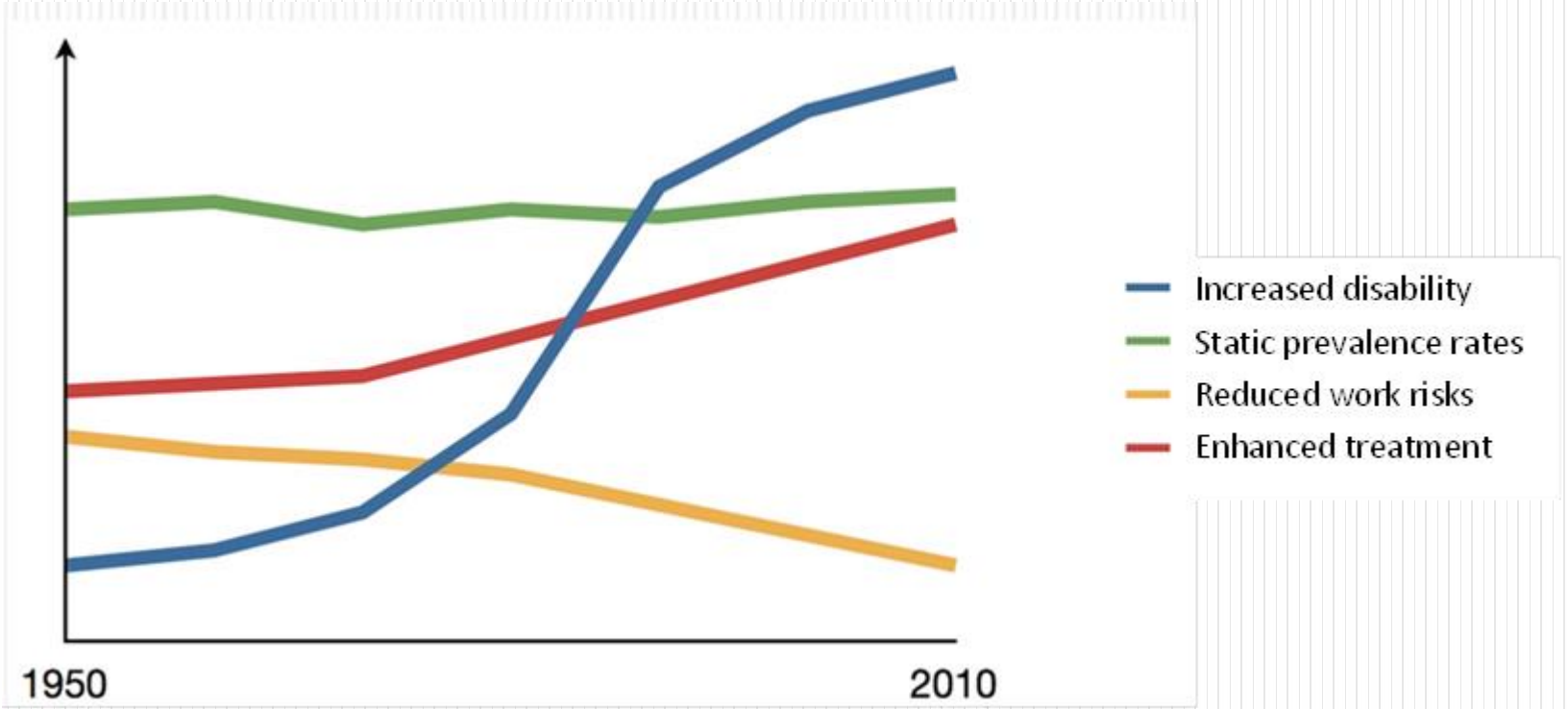
- Less severe illnesses and injuries
- Responsible for ~70% of absence and long-term incapacity
  - Musculoskeletal conditions
  - Mild/moderate mental health problems
  - ‘Stress’

Musculoskeletal problems

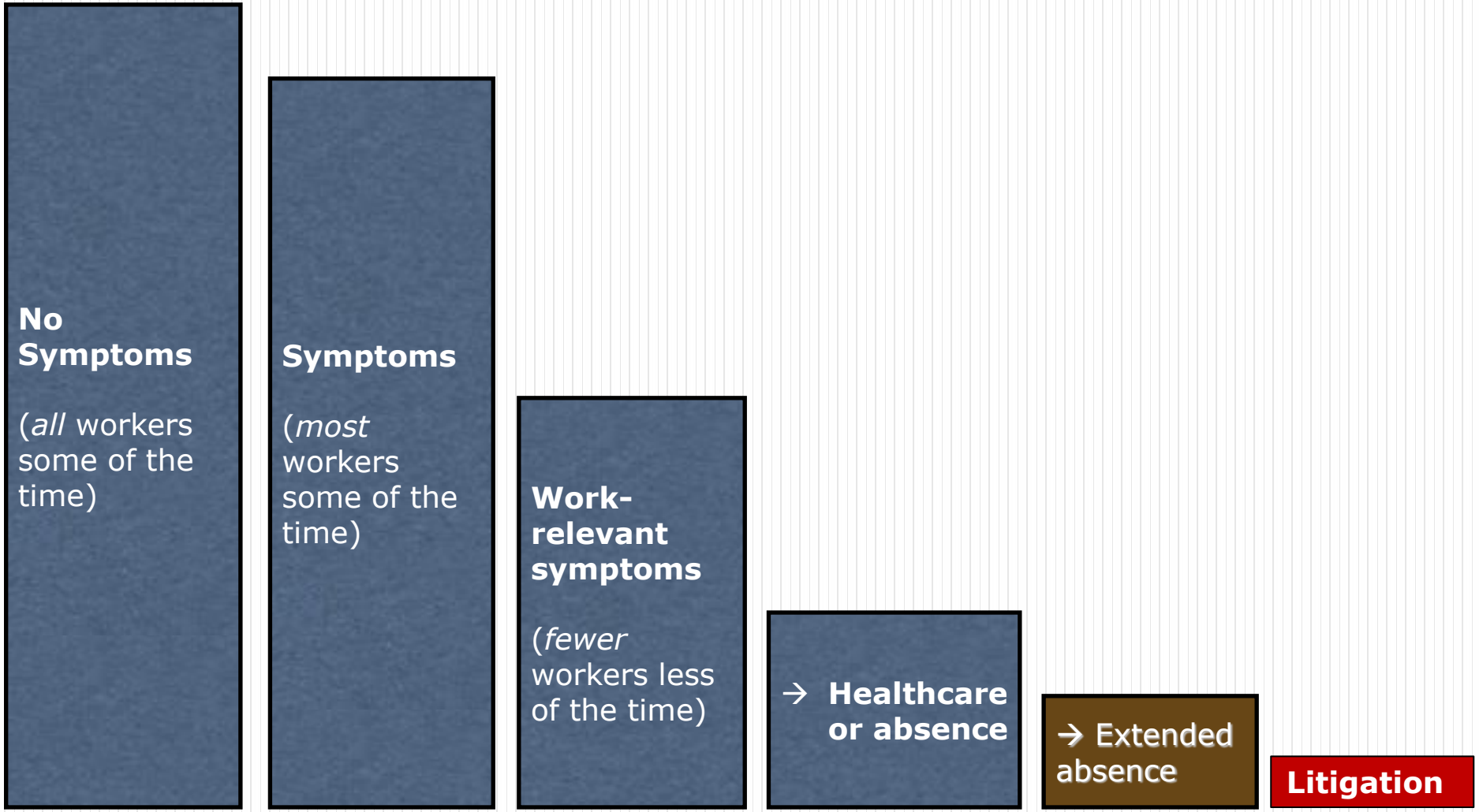
- High prevalence across population
- Characterised by symptoms more than disease or impairment
  - Coexisting symptoms common - physical and mental
- Untidy episodic pattern
  - varying severity at irregular intervals over life course
- Care seeking for ~10% of episodes
  - most episodes settle uneventfully
- Multifactorial causation
  - work usually only one contributory factor
- Most people remain at work or return to work quite quickly
- Essentially whole people, with a manageable health problem
  - *given support, opportunities and encouragement*



