Middle Articles

CONTEMPORARY THEMES

Return to Work: Experiences of a Hospital Rehabilitation Officer

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Summary: Successful return to work after illness or injury often depends on an efficient exchange of information between doctor and employer. Rehabilitation officers with experience in industry have been employed by the Royal National Orthopaedic Hospital, Stanmore, for several years and have established their value in acting as direct links between hospital and industry.

Introduction

Recently many doctors have been discussing the difficulties that they have had in returning their patients to work and the services that are available to help them—including those of the Department of Employment and Productivity. They have asked whether there ought to be other facilities. One possibility is that there should be more hospital rehabilitation officers. At present there are very few of them, but those there are have shown themselves to be remarkably effective. When the country's resettlement services are reviewed it is essential to consider the reasons for their success and whether the basic principles underlying their work should be applied more widely.

The main function of a hospital rehabilitation officer is to help patients to return to work by contributing to their assessment within the hospital and by visiting places of employment to undertake any necessary inquiries, observations, or negotiations. He is available to discuss employment problems with patients, doctors, and other hospital staff; and also spends half of his time in industry negotiating the best solutions with management, foremen, and unions.

Unfortunately there is no scheme of training for a hospital rehabilitation officer, and therefore the usual arrangement is a brief apprenticeship with an established officer. The senior officer at the Royal National Orthopaedic Hospital (J. W. D.), who has now been doing this work for over 16 years, was originally in the Army and was training as a cost and works accountant in engineering before starting as a hospital rehabilitation officer at Hill End Hospital. He now also works in the Centre for Plastic Surgery at Mount Vernon Hospital and at St. Albans City Hospital.

The Hospital's Responsibility

The Royal National Orthopaedic Hospital employs two hospital rehabilitation officers, who were picked for their personal qualities, their understanding of people, and their background in industry. At Stanmore, where there are almost 200 beds for adults with a variety of orthopaedic conditions, including those arising from trauma, these two officers handle the employment problems of 350 patients a year. In an orthopaedic hospital such problems are often encountered soon after admission and possibly some weeks or months before discharge from hospital. There can be no question of delaying rehabilitation until after the patient has been discharged; full advan-

tage must be taken of the patient's time in hospital to carry out as much of the rehabilitation as possible. Early assessment inevitably necessitates contributions from many people within the hospital, informal discussions, and conferences. Nevertheless, it is at this stage, when the prognosis is uncertain and decisions are still being taken, that the patient's employment problems should be tackled and industry contacted. The hospital rehabilitation officer is accepted and involved in these deliberations much more readily than an official visiting from the employment exchange.

The consultant must take a lively interest in his patient's resettlement from an early stage. Essential information regarding the patient's expected pattern of recovery and the likely outcome in terms of function must be explained to the hospital rehabilitation officer, and to the patient if he is to co-operate to the full. Later the consultant's advice may be modified or made more complete when the hospital rehabilitation officer has reported back after his first visit to the place of work. The ward sisters, physiotherapists, occupational therapists, medical social workers, appliance officers, or teachers for adult education may be aware of factors which could influence the patient's capacity to work and are expected to pass on this information. The general practitioner or local authority may be contacted, and it may be necessary to visit the patient's home or arrange special assessment in occupational therapy, physiotherapy, or the department of adult education. Above all, the rehabilitation officer must get to know the patient as a person, his motivation to return to work, and other problems, including compensation. Many misconceptions about compensation can be removed by explanations in the early weeks after injury.

