TNO Kwaliteit van Leven

TNO-rapport

Arbeid
Polarisavenue 151
Postbus 718
2130 AS Hoofddorp

www.tno.nl/arbeid

T 023 554 93 93
F 023 554 93 94

018.10296.01.01

Bijlagen

Blinde vlek voor arbeid in de gezondheidszorg: buitenlandse remedies voor Nederlands probleem?

Datum 23 september 2005

Auteurs P.C. Buijs
A. Weel

Inhoudsopgave

1	**Projectteam, consulenten, e-mail werkgroep, definitief projectplan en position paper**	**3**
2	**Vragenlijsten voor de e-mail werkgroep, voorjaar 2004**	**11**
3	**Resultaten vragenlijstonderzoek e-mail werkgroep**	**13**
4	**Resultaten literatuursearch**	**33**
4a	**The process of concept mapping**	**46**
5	**Concept mapping nationaal**	**48**
6	**Concept mapping internationaal**	**56**
7	**Interviews met sleutelpersonen**	**60**
8	**Werkbezoeken**	**66**
9	**Symposiumvoostel voor "Milano 2006"**	**67**
10	**Letter of support world health organization**	**69**
11	**Artikelen**	**76**

1 Projectteam, consulenten, e-mail werkgroep, definitief projectplan en position paper

A. Projectteam
Projectleider: Dr P.C. Buijs, bedrijfsarts, senior adviseur/onderzoeker TNO
Medewerkers: Dr A.N.H. Weel, bedrijfsarts-onderzoeker, Mediforce; secretaris EASOM
(Dr. J.R. Anema was aanvankelijk ook als medewerker ingeboekt, maar heeft dat niet kunnen effectueren wegens het aanvaarden van een betrekking elders)

B. Consulenten
Consulenten: Prof dr F.J.H. van Dijk, Coronel Instituut, Amsterdam
Prof dr P Westerholm, Arbetslivsinstitutet, Stockholm
Mw. B. Froneberg, ILO, Geneve
Mw. G. Eijkemans, WHO, Geneve
Toegevoegd: Prof. dr C. van Weel, hoogleraar Huisartsgeneeskunde, KUN, president-elect WONCA

C. e-mail Werkgroep
Jacqueline Agnew, Johns Hopkins, Baltimore
Alberto Aguilar Salinas, Mexico
Boguslav Baranski, Lodz, Poland
Jean-François Caillard, Rouen, France
Edith Clarke, Ghana
Ian Eddington, Toowoomba, Australia
Edward Emmett, Pennsylvania, USA
Gerry Eijkemans, WHO, Geneva
Marilyn Fingerhut, NIOSH, Washington DC, USA
Giuliano Franco, Modena, Italy
Jean-François Gehanno, Rouen, France
Ivan Ivanov, WHO, Copenhagen, Denmark
Emilia Ivanovich, Sofia, Bulgaria
Reinhard Jäger, Linz, Austria
Jerry Jeyaratnam, Sri Lanka
Robert Karasek, USA
Katherine Kirkland, AOEC, Washington DC, USA
Alastair Leckie, UK
Max Lum, NIOSH, Washington DC, USA
Ewan MacDonald, Glasgow, UK
Pirjo Manninen, Kuopio, Finland
Raphael Masschelein, Leuven, Belgium
René Mendes, Belo Horizonte, Brazil
Glen Pransky, USA
Giso Schmeisser, Dresden, Germany
Ferdi Smith, Durban, South Africa

D. Definitief Projectplan
Projectplan blinde vlek voor arbeid in de gezondheidszorg: buitenlandse remedies voor nederlands probleem?

> "In de reguliere zorg (is) te weinig aandacht voor het aspect arbeid of werkhervatting."
> De Geus en Hoogervorst aan 2e Kamer, 1-10-2003[1].

Inleiding

Doelstelling: Verbetering van de aandacht in de curatieve zorg voor de relatie gezondheid - arbeid, door inventarisatie en zo mogelijk toepassing van ervaringen uit het buitenland.

Beleidsrelevantie: In ons land wordt gebrek aan die aandacht – ook wel bekend als 'blinde vlek voor arbeid' in de zorg - gezien als een belangrijke oorzaak van ziekteverzuim en WAO, die bovendien arbo-curatieve samenwerking bemoeilijkt, die juist bedoeld is om verzuim en WAO tegen te gaan. Immers, als behandelend artsen geen verband leggen tussen klachten van patiënten en hun werk, zullen ze ook geen contact zoeken met bedrijfsartsen.
Dit probleem is al decennia bekend[2] en heeft m.n. vanaf begin jaren 90 tot tal van initiatieven geleid[3] – vooralsnog echter met onvoldoende resultaat. Gezien deze 'beleidsresistentie' is het nuttig om na te gaan of deze blinde vlek ook in het buitenland als knelpunt wordt gezien, en zo ja, of men daar oplossingen gevonden heeft, die ook in ons land toepasbaar zijn.

Nadere probleemomschrijving
Als in Nederland werknemers problemen krijgen met hun gezondheid, gaan ze vaak naar hun huisarts of medisch specialist.Die hebben echter meestal weinig kennis van of oog voor de rol van arbeid: causaal – werk als (mede)oorzaak van (verergerende) klachten – of conditioneel – werk als aan te passen omstandigheid, zodat men met bepaalde aandoeningen, klachten of beperkingen toch kan doorwerken of (snel) weer kan hervatten. Daarnaast beseffen curatieve artsen onvoldoende dat aangepaste werkhervatting het genezingsproces bevorderen kan. Ook nemen zij weinig contact op met collegae, die wél die kennis hebben: bedrijfsartsen.
Hierdoor lopen behandelend artsen, maar vooral hun patiënten onnodig risico op inadequate anamneses, behandelingen ('Neem voorlopig maar rust!', zonder een vervolgafspraak), verwijzingen naar voorzieningen zonder arbeidsgeneeskundige expertise, maar wèl met lange wachttijden; niet verwijzen als dat wel zou moeten; zonder afstemming tegenstrijdige advies geven aan dat van de bedrijfsarts, of oordelen zonder voldoende kennis van de arbeid ('Met die knie kunt U nooit meer werken!') - terwijl bekend is, dat werknemers het oordeel van hun behandelend arts vaak het zwaarst laten wegen. Ten slotte houdt het bovenstaande ook nog het risico in van medicalisering van klachten met een niet-medische oorzaak, zoals verstoorde arbeidsverhoudingen, waar de behandelend arts géén, maar de bedrijfsarts wèl zicht op heeft.

---

[1] Uit Actieplan (p5) bij brief aan Tweede Kamer, dd 1-10-2003, over project Sociale Zekerheid en Zorg

[2] Bv. Draaisma & Smulders ('78), Buijs ('84), KNMG ('91), SER ('98), Platform Wachttijden ('99)

[3] Bv. van VWS/SZW, KNMG, NVAB, LHV, NHG, OMS, ZonMw, CvZ, Platform Wachttijden, NWO.

Kortom, de ‘blinde vlek voor arbeid’ bij behandelaars verhoogt de kans op inadequate zorg, en daarmee op onnodig (lang) verzuim of zelfs WAO - intrede.

‘Blinde vlek voor arbeid in de zorg’: een Nederlands probleem?
De gangbare gedachte is, dat deze ‘blinde vlek’ typisch Nederlands is vanwege onze unieke, al een eeuw geldende Scheiding Behandeling – Controle, waardoor curatieve artsen zich steeds meer afzijdig hielden van de relatie arbeid - gezondheid. Bij recente internationale OHS- congressen[4] bleek echter, dat veel buitenlandse key figures deze ‘blind spot for work in health care’ en de insufficiënte communicatie met curatieve artsen goed (her)kenden. Pogingen tot verbetering in eigen land ten spijt beschouwden zij het als een ernstig, universeel probleem dat als zodanig nog niet eens in de internationale vakpers beschreven is. Men was dan ook erg geïnteresseerd in hoe ons land ermee omging, moedigde ons aan er iets mee te doen en zegde toe om per e-mail of anderszins naar vermogen mee te werken[5].
Als de ‘blinde vlek voor arbeid’ in de gezondheidszorg inderdaad veel internationaler blijkt te zijn dan wij dachten, kan dat tot een vruchtbaar tweerichting verkeer leiden: wat kunnen wij leren van het buitenland, en wat kan het buitenland leren van ons. Het eerste kan ons helpen bij het oplossen van ons probleem en is daarom hoofddoel van dit project. Het tweede lijkt echter ook niet onbelangrijk: met onze recente initiatieven om die blinde vlek tegen te gaan en betere arbocuratieve samenwerking te bewerkstelligen konden we wel eens voorliggen op tal van vergelijkbare landen. Dat is prettig, omdat hier een terrein betreft, waar ons land al jaren bekend staat als zorgenkind, vanwege het ziekteverzuim en vooral de WAO instroom – niet voor niets internationaal ook wel aangeduid als Dutch Disease ….
Vandaar onderhavig plan om een internationaal project te starten over dit thema, enerzijds om kennis op te doen ten behoeve van het bestrijden van genoemde ‘blinde vlek’, anderzijds vanwege de gerede kans op goodwill over de grens.

PROJECTPLAN DEEL ÉÉN: KENNISVERWERVING

FASE A POSITIONERING EN ORIËNTATIE

A 1. Start
1. Vaststellen definitief projectteam en projectplan;
2. Inventariseren relevante Nederlandse (onderzoeks)literatuur;
3. Benaderen internationale contacten met de vraag om medewerking (zie o.a. noot 5);
4. Daaruit formeren van internationale e-mail werkgroep;
5. Verzoek om toezenden van hen bekend relevant (onderzoeks)materiaal over blind spot;
6. Korte vragenlijst maken en zenden naar emailgroep over het thema, om 1e indruk te krijgen van situatie in diverse landen (aard, omvang, ernst e.d.);
7. Verwerken vragenlijsten, mede t.b.v. A2.

[4] EASOM congres- en werkbezoek (Baltimore/Washington/New York, okt 2002), ICOH-congres A’dam (nov 2002), 3-jaarlijkse ICOH-Congres (Brasil, febr/mrt 2003), allen samen met André Weel (NSPOH).

[5] Bv. ICOH-voormannen als Jorma Rantanen, Peter Westerholm, Jean-François Caillard en Jerry Jeyaratnam (Singapore, JOEM), Kathreen Fingerhut (WHO), Brigitte Froneberg (ILO), Horst Konkolevsky (‘Bilbao’), Jacky Agnew (John Hopkins, VS), Pete Abeytunga (CCOHS, Canada), Paulo Meirelles (ACADAMT, Brasil) e.v.a.