Prevailing paradox



CHP epidemiology – the key to understanding



The elephant in the room

Symptoms exist irrespective of the nature of work

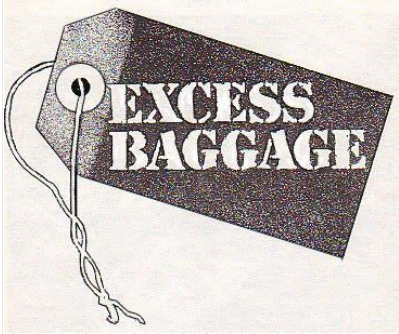
Symptoms ≠ care seeking, diagnosis or ℞

Work-relevant symptoms

- Symptoms can affect workability
  - symptoms may be more pronounced at work
  - work may be difficult because of symptoms
- How we deal with work-relevant symptoms can have major repercussions

The slide to disaster

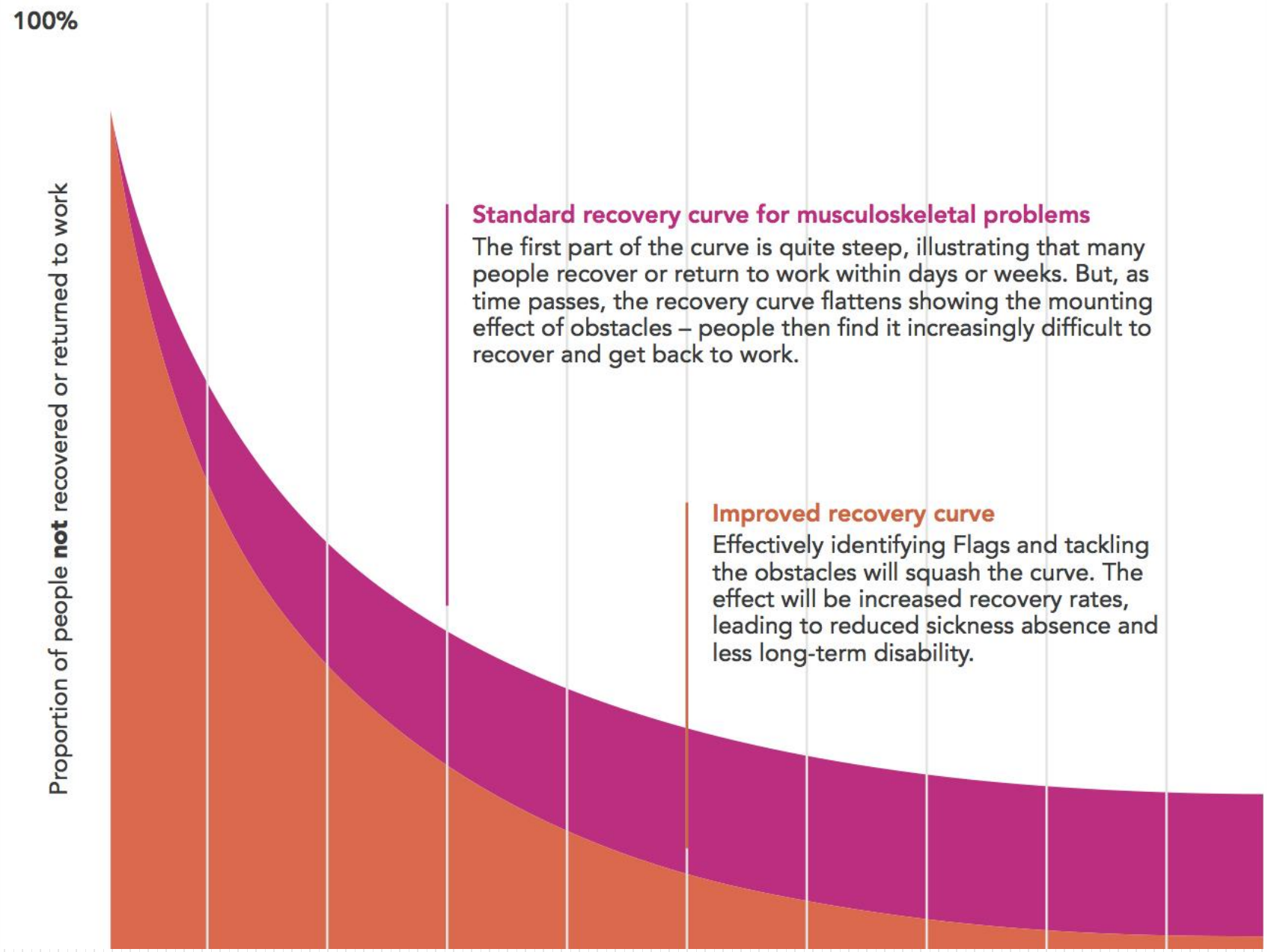
social constructs → escalating obstacles