Common Problems

It is a mistake to imagine that the common problem is to find new work. Usually the man should return to his former employer, preferably in his former job, and therefore the essence of good resettlement is to make adequate contact with the man's employers without delay. This is done as soon as some idea of the prognosis is formed and normally within the first two weeks after injury or illness. Sometimes this contact is made by telephone or by letter, but if problems are at all likely to arise the rehabilitation officer visits the place of work. On his visit he must start with someone in a position to take decisions, usually a personnel manager, works manager, or foreman. Once a decision has been taken that the firm is to co-operate the matter is then usually referred to a foreman or shop superintendent on the floor; and in many instances the rehabilitation officer requests the help of a union representative because he too has every reason to look after the interests of one of his union members. In our experience union representatives have been extremely helpful, even with difficult problems such as guaranteeing cover to the employer when the patient is likely to have recurrent disability. The rehabilitation officer will see the patient's job and its exact nature will be explained to him. He may need to make measurements, to time another man

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doing a similar operation, and he may photograph the job so that he can explain it better to the hospital staff. At the same time he will discuss the patient's transport problems and how he will get to his job: if he is to come by car or motor vehicle, where will he park it and how will he proceed from there? Similarly he will study access to toilet and meal facilities. He will also keep an eye open for other work with the same firm which might be suitable in case the man could not manage his old job. Often the hospital rehabilitation officer is invited to discuss the problem with the works medical officer or the works sister.

A visit of this kind is usually much appreciated by the employer. The hospital rehabilitation officer is welcomed as a representative of the hospital and his knowledge is respected because within the limits of ethics he can explain all that he has learnt about the patient's condition from his discussion and observations within the hospital environment. He may also dispel unnecessary worries about loss of productivity or the likelihood of the man injuring himself in machinery at work. It is this direct discussion to iron out practical problems that is all-important and much more satisfactory than attempting to express the hospital experience in a letter or on a standard form.

Hospital rehabilitation officers have acquired considerable experience and many important contacts. Because of this, an officer seeing a new patient is likely to know the firm, the work, and probably the foreman, so that minor problems can often be handled effectively by telephone or letter. Nevertheless, he will visit the firm if there is any doubt. He has gradually become able to judge whether resettlement is likely to be difficult, but it does not follow that a simple medical problem is necessarily a simple resettlement problem.

Re-employment

There are times when a patient cannot return to his former employer but can continue with a similar occupation. This is not difficult if he lives in an area well known to the hospital rehabilitation officer, but it may present problems when he lives at a distance. There are, then, a variety of ways of tackling the problem. Often the man's employers are helpful because they know all the firms in the area doing similar work. In an entirely new area the first firm contacted can often lead to other contacts. Alternatively the Department of Employment and Productivity or the local chamber of commerce will help. But whenever there is likely to be difficulty the key to success is to visit the firm personally and usually to accompany the patient when he goes for an interview. In this way the hospital rehabilitation officer can act as a link between the hospital and the prospective new employer and make any necessary explanations. Often employers are reluctant to take the risk in employing a man because they do not understand the precise significance of his disease or disability. It is therefore essential to explain this and to give details of the patient's capacity to work and to continue working, backed up by evidence from the hospital assessment.

Whenever possible a patient is placed with his old firm or in a new firm with work closely related to his former employment or which at least takes advantage of his skill and experience. But when the disability makes this impossible and a new occupation must be chosen this inevitably involves a more thorough assessment. With an inpatient in an orthopaedic hospital this can almost always be done while the patient is still in the hospital, and hence it is seldom necessary to refer the patient subsequently to an industrial rehabilitation unit of the Department of Employment and Productivity. But when training is going to be necessary after discharge from hospital this is organized at the earliest date, and the patient is prepared in every way possible for his future occupation during the inpatient period—particularly by help from the teachers in adult education.

Once a patient has been placed in work it is made clear to the employers that if any difficulty arises the hospital rehabilitation officer will gladly advise or make a further visit. This is reassuring to the employer and the patient, and in many instances it has prevented patients from losing their work unnecessarily. In addition, follow-up letters are sent to the patient during the first five years and indefinitely if the patient is likely to have recurring problems.

Advantages of Long Associations

Contacts with employers mature with time. Once employers have been helped by this service and have become satisfied that it is of value to themselves and their employees, negotiations over subsequent patients are much easier. For this reason there are considerable advantages in having hospital rehabilitation officers who stay with particular hospitals for the whole of their careers.

It is also helpful to the consultant and the rest of the hospital staff who are helping with the resettlement if they know in detail the patient's work problems. Often this helps the consultant to take clinical decisions; for instance, it may help a surgeon contemplating reconstructive surgery of the hand. Problems of work and the atmosphere of industry are brought back to the hospital so regularly that resettlement in work becomes a live, everyday problem of which the hospital staff are fully conscious and well informed.