A 2. Positionering/oriëntatie
1. Opstellen concept position paper over het thema;
2. Commentaarronde e-mail werkgroep;
3. Verwerken + vaststellen definitief position paper;
4. Oriëntatie op en keuze van geschikt internationaal kader (ICOH, NWO, 'Bilbao').

A 3. Eerste internationaal artikel
1. Concept opstellen voor (opiniërend) artikel, bedoeld om het thema onder de internationale aandacht te brengen;
2. Commentaarronde e-mailgroep, m.n. ter onderbouwing van het probleem, en voor suggesties van geschikt tijdschrift, bij voorkeur curatief;
3. Verwerking van 2) + aanbieden nieuwe versie aan internationaal tijdschrift;
4. Verwerking commentaar peer review in definitief artikel;

FASE B KENNISVERWERVING

B 1. Literatuur search
1. Opstellen en verantwoorden van groslijst van engelstalige zoektermen;
2. Commentaarronde emailgroep houden en verwerken;
3. Doen van de feitelijke search;
4. Lezen en bespreken van relevante (onderzoeks)literatuur door projectteam;
5. Maken van tussenrapportage met relevante summaries en 1e conclusies;
6. Commentaarronde bij emailgroep;
7. Verwerken in definitieve versie t.b.v. artikel (zie B3)

B 2. Concept mapping ter bepaling van omvang, ernst, mogelijke oorzaken, beïnvloedende factoren en oplossing(srichting)
1. Opstellen concept - vragenlijst, mede op basis van het voorgaande;
2. Commentaarronde e-mailgroep;
3. Verwerken in definitieve vragenlijst;
4. M.b.v. emailgroep lijst opstellen van ca. 20 key figures uit diverse continenten;
5. 1e ronde concept mapping;
6. Verwerking 1e ronde + voorbereiding 2e ronde;
7. 2e ronde;
8. Verwerking resultaten + conclusies trekken in definitieve rapportage.

B 3. Tweede internationaal artikel
1. Opstellen concept artikel door projectteam, mede op basis van A 3, B 1 en ev. 2;
2. Commentaar emailgroep en advisering over (curatief) tijdschrift;
3. Verwerken commentaar + aanbieden artikel aan internationaal tijdschrift;
4. Verwerken commentaar peer review in definitief artikel.

FASE C VOORBEREIDING VOOR IMPLEMENTATIE

1. Omwerken van internationale artikelen (A3 en B3) voor plaatsing in Nederlandse vakbladen (NTvG, H&W, TBV of MC);
2. Het opstellen van een **Implementatieplan**, o.a. inhoudende:
   - een internationale workshop/expert meeting, m.n. over oplossingen;
   - **(Aftasten mogelijkheden voor/behoefte aan) internationale conferentie;**
   - Vertalen buitenlandse oplossingen naar Nederlandse situatie;
   - Organiseren van Nederlandse Werkconferentie over oplossingen;
   - Schrijven van artikelen ter zake voor de vakpers, patiënten- en leke-bladen;

- Thema inbrengen in de relevante opleidings-, na- en bijscholingscircuits;
- Idem bij (besturen van de) artsenorganisaties, GGZ, ziekenhuiswereld e.d.;
- Idem bij organisaties van werkgevers en werknemers.

E. Position paper "Blind spot for work in health care: only a dutch problem?"
A *working document*

> "In the regular health care, too little attention is paid to issues of work or return to work".
> Mr. De Geus (Dutch Minister of Social Affairs and Employment) and Mr. Hoogervorst (Dutch Minister of Health) to Parliament, October 1, 2003

1. INTRODUCTION: Relevance for health care and social policies
In the Netherlands, the lack of attention in curative health care for work influence on health aspects – also known as 'blind spot for work' – is considered to be a major cause of sickness absence and disability for work. For if treating physicians do not relate the health complaints of the employees among their patients to their work, they are at risk to make an incomplete or false diagnosis, or to choose an inadequate therapy. Also they will not contact occupational physicians when necessary - so hampering the starting co-operation between curative and occupational physicians, just intended to oppose sickness absence and disability for work.
This problem is already known for decades and has induced a lot of initiatives and actions, especially from the early nineties on – as yet with insufficient results. Because of this 'resistance' for policy measures and actions, it is important to investigate if this blind spot is also considered to be a bottle-neck abroad, and, if so, to find out if solutions have been found there that are applicable in the Netherlands too.

2. PROBLEM ORIENTATION

2.1 Backgrounds
In the Netherlands, workers having got problems with their health often consult their family doctor or a medical specialist. Those physicians mostly have not so much knowledge about or attention for the role of work with respect to the health problems: be it in a causal way – work as (additional) cause for the (increasing) complaints – be it in a conditional way – work as an external circumstance to be adjusted, in order to enable people to continue their work or to return to work (partly or completely) with the given complaints or impairments.
A consequence of this lack of knowledge about the role of work in health care is also observed in many therapeutic strategies. Treating physicians seldom take into account the nature of their patients' work in prescribing drugs, physical therapy, chemotherapy and so on. However, these therapies may interfere with their patients' recovery and their ability for work. The so-called blind spot is not only present at the diagnostic level (in ignoring the work as a causal factor for disease) but also at the therapeutic one (in ignoring the consequences of treatment for work).
Moreover, curative physicians realise insufficiently that returning to work that has been adjusted appropriately may promote and accelerate the process of medical recovery. As a result, they rarely contact colleagues who do have this knowledge: the occupational physicians. In the opinion of the latter, curative physicians should redefine their objectives in examining and treating patients: not only medical recovery, but also return to their normal daily and working activities have to be the aims of treating patients. A therapy that will counteract working abilities and return to work is to be

avoided as much as possible, and to be started only after a careful weighting of pros and contras.

2.2 First problem definition

For this reason, treating physicians, but especially their patients, are at unnecessary risk of incomplete medical histories; improper treatment advices ('Take your rest for the time being!' - without arranging a next consult); referrals to health care provisions without expertise in occupational medicine, but with long waiting times; omitting referrals where these are necessary; giving advices contradictory to those of the occupational physician, without attuning with the latter; judgements without proper knowledge of the working conditions and the possibilities for adjustment ('With that knee of yours you will never be able to work again!') – while it is known that the judgements and advices from their treating physicians are quite decisive for most workers. Contradictory advices harm the credibility of all physicians involved. But due to the assigned superiority of the treating physicians, this discrepancy is most harmful for the position of the occupational physicians.

In the end there is a risk of medicalisation of complaints with a non-medical cause, like psychological complaints due to disturbed working relationships. In the latter, the treating physician mostly has no insight, but the occupational physician is supposed to have so.

So the central hypotheses for research into the problems defined above are:

(1) There is a 'blind spot for work' in treating physicians.
(2) This 'blind spot' is increasing the risk of inadequate health care, and therefore also the risk of unnecessary, too long sickness absence periods, or even permanent disability for work.

2.3 Is there a 'Blind spot for health care' in occupational physicians?

The above considerations show some partiality, in a sense that only the treating physicians seem to be "accused". The impression might arise as if they are ignoring the working situation intentionally. Of course this is not our intention. The 'blind spot' may well be explained from a historical point of view, and some mechanisms may be assigned that are maintaining it at present (e.g. basic medical training, continuing medical education, insurance systems, money streams, obstacles for information exchange).

The question arises if there is some analogy of this 'blind spot' at the occupational medical side. For example: an attitude in occupational physicians of keeping themselves aloof from the quality and effectiveness of the diagnostic and therapeutic strategies chosen by the treating physicians. And of avoiding discussions about these issues. Are they aware enough of the professional guidelines for general practitioners and medical specialists, so that they are able to discuss diagnostic and therapeutic issues with them upon a basis of equality? Are they aware of the danger of contradictory advices? These considerations should also be a point of attention for the international inventory and assessment of the problem defined.

2.4 'Blind spot for work in health care': a Dutch problem?

The current opinion in the Netherlands is this 'blind spot' to be a typically Dutch problem because of our paradigm called Separation of Treatment and Control, unique in the world, existing for more than one hundred years, meaning shortly that Dutch treating physicians do not certify sickness absence and Dutch occupational physicians do not treat. By consequence, the treating physicians kept more and more aloof from the relation between work and health.

However, in recent international conferences about occupational health and safety many foreign key persons recognised very well this ‘blind spot for work in health care’ and the insufficient communication with treating physicians in their own countries as a serious problem too. In spite of some attempts to improve the situation in their own countries, they considered this to be a serious, possibly universal problem that has not yet been described even in the international scientific literature. They were very interested in the way these problems were faced in the Netherlands, encouraged us to take some action and promised to co-operate by e-mail communication or otherwise to the best of their abilities .
If the ‘blind spot for work’ in health care turns out to be much more generally present on the international level than we supposed at first, this assessment may lead to a fruitful two-way traffic. What may the Dutch learn from other countries, and what may other countries learn from the Netherlands? The first approach may help us in solving our problem, so this is the principal objective of this project (also because of its funding by the Dutch Ministry of Social Affairs). The second approach however, is not unimportant at all: with the Dutch initiatives from recent years to eliminate this blind spot and to realise better co-operation between treating and occupational physicians, we might have created something positive in a domain where the Netherlands are already known for years to be "The sick man of Europe" on account of the high sickness absence and especially the high disability figures – denoted internationally as *Dutch Disease ….*

2.5 Project objectives

The above considerations allow to define the objectives of this project.

From a national point of view:
Improvement of the awareness of Dutch treating physicians (in curative health care) for the relation between health and work, by collecting, studying and – as far as possible – applying of information, practices and experiences in this field from abroad.

From an international point of view:
Improvement of the awareness of treating physicians (in curative health care) for the relation between health and work, by collecting and studying information, practices and experiences in this field from representative countries with different health care systems; making the results accessible; promoting exchange of experiences and good practices.

i From: Action Plan (p5) in letter to Second Chamber, October 1, 2003, about project Social Security and Care

[ii] E.g. Draaisma D, Smulders P (1978), Buijs P (1984), Royal Dutch Organisation of Physicians (KNMG) (1991), Social Economic Council (SER) (1998), Committee on reducing Waiting Lists (’99)

[iii] E.g. from Ministries of Health / Social Affairs, KNMG, Dutch Occupational Physicians (NVAB), National Board of General Practitioners (LHV), Netherlands Institute for General Practice (NHG), Dutch Medical Specialists (OMS), ZonMw, College of Care Insurances (CvZ), Platform Reducing Waiting Lists, Dutch Organisation for Scientific Research (NWO).