- Before symptoms — Person
- At onset of symptoms — Person
- At time of seeking healthcare — Patient
- If signed off work — Beneficiary
- On failure to recover/participate — Dispossessed

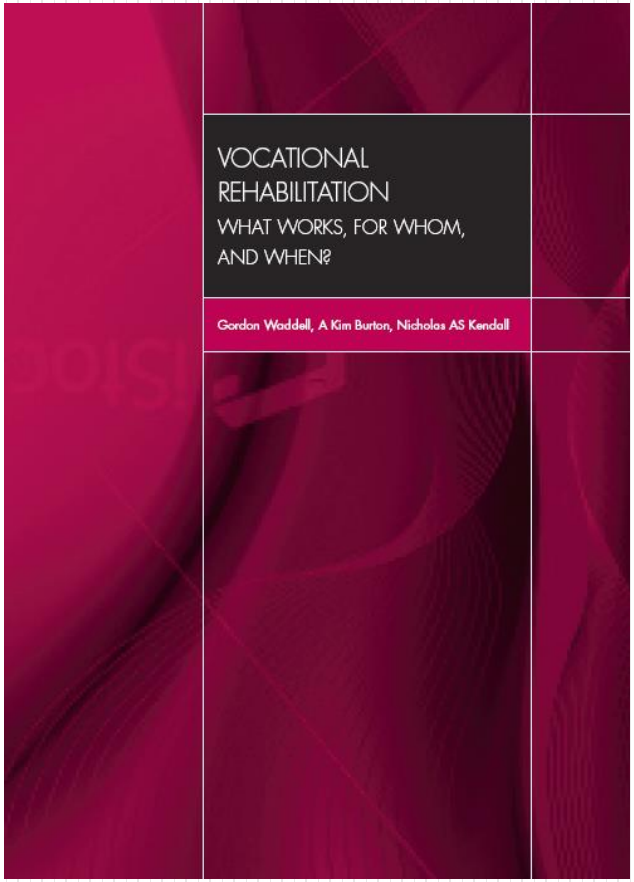
adapted from Hadler

The challenge: shifting the recovery curve



Vocational rehabilitation

- A review for Vocational Rehabilitation Task Group (2008)
  - *G Waddell, K Burton, N Kendall*
- VR can be effective + has cost-benefits
  - ***sooner rather than later***



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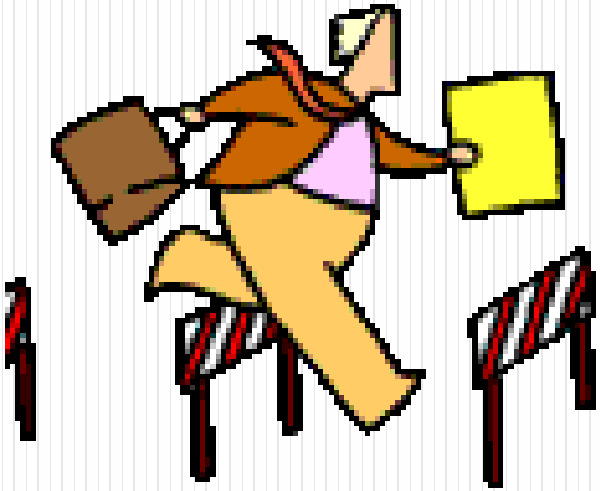
Integrated approach

- *VR is whatever helps someone with a health problem to stay at, return to, and remain in work*
- SAW and RTW don't just happen – action needed!
- Healthcare alone not enough
  - voc rehab not something to try after healthcare has finished/failed
- Workplace must be involved
  - from day #1
  - working whilst recovering

The obstacles model

- overcoming obstacles to work participation



Why do some people become disabled?