Case Histories

The following case histories help to illustrate the factors involved in resettlement.

Case 1

A fifth-year apprentice Monotype-caster operator in the printing trade attended the hospital with rheumatoid arthritis resulting in virtual ankylosis of both knees and hips. His job involved standing all day and bending and frequently lifting heavy castings weighing between 9 and 56 lb. (4 and 25 kg.). If he was to stay within the trade for which he had been apprenticed the obvious occupation for him was that of Monotype keyboard operator, a full-time sedentary occupation. Unfortunately his firm carried no keyboard work and it was necessary for him to join a different union. Owing to the good relationship that had been built up over the years between the hospital and the unions concerned, the necessary negotiations were completed while he was in hospital. He was provided with a new union card and enrolled in a course of keyboard operating, to start as soon as he was discharged from hospital; in addition, he was promised a job at the completion of his training. As it was expected that his arthritis might result in recurrent time off work, this possibility was discussed during the preliminary negotiations and the unions gave a guarantee to the employers that this young man's absences from work would be covered and production would not suffer. In fact he was away from work 82 days in his first two and a half years, but he has now been doing the same job for seven and a half years and has not lost a day from work in the past five years. He is paid the top rate for the job at £32 a week.

Case 2

A 20-year-old woman had been severely paralysed by poliomyelitis. She obtained General Certificate of Education "O" level certificates in six subjects but was chairbound, and applications for supplying a motor-propelled vehicle had been turned down because of the extent of her paralysis. She had never been employed and the Ministry of Labour thought it was wrong to give her any hope that she could be employed in her locality. The first problem to be solved, therefore, was her means of transport. After assessment and a period of driving instruction a specially modified motor vehicle was supplied by the Ministry of Health. But even when she had the vehicle and had passed her driving test the Ministry of Labour still felt that it would be impossible to find her local employment.

Letters to the Chamber of Commerce and to 16 firms produced no result, and it was decided that the hospital rehabilitation officer

should make a one-day visit to provide direct contact. A canvassing tour was then done, starting from the centre of the town, and employment was eventually arranged with a receptive employer who had suitable ground-floor accommodation. She remained with that firm as an accounts clerk for five years, but the firm was then taken over by a larger organization and she decided to leave. During the course of the day's survey several of the employers visited became interested in the problem, and some of those who expected to move later into ground-floor premises took her personal details. She now works for one of the employers who showed this initial interest.

Discussion

There are many important factors in work-resettlement of the physically disabled, and obviously the hospital rehabilitation officer represents only one way of tackling some of the problems. Often the only requirement is for the doctor to make direct contact with the employer, perhaps with the help of a social worker. Sometimes a new job is required, and the Department of Employment and Productivity can provide an excellent service through their employment exchanges, industrial rehabilitation units, Government training centres, and other facilities. But between these two approaches there is a gap. In our experience there is inadequate help for patients with difficult employment problems who need to return to their own jobs or to similar work which will take advantage of their former skills and knowledge. This is a big problem, and is by no means confined to orthopaedic patients. It applies particularly to disabilities that are variable and unpredictable and to diseases that are not immediately understood by people without medical training. Good examples of such diseases are rheumatoid arthritis, schizophrenia, epilepsy, and heart disease.

Almost everything depends on an efficient exchange of ideas and information between doctor, employer, and patient. All too often the doctor does not understand his patient's work situation in any depth, and the employer, who has to decide whether he is wise to employ a patient, may have a very limited understanding of the medical problems and the significance of the disability. Unless there is adequate communication between doctor and prospective employer—either direct or through a knowledgeable intermediary—the patient is likely to remain unemployed. Success depends on early discussions, mutual confidence, and continuing contact until the problem is solved.

Theoretically and ideally, the disablement resettlement officers (D.R.O.s) of the Department of Employment and Productivity should work closely with doctors and employers to provide this

service. Some do, with excellent results, but more often they are not given the opportunity, and no one could claim that this problem is being adequately solved throughout the country. Industrial medical officers are invaluable, but they are not universally available. What then should be the answer?