[iv] ICOH conference and working visits (Baltimore / Washington / New York, Oct 2002), ICOH conferences about Occupational Health Services Research (Amsterdam, Nov 2002

and Ghent, Nov 2003), triennial ICOH congress (Brasil, Feb 2003), all together with André Weel (Netherlands Occupational Medicine Association).

[v] E.g. ICOH leading men like Jorma Rantanen, Peter Westerholm, Jean-François Caillard and Jerry Jeyaratnam (Singapore, JOEM), Kathreen Fingerhut (WHO), Brigitte Froneberg (ILO), Horst Konkolevsky (European Agency for Safety and Health at Work), Jacky Agnew (John Hopkins, USA), Pete Abeytunga (CCOHS, Canada), Paulo Meirelles (ACADAMT, Brasil) and many others.

2 Vragenlijsten voor de e-mail werkgroep, voorjaar 2004

First questionnaire from the project "Blind Spot for Work in Health Care"
Questionnaire 1
14 February 2004

Do you recognise the problem described in the position paper?

Do treating and occupational physicians in your country contact each other about individual clients?

Do you have personal experiences with this phenomenon? Could you indicate their nature?

Could you give a brief description of the problem in your country?

Are there waiting list problems for employees looking for medical care in your country? If yes, what solutions have been tried?

Does your country have a separate insurance system for occupational diseases and accidents?

Does a distinction in professional status between occupational and treating physicians exist in your country?

Are you aware of scientific articles describing the problem?

Questions regarding the project "Blind Spot for Work in Health Care"
Questionnaire 2
8 June 2004

1. Does the position paper provide an appropriate basis for the project?

2. Are you missing arguments or facts in the paper?

3. What priorities do you observe for research regarding the blind spot problem?

4. Do you know literature, current or planned research on this issue?

5. Which Ministries in your country are responsible for clinical and for occupational health care?

Last but not least, a core question of great importance for the continuation of this project next year. We appreciate your answer very much!

6. In your country, is any attention paid to this problem in daily practice, or in medical education programmes? Are you aware of good practices / solutions of this problem?

Thank you for your cooperation!

3 Resultaten vragenlijstonderzoek e-mail werkgroep

Questions regarding the project "Blind Spot for Work in Health Care"

Overview of received answers, August 2004

Answers received from:

Edith Clarke (**EC**), Ghana
Ian Eddington (**IE**), Australia
Giuliano Franco (**GF**), Italy
Alastair Leckie (**ALe**), UK
Arve Lie (**Ali**), Norway
Pirjo Manninen (**PM**), Finland
Raphael Masschelein (**RM**), Belgium
John Meyer (**JM**), USA
Giso Schmeisser (**GS**), Germany
Ferdie Smith (**FS**), South Africa
Lilia Fatkhutdinova (**LF**), the Russian Federation
Gregory Wagner (**GW**), USA
Robert Castellan (**RC**), USA
Bernadine Kuchinski (**BK**), USA
Jean-François Gehanno (**JFG**), France
Ewan MacDonald (**EM**), UK
René Mendes (**ReM**), Brazil
Ivan Ivanov (**II**), Bulgaria, WHO
Boguslaw Baranski (**BB**), Poland
Reinhard Jäger (**RJ**), Austria
Abdeljalil El Kholti (**AK**), Moroc

1. Does the position paper provide an appropriate basis for the project?

EC: it does.

IE: yes: the definition of blind spot is clear and unambiguous and the hypotheses concerning it are stated.

GF: yes.

ALe: in my opinion, yes.

ALi: yes. I find the questions that you raise highly relevant. The discussion has been around in my country for some time!

PM: yes.

RM: The basic statement of the blind spot for work in health care is true for most of the Western and industrialized countries, so this is certainly not a Dutch problem .

The consequences are clear:

1. the risk for a non-optimal medical diagnosis and treatment by the curative medical doctor (by neglecting some important aspects in the diagnosis and treatment)
2. A non-optimal handling of the social and economical aspects of the disease in the framework of social security (work disability compensation, rehabilitation, return to work).

JM: Yes- I believe that this is a common theme throughout most developed countries in the lack of attention that is paid to occupational health by practitioners.

GS: yes.

FS: Yes, the position paper provides an appropriate basis for the project.

LF: Yes, it does.

GW: yes.

RC: yes.

JFG: Yes, although some quantitative data concerning the extend of the problem in the Netherlands, if available, could deserve more emphasis.

EM: The position paper summarises the issues very well and is an appropriate basis for this project.

ReM: Yes. As a preliminary introduction to the issue, it is OK. However, for a more comprehensive understanding of the determinants of this picture, not only in The Netherlands, but also in most countries, there is a need for going deeper in the discussion of the determinants and the background for this phenomenon.

II: The problem is very interesting, and I have the feeling that it is not only about Netherlands. The issue is that clinical medicine looks at the human body in isolation from the human environment. These are the consequences of the biomedical model of medicine which is being reinforced by the advancement of medical technology and pharmaceutical. Public health is another approach, which looks at the linkages between health and human environment at population level. What you are focusing at in this project is the intersection between clinical medicine and public health. You don't address the reasons for the phenomena that you observe/suspect. There might be several reasons why clinical physicians ignore the occupational aspects of their patients. The first reason could be the above mentioned biomedical model which frames the paradigm and the relationships in the medical society and patient-doctor relationship. The second reason could be that clinical physician are not trained in occupational health. A third reason would be that occupational diseases are contested and represent challenge of established power structures; therefore physicians (who are usually upper middle class) do not want to enter in conflict situations.

Finally, I think that the involvement of sociologists, particularly sociologist of health and illness (medical sociologists) in the project would help to frame the questions and to design the appropriate research instruments.

BB: It is my belief that you have identified an issue in management of health determinants of those employed or those at work which is really "a blind spot". However, I doubt unfortunately whether direct objectives you have posed in your study are feasible.
You assume in both objectives that there is considerable experience in other countries on contribution of treating physicians to maintenance of work ability, on considering by them the working conditions and organization while diagnosing or deciding on sick leave. With exception of Finland I doubt whether such experience exist already available in a form expected by you. .

Position paper identifies problem quite well, however conclusions were reached to earlier before other countries representatives could provide their views. Nevertheless it is a good initiative, should not be lost. It is true that sick leave certificates in Poland are given to sick employee by treating physician but I will not say that while doing so or while diagnosing the they (Polish general practitioners) are very different from their Dutch colleagues.

RJ: Die Problemlage ist hier sehr ähnlich wie du sie in deinem Positionspapier schilderst. Ich sehe dafür im wesentlichen zwei Ursachen:

1. Die Arbeitsmedizin ist in Österreich nicht wirklich in das Gesundheitssystem integriert, sie existiert eher neben der kurativen Medizin mit nur wenigen Kontakten dorthin und ist als eigene Fachrichtung noch wenig etabliert. Der Facharzt für Arbeitsmedizin wurde nur wegen der Harmonisierung mit EU-Recht eingeführt, und wir haben viel zu wenig Ausbildungsstellen für Fachärzte.
2. In der universitären Ausbildung zum Allgemeinmediziner hat es bisher überhaupt keine verpflichtenden Lehrveranstaltungen oder gar Prüfungen in Arbeitsmedizin gegeben, diese wurden erst mit dem neuen Curriculum letztes Wintersemester eingeführt. Es wird also noch eine Medizinergeneration lang dauern, bis Allgemeinmediziner und Ärzte anderer Fachrichtung zumindest eine Basisausbildung in Arbeitsmedizin erhalten haben und damit den möglichen Nutzen unseres Faches für die Behandlung und vor allem die Rehabilitation einschätzen können. Postpromotionelle Weiterbildungsveranstaltungen in Arbeitsmedizin für Allgemeinmediziner sind bisher mangels Interesse nicht zustande gekommen.

AK: I agree with the position paper and I think it's a relevant basis for the project.

2a. Does the paper contain statements you do not agree with?

IE: no, the paper is carefully and diplomatically written. There may be some definitional problems with the psychology illness interface. In Australia psychosomatic disorder is defined as an illness. This may well be the case in the Netherlands and the words at the end of Section 2.2 (the second last sentence) may not suggest otherwise for the Netherlands as well. However there may be some definitional semantic differences here needing some definitional clarification for the purposes of the study.

ALe: I know that this is not uniquely a Dutch problem or a Dutch disease.

PM: no.

2b. Are you missing arguments or facts in the paper?

EC: --

IE: no. The paper cogently explains the intention. In 2.3 I would add time as a major factor. I guess money is time and this covers most of the time issue. However there are a number of professionals who have been financially successful to such an extent that they no longer feel the need to hurry through consultations etc. However these persons may well still be prevented from widening their horizons in the manner required (by informing themselves by first hand visits etc of working conditions and so on) simply because they are already still very busy.

GF: no.

ALe: nothing I have noticed.

ALi: no!

PM: no.

RM: The problem is not limited to a communication problem between the treating physician and the OHP. There are important structural, organizational and socio-cultural reasons that can explain the basic problem and that should be taken in consideration for the further project:

1. The division between curative and preventive medicine (making communication more difficult)
2. The complexity of organized work in our modern society: it is quite impossible to train each curative doctor in all possible work-related health and safety risks of their patients-workers. The need for further specialization in medicine has an increasing focusing and narrowness as a consequence
3. The rather conflicting position on the governmental level between the "health based approach" and the "labor based approach" of work-related health problems and occupational health. In the latter model the OH Phys. becomes an isolated medical doctor working in a "non-medical environment"
4. The individual worker himself is not always positive in a close collaboration between OH Phys. and curative doctors because he fears a conflict between his right of work and his right of health
5. There is a basic problem of basic medical training programs for medical doctors: in most countries there is not enough attention for the "work factor", both as a risk factor and as a "effect factor".

JM: More complicated in the United States: there is a separate pathway and payer for care of people injured at work. If an individual is injured at work, he or she has to apply for workers compensation, which pays for the medical care of the injury and for lost wages during the time that he or she is out of work. Entirely separate from this is the private health insurance that pays for all other health-care (non-work-related illnesses and injuries, for example high blood pressure, heart disease, etc.). There is no national health care system in the US for working-age people outside of the indigent or severely disabled. Therefore, whether the occupational injury gets paid for, and who pays for it, is dependent on whether it occurred at work, or outside of work. The injured worker must file a claim against the employer to obtain these benefits- they are

not provided automatically or through an assumption that health care is guaranteed for the injury by a mechanism such as a national health service.