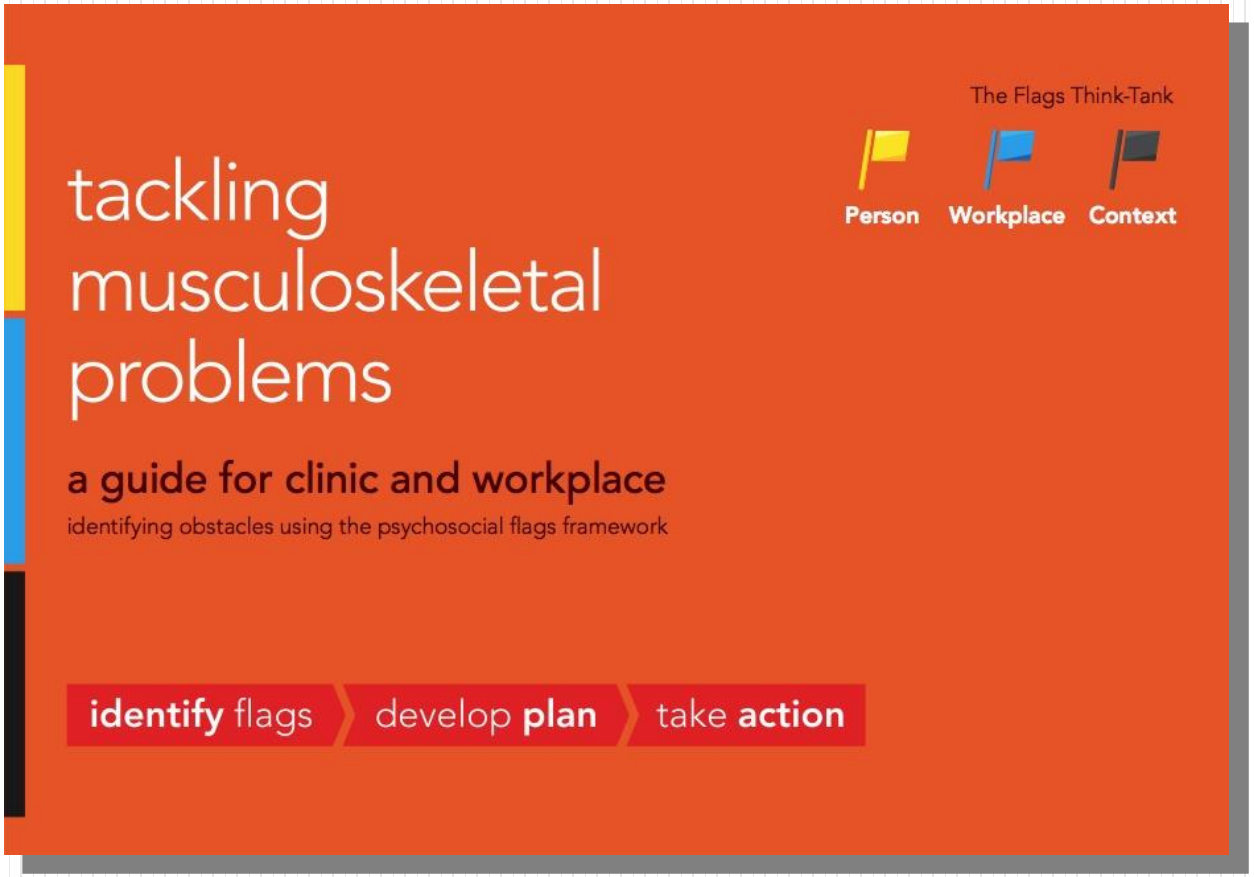
- They do not have a more serious health condition or more severe injury
  - So, it's not about what has happened to them; rather its about why they don't recover
- They face **obstacles** to recovery and participation

→ biopsychosocial approach

Tackling Musculoskeletal Problems

A GUIDE FOR CLINIC AND WORKPLACE
identifying obstacles using the psychosocial flags framework

Kendall, Burton, Main, & Watson: TSO Books, 2009 **ww.tsoshop.co.uk/flags**



Psychosocial flags framework

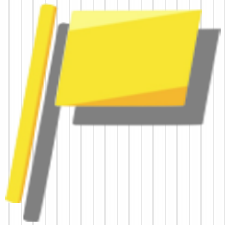
PERSON

WORKPLACE

CONTEXT

- Flags are things we can observe that indicate problems ahead
- They flag up obstacles to being active and working
- They point to what needs to be done

Important flags to identify - Person



Psychological factors are associated with poor clinical recovery

Thoughts

- Catastrophising (focus on worst scenarios)
- Unhelpful beliefs and expectations about pain, work, and healthcare
- Low expectations of *recovery*
- Preoccupation with health

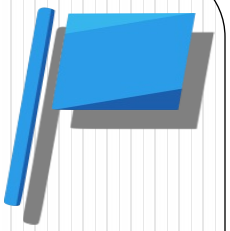
Feelings

- Worry, distress, low mood (± diagnosable anxiety or depression)
- Fear of movement
- Uncertainty (about the health problem)

Behaviours

- Extreme symptom report
- Passive coping strategies
- Serial care seeking

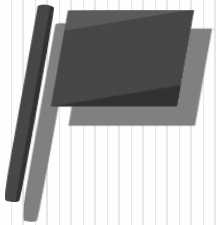
Important flags to identify - **Workplace**



Psychosocial workplace factors associated with persisting absence

- **Employee**
  - Fear of re-injury
  - Low expectation of *resuming work*
  - High physical job demand (perceived or actual)
  - Perception of high mental job demand (‘stress’)
  - Low job satisfaction
- **Workplace**
  - Lack of employer communication with employees
  - Lack of job accommodations/modified work
  - Low social support or social dysfunction in workplace

Important flags to identify - **Context**



- Significant others with negative expectations or beliefs
- Ineffective management
  - (lack of involvement/investment: poor line management)
- Unhelpful policies/procedures used by company
- Process delays
  - (e.g. waiting lists, claim acceptance)
- Role ambiguity or disagreements between key players
  - (employee <> employer <> healthcare)
- Financial, compensation or legal issues

Identifying flags - simple stepped hierarchy:

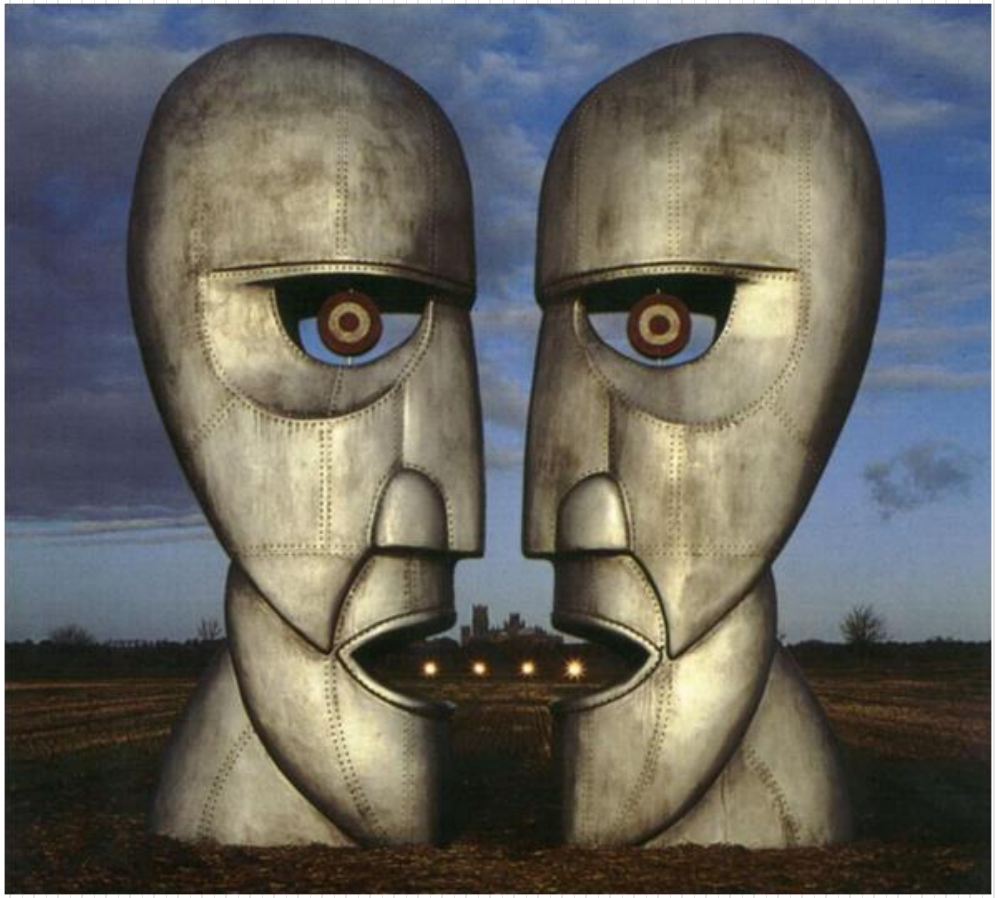
- Observation
  - Open questions
    - Structured questionnaires

Useful questions to ask

- What do you think has caused your problem?
- What do you expect is going to happen?
- When do you think you'll get back to work?
- How are you coping with things?
- Is it getting you down?
- What can be done at work to help?

develop **plan**

take **action**



Develop a plan *with* the person

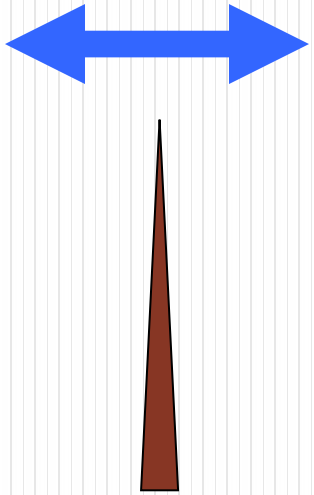
Key Players Communicate:

- agree the specific obstacles and actions
- agree timeframe and communication channels
- use (conditional) confidentiality waivers
- emphasise ability rather than disability
- all players sign up to the plan
- key players work together to ensure accommodating workplace

Action:

- Stepped care approach
  - just what's needed when its needed
- Identify and tackle obstacles
- Myth-busting info/advice
- Work-focused healthcare:
  - deal with biomedical issues whilst supporting early return to work
  - psychosocial problem-solving
- Workplace accommodation
  - ease the worker back to usual duties
- Communication between the players to interweave the actions