One solution would be for many more D.R.O.s to be seconded to hospitals, where they would have offices and become regarded as members of the staff. Similarly they could be more readily available to visit general practitioners regularly to discuss employment problems. The difficulty with these suggestions is that they have always been possible since the beginning of the D.R.O. service, but this collaboration and direct discussion has been sporadic and virtually never to the degree developed by hospital rehabilitation officers. The medical profession is partly responsible in failing to seek out D.R.O.s and help them to contribute more fully; but it will continue to be difficult to establish the essential collaboration until further improvements have been made in the roles, career structure, and training of D.R.O.s.

At present D.R.O.s are usually employment officers who have received a brief period of special training; and they remain D.R.O.s for a few years, sometimes only two, before going on to other work. We believe that this is such an important job, with so much to learn, that it is astounding that it has not become part of a lifetime career service. It is not a task to be picked up briefly during an appointment mostly devoted to other things. Because of our own experience and observations of some excellent D.R.O.s and group D.R.O.s it is easy for us to visualize an improved service, and we should like to see more D.R.O.s given an opportunity to apply some of the principles that we have found to be so successful. They should be more deeply involved in medicine and industry and given better opportunities to learn about both. They need to know more about other rehabilitation services and the people who work in them, and particularly about patients, with all their hopes and fears and obstacles to resettlement.

As there are already over 1,100 D.R.O.s, who need to establish close links with general practitioners as well as hospitals, we do not suggest a major switch to hospital rehabilitation officers employed by the Department of Health and Social Security. Nevertheless, a strong case can be made for appointing hospital rehabilitation officers to certain hospitals with special resettlement problems, especially orthopaedic and psychiatric hospitals, and to general hospitals with a particular emphasis on rehabilitation and resettlement.

CONFERENCES AND MEETINGS

Vienna Conference on Treatment of Leukaemia

[FROM A SPECIAL CORRESPONDENT]

An international congress on the treatment of leukaemia and lymphoma was held in Vienna from 24 to 26 March 1969. The action of cytostatic drugs, the results of therapy with new antileukaemic agents—such as asparaginase and daunomycin—and the immunotherapy of leukaemia were discussed.

Chemotherapy

B. MORNINGTON (London), considering the action of 6-mercaptopurine and azathioprine, presented work by himself and his colleagues to show how these drugs achieve their effects. Initially azathioprine was broken down into 6-mercaptopurine, 6-thiouric acid, and several other metabolites; 6-mercaptopurine was then bound to phosphate and ribose, and it was in this form that it had

been shown to inhibit the enzyme phosphoribosyl pyrophosphamidotransferase and thus affect nucleic-acid production. Both 6-mercaptopurine and azathioprine had an antileukaemic and immunosuppressive activity, and in comparative studies the dose-requirements for immunosuppression had been found to be one-third of those required for the treatment of leukaemia.

G. BONADONNA and his colleagues (Milan) described the metabolism of tritiated daunomycin in both animals and man. They emphasized that in rats this drug was rapidly taken up into all the tissues except the brain, whereas in man it could be found for up to three days in the blood stream of patients with malignant disease. Hence this persistence would support the use of an intermittent administration in order to avoid toxicity. K. WILMS (Tübingen), studying the enzyme

deoxyribonucleic-acid polymerase (which is found particularly in proliferating cells), commented on the immediate fall which occurred in the level of this enzyme in patients who had recently started radiotherapy or chemotherapy. When deoxyribonucleic-acid levels fell rapidly the patients were likely to have a remission, and this fall usually preceded changes in the peripheral blood count by some time.

Predictive tests in asparaginase therapy were also discussed. W. M. GALLMEIER and C. G. SCHMIDT (Essen) described the use of an in-vitro test in 73 patients, stating that it had been possible to detect whether the tumour to be treated was dependent on asparagine. In acute lymphoblastic leukaemia there appeared to be some correlation between the results of the test and the results of treatment, but this was not found in other