Because these workers' compensation systems are prone to adversarial proceedings and litigation, there is considerably less reporting of occupational disease in the US. Primary care physicians are reluctant to file a claim on behalf of an injured worker for fear of involvement with the legal system or because they do not know the specific procedures to do so. Lack of time to complete paperwork is also cited as a problem. Injured workers fear retaliation by the employer, although such cases are at least ostensibly prohibited. There is an incentive on the employer's part to contest many claims of occupational injury, because they are responsible for paying the costs of this injury either directly or indirectly. There are therefore substantial barriers to the filing of a workers' compensation claim, and barriers to the physician's willingness to represent an injury/illness as work-related.

So on the whole, this is much more confusing than what goes on in Europe. Part of the problem is that there is a separate source of payment for medical care for injured workers (workers' compensation) apart from the usual health care insurance. In addition, there is considerable evidence of cost-shifting now that millions of workers have no regular health care insurance or benefits – since companies are mandated by law to carry coverage for workers compensation but are not mandated to provide regular insurance, a worker can attempt to get care for a back injury, for example, paid for by indicating that it occurred at work.

GS: no.

FS: Considering the position and the legislation existing in the Netherlands as well as in most other countries in Europe, I think that it covers all the important arguments. The position in most developing countries however, is quite different. The most important being that most workers are not covered by an OH service.

LF: Not at the moment.

GW: Additional information about the nature of medical practice and funding in the Netherlands might be useful to the international audience. Also, general information about social benefits programs as they relate to work, health, and work-related disease and injury would be useful.

RC: no.

JFG: A comparison of the differences in the organisations of occupational health systems could be useful since it seems to be one of the factors, but not the only one : we do not apply the Separation of Treatment and control paradigm in France, nevertheless we also face this blind spot problem.

EM: I think that you are assuming that the situation in the Netherlands is unique. The reality is that in the UK the situation is very similar but we do not have the same level of coverage of the workforce by occupational physicians in the UK (34% in an EU report) and what services are provided can be very variable. Occupational physicians by law, can treat workers, but generally do not, because of the formal relationship of every citizen with the system of primary care. If the OP wishes to intervene in treatment he/she would have to get the agreement of the primary care physician (the "Gen-

eral Practitioner" – GP) as a matter of professional courtesy. A further impediment is that the OP may only be contracted to fulfil a limited role. Enterprises have no legal obligation to provide occupational medical services and many do not. As a result many occupational physicians become deskilled in therapeutic medicine.
The blind spot as described is exactly the same in the UK.
A missing fact in your paper is that in the objectives and targets set by politicians for the health care systems rarely if ever, refer to the working age population. There is a political blind spot too. I have had meetings with two senior politicians in the past two weeks and both acknowledged this. The ambulant worker who is off work, is no ones priority in the state provided health care system. In the UK the costs of long term incapacity benefit (people off sick for more than 6 months and unemployed) are now over £90, 000 million pounds per annum (that's right 90 Billion). This at a time of declining populations. So I would suggest that these social costs are highlighted, and they must be comparable elsewhere. There is good evidence here that a significant number of these people could be rehabilitated back into the labour market .
I am involved in a major RCT of rehabilitation interventions for individuals in work, but off sick between 6 weeks and 6 months and considered to be at risk of job loss. This is a 17 million pound project funded by government, so they are getting worried about it.

ReM: From an international perspective, I believe that both the historical background and the current "health care model" must be analysed, country by country. There are very unequal. However, I think there is a common or similar root or basis for all countries, and some specificities that may aggravate them. The Dutch case is an example of a particular model. Also, I do not think there is necessary to go so in depth in the "diagnosis" step; instead, it is most important and urgent to invest in "solutions" strategies and experiences.

II: The argument that the blind spot is causing disease and disability is very powerful. However, I think it would be more convincing if this argument is supported by some facts.

BB: In what situation or for what purpose a general knowledge on work-related or work-aggravated diseases would be useful for treating or diagnosing physicians?

Let assume they know that this case of hypertension or gastric ulcer is related to work or stress at work. But, how treating physician can alter this etiological factor? He/she would have to discuss this with occupational physicians, but they both are not paid to meet and consider such issue. . It is not in their tasks and post description. Even occupational physician is more prone to assess a link between disease or its symptoms and work, but only few occupational physicians are capable to work so close with the management to have impact on work organization or working conditions. Awareness and knowledge may be insufficient to alter behaviour of those physicians. I have heard from Polish Social Insurance Institution (it pays for sickness absence, but not for health care of sick employee) that treating physician do not pay sufficient attention to facilitate return of sick person to work. Why? The return to work is not a criterion for evaluation of general practitioner work.

So what seems to me to be missing is a description of the project to search relation between occupational physician and treating physician to act as team helping each other to attain a final goal of each of them. It could be that this relationship could be studied on selected diseases only e.g hypertension, ischemic hearts disease or any disease

which dominates sickness absenteeism. I am not able now to discuss a design of such study, since we do not know whether he initiators will be interested.

RJ: Es handelt sich also sicher nicht um ein typisch holländisches Problem, allerdings spielt meiner Einschätzung nach die strikte gesetzliche Trennung bestimmter ärztlicher Tätigkeiten eine Rolle. Der im Positionspapier genannten Trennung von Behandlung und Kontrolle in den Niederlanden entspricht in Österreich die Trennung von präventiver Arbeitsmedizin und kurativer Medizin, und ich würde es für interessant halten, im Rahmen des Projektes auch auf die Erfahrungen in Finnland zurückzugreifen (oder auf die aus der ehemaligen DDR), wo Betriebsärzte auch Teil der kurativen Primärversorgung waren bzw. sind, und wie sich diese Organisationsform auf die Kooperation zwischen den verschiedenen Fachrichtungen auswirkt.

AK: No.

3. What priorities do you observe for research regarding the blind spot problem?

EC:
The seeking of answers to research questions such as :

a) What are the perceptions of stakeholders to the 'Blind spot' issue, i.e. family physicians, occupational physicians, other physicians & health care workers, the worker patient etc with respect to issues such as;
    1. Does there really exist a problem / gaps in patient management;
    2. If so, what is the nature of the problem /gaps?
b) Possible solutions from various stakeholders;
c) Period of intervention where proposed solutions could be tried out;
d) Monitoring phase- To assess extent of application of the interventions;
e) Evaluation of effectiveness of proposed solutions in minimizing the blind spot.

IE: --

GF: --

ALe: Is it a problem elsewhere? Literature search – not just in the Netherlands. Follow the project plan.

ALi: ?

PM: --

RM: Identification of the gaps in knowledge and in practice: how are the curative medical doctors trained to deal with the "work factor", not only in the basic medical training but also during their further medical specialization. There should be given more attention to the development of more appropriate instruments (questionnaires, checklists) to allow a quick survey of the relevant aspects in the work status of the patient by the curative doctor (look at the actual clinical medical files and try to find relevant work information). Further attention should be given to develop more efficient ways of communication between the curative doctors and the OH Phys.(taking in account the complex rulings about medical data).

JM: A possibly useful approach would be to compare occupational health care by primary physicians in the US, where barriers to recognition and management of occupa-

tional illness are very different, to those in Europe where payment for treatment of occupational disease is subsumed under other disease treatment. My suspicion is that European doctors may have a 'blind-spot' for recognition and adequate treatment of disease, but in the US there is a willingness not to attempt to recognize it.

GS: Finding ways to bring more attention to the topic.

FS: priorities for research must lie in the field of disability management in the workplace, and finding an appropriate approach to present such programs to management.

LF:
1. Reasons that underlie distinctions of health care systems from the point of view of occupational health care (historical, cultural, financial and so on).
2. Medical education (undergraduate, postgraduate, continuous).

GW: I am uncertain what you mean by this. Clearly, better understanding the barriers to adequate/effective health care experienced by people who work (in order to design effective strategies to overcome them) is an important research need.

RC: At some level, education alone can influence physician behavior. But it seems to me that there are three ways which are more likely to impact their behavior: 1) legal "requirements" (but even legal requirements may not affect physician behavior is there is no effective enforcement of the requirements); 2) ethical "requirements" (but the issue would be not only how to effectively establish a sense among physicians that the ethical practice of medicine requires attention to work concerns, but also how to reinforce this sense so that practice behavior is changed); 3) financial incentives/disincentives (In my opinion, financial aspects will likely to have the most influence on physician behavior in the USA, but the health care system is terribly complex in this country and not entirely intuitive, so it would be a challenge to collect data and then translate findings that would impact on financial aspects of individual physicians or the organizations for which they work.) In sum, I think each of the above three should be considered and addressed, though perhaps most resources should be given to addressing the third.

JFG: The level of undergraduate occupational health teaching in medical schools for future GP or medical specialists and the needs for CME in occupational health of current GP or medical specialists should be assessed, since it probably accounts for part of this blind spot problem. When such physicians see patients with work related diseases, the relation with occupational factors usually not come to light since they are even not aware that such relation could exist.

EM: As above – effectiveness of rehabilitation.
Attitude surveys to prove the hypotheses.
Role and competencies of Occupational physicians
Access to vocational rehabilitation for individuals who attend their GP.
Etc, etc!

ReM:
- **Basic Medical Education**: what <u>all</u> Medical Doctors (among other health professionals) should know about Occupational Medicine? May be it is necessary to invite Bernardino Ramazzini (1633-1714) to teach how to approach workers/patients, as part

of his classes on Internal Medicine (not "Occupational Medicine"...) in the Medical School.

- **Health Information Policy and Management**: health information about workers (individuals) and specific groups must be stored and analysed in an integrated manner, an integrated data bank, etc. and not in fragmented pieces or sub-systems. The classical division between health data generated in Occupational Medicine routines (pre-employment, periodical examinations) and by other health care systems, including Social Security data, must be adjusted and improved towards an unique health data bank. In other words: a policy and a system able to get all relevant information related to health, including occupation and occupational history as a basic piece for clinical and epidemiological thinking...

- **Permanent Education** models and schemes for "on the field" active medical professionals, trying to invite them or to push them closer to the workers´ health issues...

- **Reporting Systems** – In my understanding, this would be a crucial issue and maybe the best strategy to spread occupational health concerns in national health systems. We are working very hard in Brazil in this direction, first by improving and amplifying the concept (and the list) of "work related diseases"; second, by having workers and trade unions informed about this concept (acting as "social control"), and "empowered" by these ideas and information; third, by creating appropriate mechanisms for reporting. Like in the UK, this could be developed by groups of disorders, like occupational dermatoses, work-related lung disorders, work-related musculoskeletal disorders, etc. step by step, involving medical doctors affiliated to different and specific medical specialities.