Who is involved in RTW

Person  Line Manager

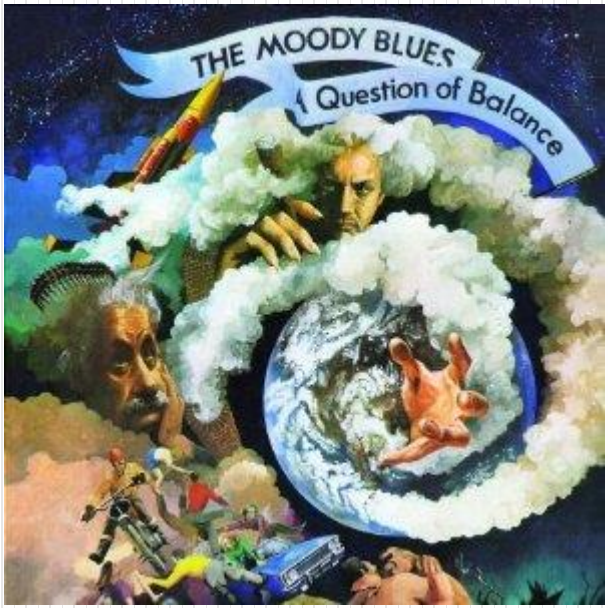
Clinician
Ergonomist

can facilitate or sabotage

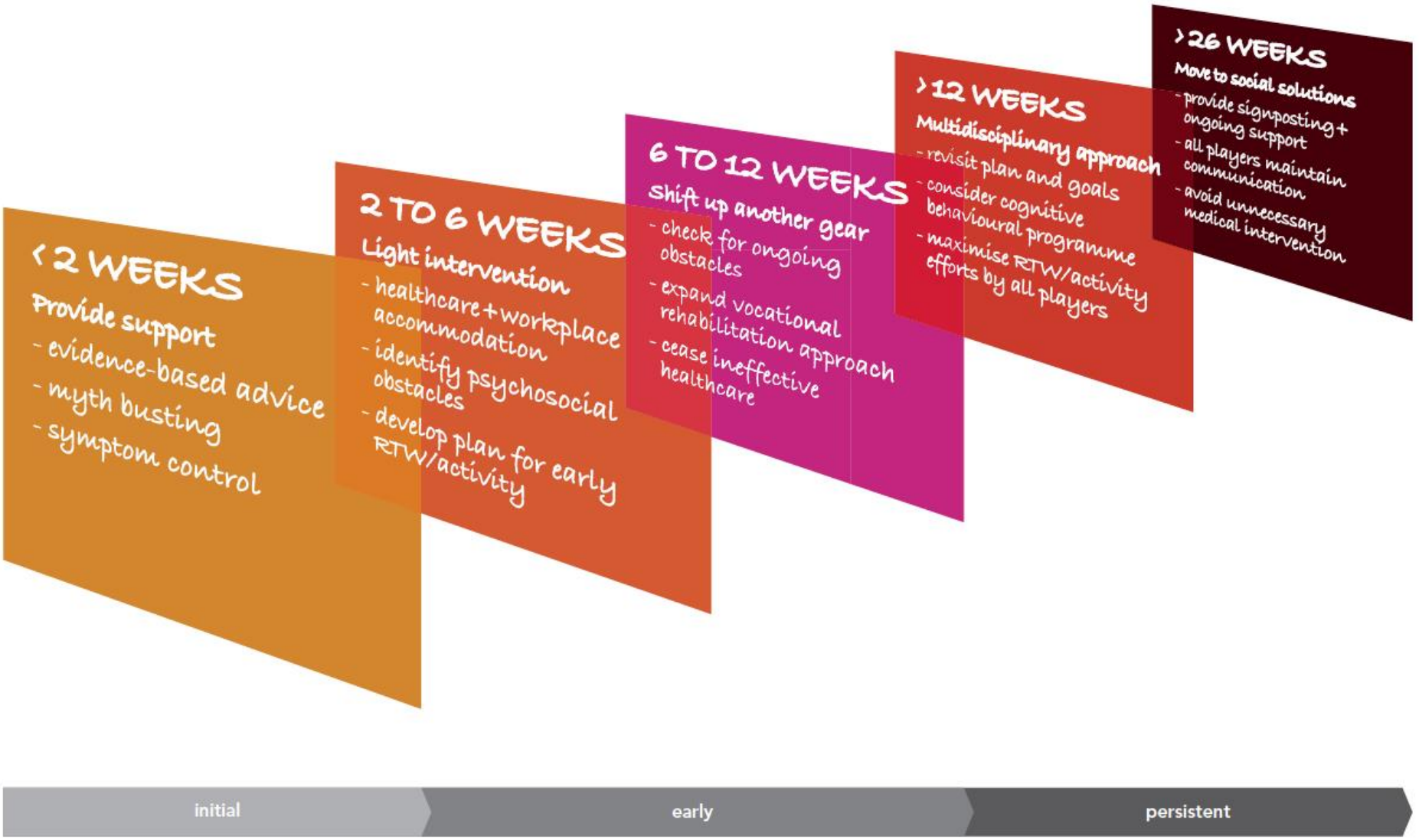
Question of balance

- Enough of what's good
- Minimise what's not

- Stepped care is optimal
  - recognising the limitations of medical/clinical intervention
    - not all health problems are medical issues



Stepped approach "just what's needed when it's needed"

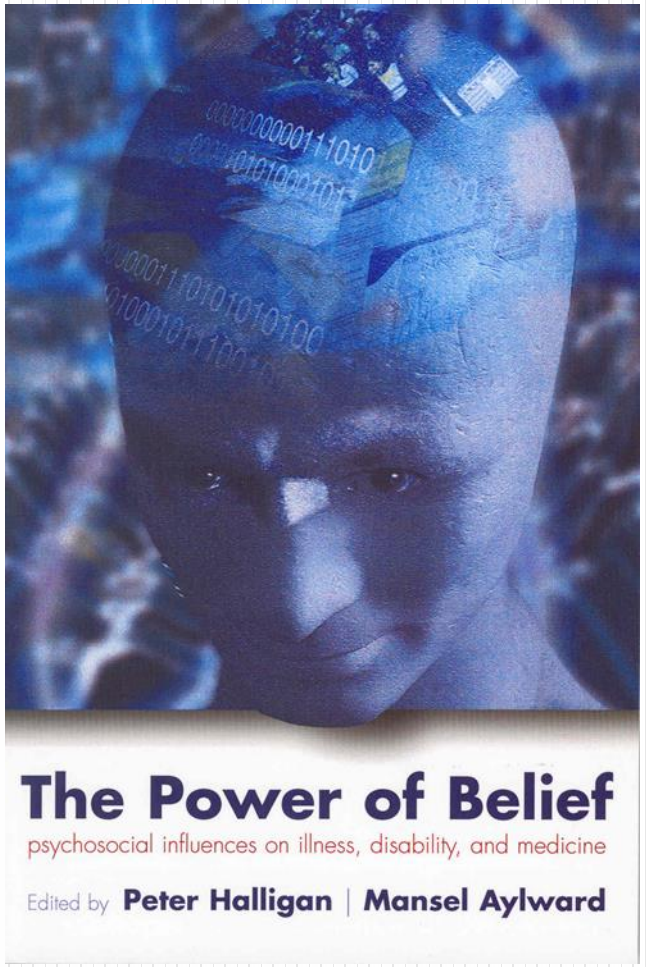


Timeframes - progressively fewer people remain as time passes - step times are approximate

Beliefs

- Beliefs are central to what we do about injury and disease
  - about whether to rest
  - about whether to seek treatment
  - about whether to work
  - about what it means for the future
- People don't cope too well when they are uncertain

- Health myths abound
  - held by clinicians as well as by the public
- Myths are major obstacles to work participation



Popular myths:

Rest always needed until pain goes

It's a health problem, so there must be a cure....