II:

- describing the situation and its implications;
- studying the reasons for blind spots: questionnaire studies, focused groups, in-depth interviews.

BB: I think development of the studying design and methodology is first priority. Insurance organizations should be "forced" to participate.

RJ: Die wesentliche Priorität für dieses Projekt würde für mich nicht ausschließlich im Bereich von Forschung liegen, da das Problem hinlänglich bekannt und beschrieben ist, sondern im Bereich von Öffentlichkeitsarbeit und Bewusstseinsbildung, sowohl in der Fach- wie auch in der allgemeinen Öffentlichkeit.

AK: The priority is focusing on the position and missions of occupational physicians to avoid a "blind spot for health car "

4. Do you know literature, current or planned research on this issue?

EC: no.

IE: no. However I will be more alert about this now that I am working with you on the issue. I will try to be helpful in finding literature although I feel that we will all go to google search and come up with the same material. There may be some papers in the communications journals which touch on aspects of the blind spot and I could attempt a search of these. Given that your team is the first on the question cogently defined it

may well be that the work will turn out to be pioneering and seminal in some respects. However I note the comment in the paper that the problem has been known in the Netherlands for some time.

GF: no.

ALe: Yes. The Department of Work and Pensions http:// www.dwp.gov.uk (a UK government department responsible for overseeing the state benefits system and now health and safety and occupational health are commissioning research across a wide range of projects. This is due to the large increase of benefits claimed due to incapacity for work over the last 10 years and the aim to reducing these. Sickness certification is being looked at too. The whole issue of vocational rehabilitation is high on the agenda in the UK. General medical practitioners who normally certify absence from work are seen as a barrier to successful rehabilitation.

I could be helpful in finding literature.

ALi: My Institute has a "bank of Ideas for Inclusive working life". They collect research literature and experiences from this area of sick leave, rehabilitation/work ability. At the present they are part of a national program on "Inclusive Working Life" (IWL) with the aim of reducing sickness absence, increasing the actual age of retirement and promoting workers with functional impairments going back to work. (I will talk about this in ICOH / Modena see my abstract attached.)There has been some research on the impact from work on sickness absence deriving from the University in Oslo: Institute of general medicine and public health: mail address: admin@samfunnsmed.uio.no.

PM: I know no other project.
I could check Finnish literature.

RM: In Belgium there is the "REGA " project dealing with the communication between OH Phys. and Insurance MD (K.U. Leuven- IDEWE). There are now small projects on the communication between GP's and OH Phys. A discussion forum is started recently to discuss the collaboration between GP's and OH Phys. (VWVA and WVVH)

JM: --

GS: no.

FS: I do not know of any research on such issues.

LF: No.

GW: no.

RC: This is not my area of expertise. Early in the existence of the US National Institute for Occupational Safety and Health (NIOSH), the Institute produced a guide on the recognition of occupational disease. I think that Susan Sama and Don Milton have published on work-related/occupational asthma studies based on records of managed care organizations—and have some data that address the lack of attention to potential work-relatedness of asthma among adults. Also, Phil Harber has been doing research

on ways to help automate a clinician's assessment of possible work issues in general patient care.

JFG:
Wynn PA et al. Undergraduate occupational health teaching in medical schools—not enough of a good thing? Occupational Medicine 2003;53:347–348.
Wynn PA et al. Teaching of occupational medicine to undergraduates in UK schools of medicine. Medical Education 2002; 36(8):697–701.
Ladou J. The Rise and Fall of Occupational Medicine in the United States. Am J Prev Med 2002;22(4):285–295.
In France, the ministry of social affairs have asked, in late 2003, for research projects concerning occupational health, including research on how occupational risk factors were taken into consideration by GP and hospital specialists. The projects accepted are not known for the moment.

EM: As above UK research project.
Some literature on this theme in UK recently.
I have just completed a follow up study of health care workers and teachers , who have retired from work on the grounds of ill health, and am planning further studies in this area.

ReM: Yes, I know. I will provide you this information as soon as possible.

II: "Illness and the Environment: A Reader in Contested Medicine" edited by Steve Kroll-Smith, Phil Brown, and Valerie J. Gunter, New York University Press, NY

BB: Not now, as I will be for our months on Turkey as OH consultant.

RJ: Ein model of good practice ist mir leider nicht bekannt, ebenso wenig österreichische (oder überhaupt deutschsprachige) Literatur zum Thema. Ich bin aber dabei, eine Literaturrecherche durchzuführen, und werde dich umgehend informieren, wenn sie Ergebnisse bringt.

AK: No.

5a. Which Ministries in your country are responsible for clinical and for occupational health care?

EC:
Clinical Care is by the Ministry of Health
Occupational Health & Safety – by Ministry of Labour (This excludes clinical care)

Though Min of Health has a small occupational health unit trying to bring on board issues of occupational health which could be integrated with primary health care practice. At the specialist level however, there are no specialized occupational health clinics.
IE: each state is different. Departments of Health are invariably implicated in oversight of GP ("treating/curative" in terms of study language) medicine. Ministries of Health or Industrial Relations or Employment and Training share the OH&S side. However as mentioned OH&S physicians in Australia also treat and this leads them to be mindful of regulations from all kinds of Ministries. Whilst Departments of Health are long standing and settled in respect of procedures prescribing treating protocols etc,

the OH&S side often gets kicked from pillar to post when there are cabinet reshuffles. The Australian Medical Association is very powerful in respect of treating physicians and dialogues with the Federal and State Governments.

GF: Ministry of health (mainly), Ministry of Labour (partly).

ALe:
For general / clinical health care:
Scotland Scottish Executive health Department
England and Wales Department for Health

For occupational health care:
Department for Work and Pensions. There is no provision of OH by statute; some employers will provide it particularly public sector and large private sector employers. Only ~7% of employees in the UK have access to OH.

ALi: Clinical health care: Ministry of health (but being a part of the hospitals the departments of occupational health also belong to this ministry!)Occupational health services belong to the Ministry of labor.

PM: for both: Ministry of social affairs and health.

RM: Belgium is a typical example of the duality between the "Health based" approach and the "Labour based" approach: Occupational medicine is the only medical discipline located outside the Ministry of health (part of the Ministry for Social Affairs). This different position is reflected in difficulties for collaboration with the curative sector but also in a different climate and thinking (e.g. controlled by the social partners).

JM: --

GS:
A: Ministry of economics and labour affairs
B: Ministry of social and health affairs.

FS: In South Africa Occupational Health Care is regulated by the Occupational Health and Safety Act, 1993, and is administered by the Department of Labor. However Occupational Medicine is deemed to be overseen by the department of Health. The Department of Health controls the National Health Laboratories consisting of the former Departments of Pathology of the University Hospitals as well as the National Institute for Occupational Health (NIOH), situated in Johannesburg. The NIOH however do keep up a working relationship with the Departments of Community Health at the Medical Faculties where Occupational Medicine is being taught.

LF: The Ministry of Health, since the beginning of 2004 - the Ministry of Health and Social Development.
GW: The US health care system is fragmented at best. There is no single ministry responsible for either clinical or occupational health services, as the fundamental care model is a non-governmental one. Each of the states has a program intended to pay for care needed by workers who suffer disease or injury from work and also to compensate them for lost wages.

The US National Institute for Occupational Safety and Health (NIOSH) (part of the Department of Health and Human Services—equivalent to a ministry of Health) provides small training grants in support of programs training occupational physicians and others.

RC: Again, clinical care in the USA is organizationally highly complex, making it difficult to answer this question. (NIOSH has no responsibility for clinical care, per se, though it has responsibilities for training of health care professionals. As I see it, most NIOSH training resources have gone towards training occupational health professionals, and not towards improving the occupational health training of non-occupational health professionals.)

JFG: In France, all medical specialities, but occupational health, are under the responsibility of the ministry of health and social affairs. Occupational health is under the responsibility of the ministry of labour. Departments of occupational medicine in university hospitals are under the responsibility of the hospital, and, therefore, of the ministry of health and social affairs.

EM: Department of Health- the NHS
Department of Work and Pensions(DWP) – Occupational health and safety

ReM: Brazil: The Ministry of Health, via "Sistema Único de Saúde" (SUS), is in the lead position, directly or indirectly, by regulating public and the private practice, and by providing Health care to people who are not covered by private schemes. Also, the Ministry of Labour is active in regulating and inspecting in plant Occupational Health Services (similar to ILO Convention 171 or Recommendation 161). Currently, there is a strong trend of moving from Labour to Health, and the Ministry of Health is very active. The National Institute of Social Security is responsible for the Workers´ Compensation System (unique and State-managed).

II: In Bulgaria, ministry of health is responsible for both. As far as I am aware, this is the case in most of the former socialist countries.

BB: Ministry of Health.

RJ: Die in Österreich zuständigen Ministerien sind:

Für das Gesundheitssystem im allgemeinen:
Das Ministerium für Gesundheit und Frauen (http://www.bmgf.gv.at/cms/site/)
Für den Arbeitnehmerschutz:
Das Ministerium für Wirtschaft und Arbeit
(http://www.bmwa.gv.at/BMWA/default.htm)

AK: The ministry of health.

5b. In your opinion, what role is played by the health care system in your country, regarding the blind spot problem?

IE: the comment for 6 below is relevant here. Officially, to my knowledge, there is no established procedure to deal with this issue. However as noted earlier I am not on the inside and there may be informal procedures and protocols in place. Neither, unfortunately, I have not succeeded in yet convincing an Australian medico to join the team.

ALe: Certification lies with GPs who have no knowledge of the workplace, are in a situation with their patient where for them to be seen to be policing a system potentially does not keep the traditional clinical doctor/patient relationship intact.

PM: See question 6. All occupational health physicians have health care in their work as you may know. The problem is more in cooperation and maybe raises a need of education from OH to other specialities.

6. In your country, is any attention paid to this problem in daily practice, or in medical education programmes? Are you aware of good practices / solutions of this problem?

EC: Currently in Ghana, there is some awareness of the need for strengthening the occupational health component of training. Consequently, medical curriculum includes a few lectures and School of Public Health has a module on OSH.

Within the Min of Health, curricula and modules are under development to integrate occupational health with in-service training.

IE: not to my knowledge. However I am not a physician and therefore cannot comment on the day to day informal practices that might go on. Also in Australia the OH&S physicians are treating physicians who generally have graduated MBBS within GP schools. However this does not mean to say that there is no blind spot. The GP occupational physicians may well face the same problem of blind spot when it comes to relationships with their colleagues. Recently (over the last 2 or 3 years) there have been courses provided for doctors whose treatment is crucial in medical conditions under the ageas of compensation and rehabilitation law. These courses aimed at having common terns and understandings so that lawyers, administrators and treating physicians can all talk in the same terms. This may be a surrogate acknowledgement of something like blind spot induced education.

GF: There is room for improvement.
Generalists and other physicians are obliged to inform competent authorities if they suspect a link between an occupational risk factor and a disease.
Not aware, but the solution is only one: education of doctors (starting from the School of Medicine) to make them aware of the possibility that a disease might be caused by working environments. Are we powerful enough to do this?

ALe: no. The DWP has some we based resource. Little teaching about occupational medicine occurs at university. Seen as a postgraduate subject with little, if any, general teaching. I offered to teach the local trainees in general practice about work and sickness certification for free and was not taken up on the offer.

ALi: As a part of the IWL process all Norwegian primary health care physicians will go through an educational program on the IWL campaign on how to contribute to the assessment of work ability (which every Norwegian physician should contribute to when filling out the sickness absence certificate - but their contribution today is regarded being inadequate and should be improved).The occupational physicians are quite concerned about how to cooperate better with the GPs, but they are quite difficult to get in contact with as they have many patients and don`t have the time! There is an urgent claim from the government that this cooperation should be improved, but the willingness to pay for it is somehow missing!!

PM: Education to occupational health physicians have been arranged in the context of assessing work ability or disability. But I see the problem to be more among other colleagues like surgeons who write long sick-leaves without taking into account job. Other point is incapability to assess occupational exposure as a risk factor in diseases as well as taking it into consideration in care and assessment of sick leave.

RM: There is certainly some evolution in the attention for this problem, coming from scientific associations. The GP's have some more attention for preventive medicine and hence also for prevention in the working place. Despite the very important changes in the medical curriculum, there is still too little attention for the occupational health aspects. We are now trying to promote a more integrative way to increase the attention for work-related aspects by working together with clinicians for presenting problem oriented clinical lessons, which include both OH and Insurance medicine aspects. A new field should be collaboration on the postgraduate specialization level and on the CME level for the different clinical specialists.

JM: The National Institute for Environmental Health Sciences (NIEHS) several years ago attempted to promote training in occupational health in schools of medicine through the use of a five-year grant program for specific curriculum development. Approximately 10-12 medical schools used this funding to enhance the curriculum in medical schools with varying degrees of success. In our own institution (the University of Connecticut) we have achieved relative success, requiring teaching of first-year medical students through a site visit to an industrial setting and small-seminar discussion of the effect on health. Junior doctors in training in primary care specialities (internal medicine) are also required to rotate through the teaching clinics of the occupational medicine division, which has proven very successful in recruitment of candidates for training in occupational medicine. Other centres have had limited success with the programs under this grant.
Courses that were established as a result of these grants are noted at http://www.aoec.org/CEEM/CEEM_courses.html

In addition, a number of teaching tools, principally videotapes and related materials demonstrating how to take an occupational history were produced.

Relevant US literature on this includes:

Storey E, Thal S, Johnson C, Grey M, Madray H, Hodgson M, Pfeiffer C. Reinforcement of occupational history taking: a success story. Teach Learn Med. 2001 Summer;13(3):176-82.

Goldman RH, Rosenwasser S, Armstrong E. Incorporating an environmental/ occupational medicine theme into the medical school curriculum. J Occup Environ Med. 1999 Jan;41(1):47-52.

Unfortunately, little evaluative material is available on these efforts. In addition, once the grant cycle had expired, there was little continuation of funding sources for these efforts and many of them have dried up.

The best solution in many cases is to integrate occupational medicine's emphasis on population-based health (epidemiology, etc) with the growing demand to teach these skills as part of an evidence-based medicine course, which is now mandated in most curricula. In this way an awareness of health at work can be made as a teaching tool in classes that teach epidemiology to medical students as part of EBM.

GS: Recently two working groups were founded:
A: Deutsches Netzwerk Betriebliche Gesundheitsfoerderung; www.dnbgf.org
B: Deutsches Forum Praevention und Gesundheitsfoerderung;
www.bfge.de/Themen/deutschesforum.html

In medical education the topic is becoming of greater importance since the new „Approbationsordnung" is coming in action.

FS: In South Africa, Occupational Medicine is being practiced at two levels. Most of the work is being done by General practitioners who have done a two year part time post graduate diploma in OH. Most of them do therefore have a general, mostly family medicine type of practice. These people therefore have a foot in both worlds. Since 1997 we also have a register for Specialists in Occupational Medicine, which consists of a four year appointment as registrar in Community Health followed by a college type of examination , with a short dissertation. After this the candidate can register as a specialist in Community Health. This must be followed by another two years as a full time practitioner in an Occupational Health post, under supervision of an already qualified OH "sub-specialist" after which the specialist may register as a "sub-specialist" in Occ Med. There are at the moment only approximately 14 names on the specialist register.
With the help of some colleagues who have done other relevant courses, especially in the USA, we have compiled a course in "Evaluation of Permanent Impairment" based on the AMA guidelines, as well as a course on "Disability Management in the Workplace". We have only presented these courses for the first time last year and did have a good response. The course was also attended by clinicians from other disciplines, i.e. Orthopedic surgeons, a neuro-surgeon and an Internist.
I do think that a team approach to the management of disability in the workplace, involving Personnel management (HR), the insurance industry (including medical insurance), Finance management, OH nursing, Occupational Therapy, Occupational Medical Practitioner and, very important, the treating doctor, is an approach that we would like to establish in all organizations. This could provide a basis for communication between OH and their colleagues in clinical practice.

LF:
1. It should be mentioned that the system of occupational health care includes two main parts. First, there is a network of departments of occupational hygiene, which are parts of the centers for sanitary and epidemiological surveillance; these departments

are mainly responsible for risk assessment. Then, there are clinics of occupational diseases, which deal with diagnosis, treatment, rehabilitation and disability assessment.
Consequently, there are two specialties in the field of occupational health with considerable differences in tasks fulfilled: 1) medical hygienists affiliated at the centres for sanitary and epidemiological surveillance, and 2) occupational physicians in clinics of occupational diseases.
The medical hygienists do not perform medical examinations. But they play the main role in the organisation of workers' health surveillance. They have to perform risk assessment, including measurements of work environment factors. Making a detailed hygienic report in case of necessity to prove the occupational origin of disease is their common duty. Their tasks also include the consultations on risk factors and elaboration of preventive programmes. Besides pure medical tasks, hygienists have had the inspection functions (at the moment it has been changing). They can fine employers or workers in case of breaking the law. Besides, the big regional centres collect the data on occupational diseases and send them to the national register.
The Ministry of Heath contained in its structure the State Committee for sanitary and epidemiological surveillance, which was responsible for a network of the centers for sanitary and epidemiological surveillance (the new Ministry has in its structure the Federal Service in the field of sanitary and epidemiological well-being and protection of the rights of the consumer; they are planning to substitute the centers for sanitary and epidemiological surveillance by the State Inspection and establishments engaged in risk identification, assessment and management, there are still a lot of uncertainty about structure and functions of these new institutions). So the main Russian problem is the discrepancy between risk assessment and diagnosis-treatment.
Patients with occupational diseases (from the approved List of occupational diseases) can be examined and get treatment at the same hospital or clinical department. Each employer must organize workers' medical examination each three years on the base of a specialized center of occupational diseases. Annual examinations can be performed on the base of any clinic, which has the appropriate license. The physicians of such clinics have to pass special education in the field of occupational health regularly (at least each five years). Occupational hygienists from the departments of occupational hygiene can control physicians' skills and competencies. Thus, physicians who perform periodic medical examinations (even without full specialization in occupational medicine) have quite good knowledge about possible relations between patient's symptoms and his (her) work.
Bottlenecks of this system are the following: 1) only workers exposed to harmful work factors should pass periodic medical examinations; 2) the system works well (taking into account work conditions at each step: diagnosis – treatment – rehabilitation) mainly concerning patients with occupational diseases; 3) a person who comes to an out-patient-clinic or hospital could be often treated without the account of work factors ("a blind spot", of cause).
Nevertheless, there are some ways to struggle with problems mentioned above: 1) university and continuous medical education; 2) expansion of a network of hospitals engaged in periodic medical surveys, and as a consequence scope by training of the increasing number of the physicians; 3) a network of the centers of medical prophylactic at regional representations of the Ministry of Health which are engaged in methodical work, including introduction including introduction of modern methods of individual prophylaxis.

2. Medical education programmes
In Russian medical universities there are several faculties (medical faculty, paediatric Faculty, medico-prophylactic faculty, faculty of dentistry, pharmaceutical faculty). Undergraduate medical training takes 6 years
The programmes of all faculties include a course on general hygiene in 5th and 6th terms (about 100-150 hours in total). The programme of medico-prophylactic faculty includes additionally extensive courses on occupational hygiene, medical ecology, youth medicine, social medicine, food hygiene spread over last four terms (9-12th terms). Each course consists of lectures, seminars, practical sessions, and includes 5-day summer practice and 3-week practical training on the base of a centre for sanitary and epidemiological surveillance as well (about 200-300 hours in total).
The separate course on occupational medicine is obligatory for students of medical, paediatric and medico-prophylactic faculties. The latter have the biggest amount of teaching hours – 95 in total. Universities usually have departments or sections of occupational medicine with specialized clinics.

University departments and centres of occupational disease are responsible for courses given to physicians who take part in periodic medical survey.

GW: Prior to joining NIOSH, I taught in a medical school. Overcoming this blind spot was the major focus of my own professional work. I expect that each medical school in the US, to a greater or lesser (usually lesser!) extent makes an effort to encourage doctors in training to have an integrated view of patients and their needs in order to optimise approaches to diagnosis and therapy.

There is an organization in the US—The Association of Occupational and Environmental Clinics—that works on this issue to some extent. The Association includes employer-independent clinics for diagnosis and treatment of work-related disease and injury. The Clinics are often associated with training centers and provide a variety of education and training in addition to care.

The US situation is quite complex and varied, but one root issue in the communication between primary care physicians and occupational physicians is one of trust. Many occupational physicians are directly or indirectly employed by the same employer who employs the injured or ill worker. Because of the social insurance scheme in the US (in particular our workers' compensation programs), the employer is motivated to minimize time off work and, minimize benefits paid, and increase the probability that a disease or injury is attributed to non-work factors. The patient and their treating physician may have alternate goals. The occupational physician and the treating may, in reality, share common goals for the health of the ill or injured worker, but there is a complexity in the various relationships as you can imagine.

I would be happy to explore these issues with you in more depth.