It hurts at work, so I was damaged by my work

Working whilst ill or 'injured' will just make matters worse

No return to work until 100% fit

Modified work means work was unsafe

We need to shift the culture

Working while recovering

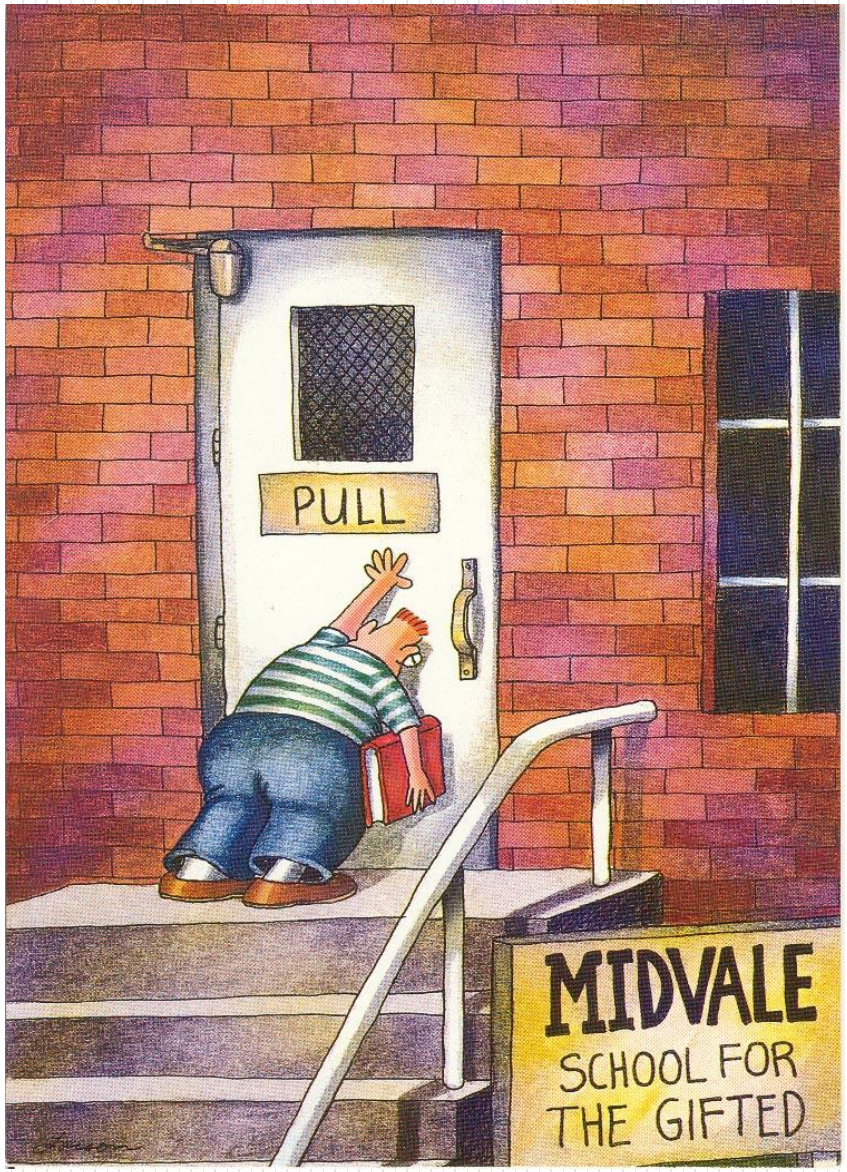
Key players must be onside and acting

- Poor communication is a major obstacle

Dispelling myths and shifting the culture

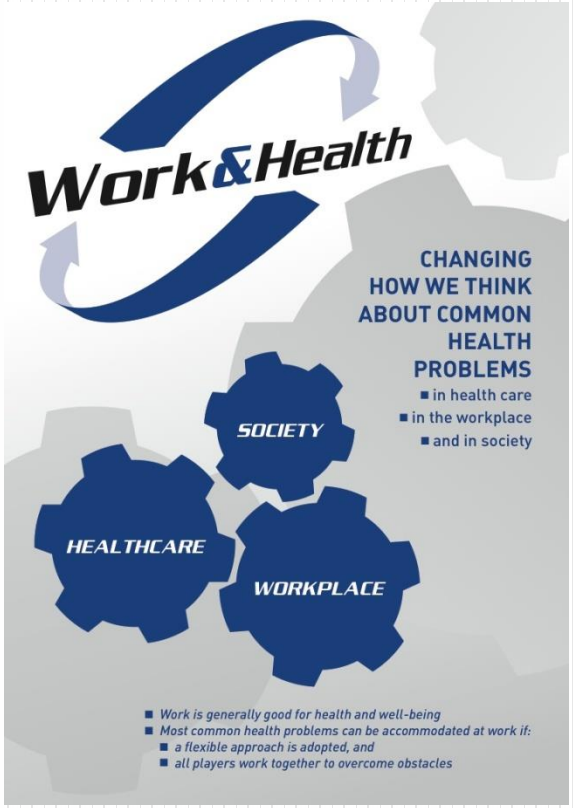
HEALTH WORK WELLBEING

- Set of guidance material developed
  - 3 leaflets
  - common set of messages
  - focus on how players interact
  - evidence-based
  - believable and doable
  - wide stakeholder support
  - target the key players



Workplace

- Players in and around the workplace
  - senior management • line managers • human resources • small employers • unions • health & safety advisers • occupational health professionals • rehabilitation providers • employment advisers • claims handlers • lawyers
  - 6 pages of information + practical advice on RTW procedures
    - PDF downloads



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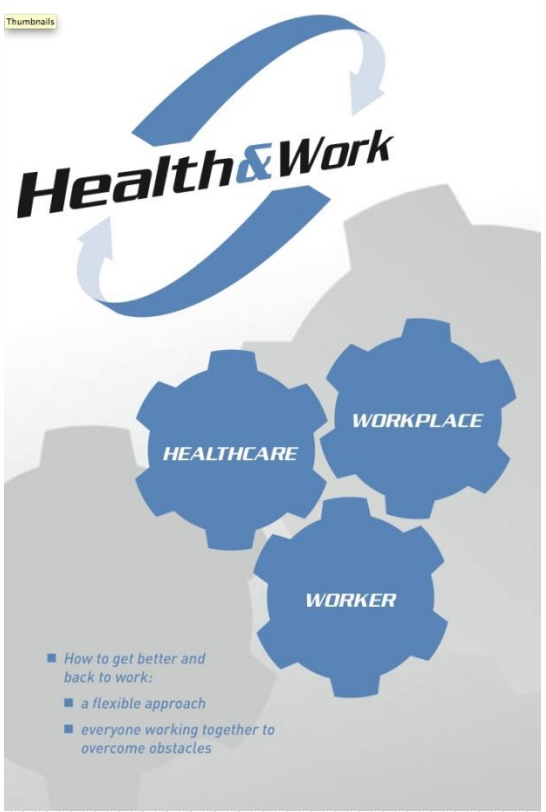
Workers-patients

- Leaflet for patients/workers
  - straightforward language
  - distribution by healthcare and employers
  - information, practical advice + stories
    - PDF downloads
    - Also 20 page booklet in style of *The Back Book*