RC: Again, I am not the expert in this area. I am aware of the oft-stated concerns (among occupational health experts) of the very limited exposure of medical students to occupational health in their education, of the very limited time (often none at all) that clinicians spend on taking a work-history, etc. This clearly is a problem, but I am not aware of any particular best practices/solutions.

BK: The 25 OM programs that NIOSH supports are approximately equally distributed in their location- in Schools of Public Health or Schools of Medicine. Several programs are joint residencies with Internal Medicine or Family Practice, producing clini-

cians who are eligible for both internal medicine and occupational medicine certifications. Those programs indoctrinate the internal medicine residents in OM to a large degree because of their joint education.

In addition, most of the supported programs, primarily ERCs [*], do some lecturing or course work in occupational medicine in the medical school for students. Clearly, not enough is done across the country to get training to medical students- primarily due to existing heavy curricula.

Another point- several ERCs conduct grand rounds in occupational medicine, which can be attended by physicians in the community. Also- because the ERCs conduct Continuing Education for practicing professionals in the region, many sponsor OM programs in the community or host programs/conferences jointly with other physican groups in the region.

Finally, Phil Harber may be a good contact- .
Philip Harber, M.D., MPH
Chief, Division of Occupational and Environmental Medicine
Department of Family Medicine
Geffen School of Medicine at UCLA
10940 Wilshire Boulevard, #1220
Los Angeles CA 90024
Telephone: 310-794-8144
E-mail: pharber@mednet.ucla.edu

[*] ERCs: Educational Resource Center multidisciplinary programs in occupational health partially funded by NIOSH and located in universities across the country, and in some universities that have single programs in OM (Training grant programs –TPGs) . See both described at http://www.cdc.gov/niosh/oep/training.html#erc

JFG: More and more attention is paid to this problem in France. The first reason is that, due to under recognition of number occupational diseases by physicians, the financial burden is supported by the national social insurance system, which is in high deficit, instead of being supported by employers who, in France, must reimburse the cost of occupational diseases and accidents to the national social insurance system.
The second reason is that physicians are more and more aware that the choice of the treatment can influence the employability and the quality of the return to work.

We are finishing a study concerning undergraduate training in occupational health in French medical schools. In summary, the majority of medical schools teach less than 10 hours and the respondents estimate than it is getting worse every year.
A reform of the medical curriculum have been implemented this year and the place of occupational medicine in it is quite narrow, especially for the final examination.
We try to convince teachers of medical specialities to include in their curricula small questions of occupational medicine, to get students aware of the possible relationship between work conditions and illnesses.

EM: **The Faculty of Medicine has introduced a new subspecialist Diploma**
Of Disability assessment Medicine.
No good solutions yet, but an area of increasing focus.

ReM: Sure. There is a national concern about this issue. We are working very hard with the above mentioned strategies. For example, the Ministry of Health sent free of charge, last year, to about 100,000 medical doctors, a "Manual on Work-Related Diseases" (700 pages, edited by our group in Belo Horizonte City), and now it is investing in training activities in a countrywide program. A National Reporting System for Work-Related Diseases has been introduced in the Health System (not for Workers Compensation purposes...), and also, all health information is going to be integrated in national health data banks. This last strategy will oblige medical doctors to fill some blanks in the official forms, in order to be paid or reimbursed (themselves) and in order to entitle workers to some Social Security benefits. There are other strategies or experiences that may be shared with you, at the due time.

II: In my opinion, the issue is very important and is often discussed. In the discussions the occupational physicians usually blame the clinicians about their ignorance of occupational health, and vice versa. In Bulgaria such debates are usually held between experts in occupational pathology and the other clinical experts.

Maybe, the Finnish model of occupational health services (which provide at the same time general health care) would be worth to look at.

BB: According to my knowledge it is not yet identified problem

RJ: Ein model of good practice ist mir leider nicht bekannt.

AK: Obviously, nobody paid attention to this problem in my country. Our problems are basically different.

4 Resultaten literatuursearch

A. Methode concept mapping

William Trochim (Cornell University New York). An Introduction to Concept Mapping for planning and evaluation. Evaluation and Program Planning 1989; 12: 1-16. (Zie bijlage 4a voor Samenvatting)

Website: www.socialresearchmethods.net

B. NIVEL

D. Somai, F. Schellevis, J.C.M. van der Burg, A. van der Beek
Visie van de huisarts op de samenwerking met bedrijfsartsen anno 2003 nog onveranderd. TSG: Tijdschrift voor Gezondheidswetenschappen : jaargang 83 (2005), nr 6, p. 265-271.

A.N. Baanders
Chronisch zieken over arbocuratieve samenwerking. www.nivel.nl: NIVEL, 2004. 2 p.
Samenvatting:Chronisch zieken: “Overleg tussen huisarts en bedrijfsarts leidt tot betere arbozorg”

T. Somai , A. van der Beek , F.G. Schellevis
Arbocuratieve samenwerking anno 2003: het perspectief van de huisarts. Utrecht: NIVEL, 2004. 35 p.ISBN 9069056550
Samenvatting:Huisarts en bedrijfsarts: weinig samenwerking

C. Ingebracht door E-mail werkgroep

Wynn PA et al. Undergraduate occupational health teaching in medical schools—not enough of a good thing? Occupational Medicine 2003;53:347–348.
Wynn PA et al. Teaching of occupational medicine to undergraduates in UK schools of medicine. Medical Education 2002; 36(8):697–701.
Ladou J. The Rise and Fall of Occupational Medicine in the United States. Am J Prev Med 2002;22(4):285–295.

“Illness and the Environment: A Reader in Contested Medicine” edited by Steve Kroll-Smith, Phil Brown, and Valerie J. Gunter, New York University Press, NY

Storey E, Thal S, Johnson C, Grey M, Madray H, Hodgson M, Pfeiffer C. Reinforcement of occupational history taking: a success story. Teach Learn Med. 2001 Summer;13(3):176-82.

Goldman RH, Rosenwasser S, Armstrong E. Incorporating an environmental/ occupational medicine theme into the medical school curriculum. J Occup Environ Med. 1999 Jan;41(1):47-52.

D. Search Occupational History

1: Occup Med. 2000 Jan-Mar;15(1):213-22, iv.

Cardiovascular evaluation of the worker and workplace: a practical guide for clinicians.

Belkic K, Schnall P, Ugljesic M.

Unlike several other branches of medicine (e.g., pulmonology), primary cardiology has yet to fully develop a discipline of occupational cardiology. The authors outline an approach for including a focused occupational history in the CV work-up and present a graded, risk-stratified algorithm for occupational cardiologic assessment. This work-up can help clinicians make specific recommendations concerning working conditions, as these impact upon the patient's CV status.

2: Am Fam Physician. 1998 Sep 15;58(4):935-44.

Recognizing occupational disease--taking an effective occupational history.

Lax MB, Grant WD, Manetti FA, Klein R.

Central New York Occupational Health Clinical Center, State University of New York Health Science Center, Syracuse, USA.

Occupational exposures contribute to the morbidity and mortality of many diseases. However, occupational diseases continue to be underrecognized even though they are responsible for an estimated 860,000 illnesses and 60,300 deaths each year. Family physicians can play an important role in improving the recognition of occupational disease, preventing progressive illness and disability in their own patients, and contributing to the protection of other workers similarly exposed. This role can be maximized if physicians raise their level of suspicion for workplace disease, develop skills in taking occupational histories and establish routine access to occupational health resources.

3: Prim Care. 1994 Jun;21(2):225-36.

Basic clinical skills in occupational medicine.

Hoffman H, Guidotti TL.

Occupational Health Program, University of Alberta, Faculty of Medicine, Edmonton, Canada.

By incorporating the principles of occupational medicine into their practices, physicians can better help those patients with job-related disorders and can improve the management of patients whose non-work-related conditions have implications for their employment. This article focuses on occupational history, physical examination skills, investigation of work sites, risk assessment, screening and surveillance, fitness-to-work evaluations and disability assessment, administration, prevention, health education and general communication, and ethical issues.

4: Gen Hosp Psychiatry. 1994 Mar;16(2):103-11.

Workplace mental health consultation. A primer of organizational and occupational psychiatry.

Sperry L, Kahn JP, Heidel SH.

Department of Psychiatry and Mental Health Science, Medical College of Wisconsin, Milwaukee.

Though there are only a few hundred psychiatrists who identify themselves as specialists in organizational and occupational issues, the need for psychiatric skills in the workplace has increased dramatically in recent years. Crucial issues include distressed employees, the effects of organizational structure and change, job stress, psychiatric disability, substance abuse, and violence in the workplace. It is important for general psychiatrists to become more conversant in work and workplace-related mental health issues. Use of an occupational history with all patients, and knowledge of organizational structures and function, are just two ways to become more aware of these matters. With business and government increasingly attentive to mental health benefits and systems,
appropriate psychiatric focus on organizational and occupational concerns
becomes ever more important.

5: Med Clin North Am. 1990 Mar;74(2):441-60.

Occupationally related disorders.

Baker DB, Landrigan PJ.

Department of Community Medicine, Mount Sinai School of Medicine, New York, New York.

Occupational disease is responsible each year in the United States for 50,000 to 70,000 deaths and for approximately 350,000 new cases of illness. Occupational diseases affect all organ systems and include pulmonary disease, musculoskeletal injuries, occupational cancer, traumatic injuries, occupationally induced cardiovascular disease, disorders of reproduction, neurotoxic disorders, noise-induced hearing loss, dermatologic conditions, and psychological disorders. Occupational diseases may be very difficult to diagnose.
Pathognomonic signs and symptoms are rare; most occupational diseases are
clinically indistinguishable from disease of other etiologies. Diagnosis is
complicated further by the long latency typical between a toxic occupational exposure and the appearance of illness. Further, there is widespread lack of information on the toxicity of most chemical substances in use in American workplaces, and workers frequently are not informed of the nature or the hazards of the materials with which they work. The occupational history is the principal clinical instrument for the diagnosis of occupational disease. All patients should undergo at least a brief occupational history that inquires about the current job, including both industry and occupation, the longest-held previous jobs, and any toxic occupational exposures to chemicals, fumes, gases, dust,noise, or radiation. Proper diagnosis of occupational disease permits proper
treatment of the affected patient and also provides a basis for recognition of other similarly employed persons who may also be at risk of toxic exposure.
Occupational diseases are highly preventable. Prevention is most efficiently achieved by removing hazardous materials from the workplace and replacing them with less hazardous substances. Other approaches to prevention include ventilation, alteration in work practices, and use of personal protective equipment. Physicians in the United States are for the most part not well trained to recognize occupational illness. At the

same time, there is a great lack of qualified specialists in occupational medicine. The majority of care of patients with occupational disease will therefore continue to be the responsibility of primary care physicians, and these physicians must become more highly attuned to the possibility that their patients may have diseases induced by toxic exposures encountered at work. The development of a heightened sensitivity of primary care providers to occupationally induced disease is an urgent priority.