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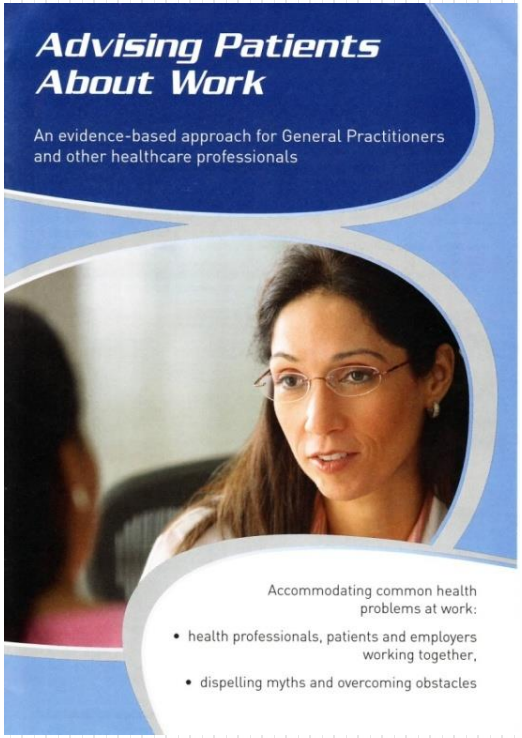
Healthcare

- Leaflet for health professionals
  - discusses evidence on work and health
  - practical advice on how to tackle this difficult topic
  - 6 pages
    - + 1-page e-summary
    - PDF downloads



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Downloadable resources

www.tsoshop.co.uk/flags

Statement of Fitness for Work

A guide for General Practitioners and other doctors

This guide has been developed in partnership with the Royal College of General Practitioners and the British Medical Association.

DWP Department for Work and Pensions

Fit note

It's a great idea, but the doc generally has limited understanding of the work or workplace.

Recommendations will need to be interpreted.....

Statement of fitness for work
For social security or Statutory Sick Pay

Patient's name: Mr, Mrs, Miss, Ms

I assessed your case on: / /

and, because of the following condition(s):

I advise you that:
- ☐ you are not fit for work.
- ☐ you may be fit for work taking account of the following advice:

If available, and with your employer's agreement, you may benefit from:
- ☐ a phased return to work
- ☐ amended duties
- ☐ altered hours
- ☐ workplace adaptations

Comments, including functional effects of your condition(s):

Sample

This will be the case for

or from / / to / /

I will/will not need to assess your fitness for work again at the end of this period.
(Please delete as applicable)

Doctor's signature

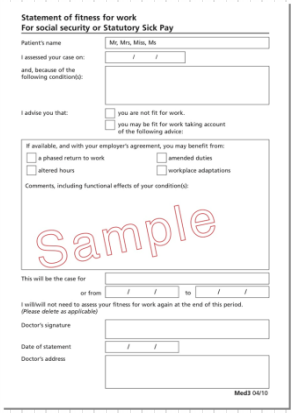
Date of statement / /

Doctor's address

Med3 04/10

Interpreting the work modification boxes

- **Altered hours**
  - Reduced work hours/days
  - Additional rest breaks
  - Allow work at home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Date of statement / /

Doctor's address

Med3 04/10

- **Workplace adaptations**
  - Reduce reaching
  - Provide seating
  - Reduce weights
  - Different department

- **Phased return to work**
  - Flexible start-finish times
  - Graded return to work
  - Start work on a Wednesday
  - Selected duties

- **Amended duties**
  - Achievable goals, scheduled at start of day
  - Reduce pace of work
  - Reduce task frequency
  - Increase task variety
  - Co-worker as buddy

The nature of workplace accommodation

- Temporality is key
- Transitional work arrangements
  - *Temporary* facilitation of SAW or RTW
  - Goal is return to usual work
  - *Not* an indictment of the job

DON'T SIT DOWN CAUSE I'VE MOVED YOUR CHAIR

- Arctic Monkeys 2011

Worker knows best

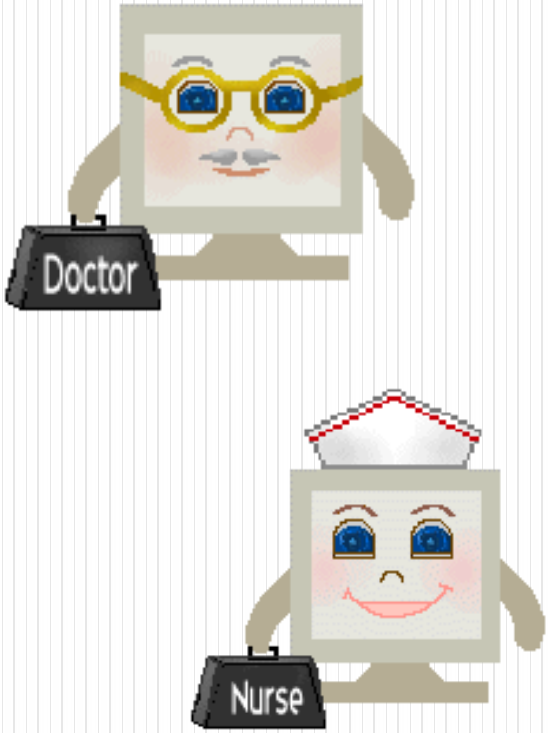
- Participatory ergonomics
  - Involve person:
    - identifying the obstacles
    - selecting the solutions
- Communication

person

line manager

clinician

Whither healthcare?



- Treatment may be needed, but
  - beware iatrogenesis:
    - what is said can undo what is done
- More and better health care alone is not the answer!
- Health care needs to work to a new integrated paradigm:
  - recovering while working
  - work *with* employer and worker

Whither prevention?

- Preventive intervention alone will have little impact on common health problems among workers.
  - Undue emphasis on ergonomic solutions may engender counterproductive beliefs
- More and better ergonomics alone is not the answer!
- Yet, ergonomics does have a major role in return-to-work and work-retention programs.
  - Workplace accommodation
  - Implementing fit note recommendations

‘work should be comfortable when we are well, and accommodating when we are ill or injured’

Nortin Hadler (1997)

Thanks for letting me talk with you

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www.spineresearch.org.uk