6: Occup Med. 1986 Jul-Sep;1(3):487-95.

The worker's perspective.

Rudolph L.

The author recommends involvement of workers in every phase of epidemiologic research or clinical surveillance programs, from hypothesis generation and study design through interpretation of results and discussion of recommendations for notification, counseling, and intervention. Clinicians must be aware of the potential work-relatedness of illness and routinely obtain an occupational history.

E. Algemene search

Preventing disability from work-related low-back pain
New evidence gives new hope — if we can just get all the players onside
John Frank MD, MSc; Sandra Sinclair Dip P&OT, MSc; Sheilah Hogg-Johnson PhD; Harry Shannon PhD; Claire Bombardier MD, MSc; Dorcas Beaton BScOT, MSc; Donald Cole MD, MSc
Canadian Medical Association Journal • JUNE 16, 1998; 158 (12) 1625 - 1631

J Occup Environ Med. 2000 Apr;42(4):352-61.
Evidence-based design: the ACOEM Practice Guidelines Dissemination Project.
Harris JS, Glass LS, Ossler C, Low P.

A steering committee and investigators from the American College of Occupational and Environmental Medicine (ACOEM) designed and carried out the ACOEM Practice
Guidelines Dissemination Project to encourage adoption of the ACOEM Occupational Medicine Practice Guidelines. The project also involved research on guideline acceptance as well as potential improvements and additions to the guidelines. To increase guideline adoption and use in improving the appropriateness and consistency of practice and case management, the design was based on existing research on guideline format, education, and adoption efforts. This article summarizes that information and the needs assessment done prior to case-based guidelines training. Other articles in this issue report on guideline adoption and use and the results of the market research on the ACOEM guidelines.

American journal of industrial medicine 37:1±5 (2000)
Introduction
The Diagnosis and Treatment of Occupational Diseases:
Integrating Clinical Practice With Prevention
Robin Herbert, MD, Matt London, MS, Deborah Nagin, MPH and William Beckett, MD, MPH

Bakker RH, Krol B, Gulden JWJ van der, Groothoff JW. Arbocuratieve samenwerking: een vergelijking van de taken en positie van de bedrijfsarts in vier landen. TSG 2005; 83: 257-264.

F. Zeven artikelen uit PSYCINFO

van-den-Hout,-Johanna-H-C; Vlaeyen,-Johan-W-S; Heuts,-Peter-H-T-G; Zijlema,-Johan-H-L; Wijnen,-Joseph-A-G
Secondary prevention of work-related disability in nonspecific low back pain: Does problem-solving therapy help? A randomized clinical trial.
Clinical-Journal-of-Pain. 2003 Mar-Apr; Vol 19(2): 87-96
Given the individual and economic burden of chronic work disability in low back pain patients, there is a need for effective preventive interventions. The aim of the present study was to investigate whether problem-solving therapy had a supplemental value when added to behavioral graded activity, regarding days of sick leave and work status. Employees who were recently on sick leave as a result of nonspecific low back pain were referred to the rehabilitation center by general practitioner, occupational physician, or rehabilitation physician. 45 employees had been randomly assigned to the experimental treatment condition that included behavioral graded activity and problem-solving therapy (GAPS), and 39 employees had been randomly assigned to behavioral graded activity and group education (GAGE). Data were retrieved from occupational health services. Data analyses showed that employees in the GAPS group had significantly fewer days of sick leave in the second half-year after the intervention. Moreover, work status was more favorable for employees in this condition, in that more employees had a 100% return-to-work and fewer patients ended up receiving disability pensions one year after the intervention. Sensitivity analyses confirmed these results.
Record 2 of 7 - PsycINFO 2000

Mold,-James-W; Hamm,-Robert-M; Jafri,-Batool
The effect of labeling on perceived ability to recover from acute illnesses and injuries.
Journal-of-Family-Practice. 2000 May; Vol 49(5): 437-440
Te process of giving a patient a diagnosis may cause harm. The adverse effects of labeling, best documented for the diagnosis of hypertension, include increased absenteeism from work and lower earnings, increased depressive symptoms, and reduced quality of life. The authors tried to determine whether the diagnosis of hypertension affects perceptions about the time required to recover from common acute medical problems. In an academic family practice clinic, using a sample of 21+ yr old patients, 11 patients with hypertension (mean age 52.4 yrs) and 11 patients without hypertension were asked to estimate how long it would take them to recover from an upper respiratory tract infection (URI), a urinary tract infection (UTI), and an ankle sprain now and 5 yrs ago (before the diagnosis of hypertension). Compared with patients who did not have hypertension, patients with hypertension estimated that it would take them twice as long, on average, to recover from a URI now and in the past. These differences persisted after controlling for age, sex, race, and education. The diagnosis of hypertension may affect patients' perceptions of their ability to recover from unrelated acute illnesses. This may have implications for the way physicians choose to present information to patients.

Moyers,-Penelope-A; Stoffel,-Virginia-C
Alcohol dependence in a client with a work-related injury.
American-Journal-of-Occupational-Therapy. 1999 Nov-Dec; Vol 53(6): 640-645

To explore to what extent occupational therapy practitioners are effective agents of change for their clients who substance abuse interferes with rehabilitation potential, the authors present a case involving a 55-yr-old female with a long history of heavy assembly-line work, which lead to multiple hand surgeries in the past. The case suggests that occupational therapy practitioners should explore substance misuse as a primary issue for intervention in some physical injury cases for which the person was referred to occupational therapy. A holistic approach was applied to this case and was guided by 3 main principles: (1) each client is unique and can only be understood as a complex interaction of body, mind, and spirit; (2) each person should assume responsibility for his or her own health; and (3) education is effective in teaching a person how to manage his or her own health. Regardless of the successful surgical and rehabilitation outcomes in this case and the client's return to work, the fact that the client reverted to drinking creates a temptation to label this result as ultimately a failure.

Stewart-Brown,-Sarah; Layte,-Richard
Emotional health problems are the most important cause of disability in adults of working age: A study in the four counties of the old Oxford region.
Journal-of-Epidemiology-and-Community-Health. 1997 Dec; Vol 51(6): 672-675
URLJ: http://jech.bmjjournals.com/
Assessed the contribution of emotional health problems to the burden of disability affecting people of working age. Data were collected from postal questionnaire survey responses of a random sample of 9,332 18-64 yr olds from 4 counties of the old Oxford region. Results show that the prevalence of disability attributable to emotional health problems was greater than that attributable to all physical health problems combined. People reporting that their work or other regular daily activity was affected by their emotional health were much less likely to report a long-standing illness, consultation with a general practitioner, or consultation with a hospital doctor than people reporting a physical health problem.

Phillips,-Mary-Ellen; Bruehl,-Stephen; Harden,-R-Norman
Work-related post-traumatic stress disorder: Use of exposure therapy in work-simulation activities.
American-Journal-of-Occupational-Therapy. 1997 Sep; Vol 51(8): 696-700
Documents the interdisciplinary use of exposure techniques during work simulation activities to facilitate return to work in a 34-yr-old man with work-related chronic back pain and posttraumatic stress disorder (PTSD). Physical therapy focused on improving sacroiliac alignment and increasing abdominal strength as lower-extremity strength and flexibility. Psychological treatment initially focused on cognitive therapy for depression and improving pain coping skills. When symptoms of PTSD were diagnosed, co-treatment between occupational therapy and psychology during work-simulation activities was proposed to help the client to achieve his return-to-work goals. Treatment consisted of 5 sessions, with work simulation activities graded to include increasing demands on the proprioceptive, visual, and auditory systems. Co-treatment using exposure therapy resulted in a positive treatment outcome, and the client was able to return to work. (PsycINFO Database Record (c) 2002 APA, all rights reserved)

Mynors-Wallis,-Laurence; Davies,-Ioana; Gray,-Alastair; Barbour,-Faith; et-al
A randomised controlled trial and cost analysis of problem-solving treatment for emotional disorders given by community nurses in primary care.
British-Journal-of-Psychiatry. 1997 Feb; Vol 170(2): 113-119
70 patients with an emotional disorder in primary care were randomly allocated to receive either problem-solving therapy (PST) from a trained community nurse, or treat-

ment as usual from their general practitioner. Interview and self-rated assessments of clinical and economic outcome were made pre-treatment, at 8 wks, and at 26 wks after treatment. Results show no difference in clinical outcome between the 2 groups of patients. However, patients who received PST had fewer disability days and fewer days off work. The health care cost of PST was greater than that of the general practitioner's usual treatment, but this was more than offset by savings in the cost of days off work. Results show that community nurses can both be trained in and successfully perform PST. The clinical effectiveness and cost-benefit of the treatment will depend on the selection of appropriate patients.

Baum,-Carolyn-M; Law,-Mary
Occupational therapy practice: Focusing on occupational performance.
American-Journal-of-Occupational-Therapy. 1997 Apr; Vol 51(4): 277-288
Emphasizes the uniqueness of occupational therapy in enabling clients to achieve their goals by helping them overcome problems that limit their occupational performance. This article shares the experiences of Canadian occupational therapy practitioners, who were challenged by their government nearly 15 yrs ago to establish a system that demonstrates effectiveness by improving the health of occupational therapy clients. By focusing on occupational performance, occupational therapy practitioners assist clients in becoming actively engaged in their life activities. This requires client-centered and family-centered practice and services that span from the agency or institution to the community. Occupational therapy practitioners must work collaboratively with persons in the client's environment (e.g., family members, teachers, independent living specialists, employers, neighbors, friends) to assist the client in obtaining skills and to make modifications to remove barriers that create a social disadvantage. A focus on occupational performance requires occupational therapy personnel to reframe how they think about occupational therapy to a sociomedical context and to take an active role in building healthy communities.

G. Uit het Activering en Reintegratiebestand van TNO

Cuypers, J.J.F.M., Eyndhoven, A.J.B. van, Theloesen, P.H.M.
Samenwerking van artsen bij werkhervatting.
Nederlands tijdschrift voor geneeskunde 136(1992)no. 22 p. 1054-1057

Het hoge ziekteverzuim en het nog steeds groeiende aantal arbeidsongeschikten in Nederland worden in brede kring ervaren als een belangrijk maatschappelijk probleem. Een verbetering van de
sociaal-medische begeleiding van zieken en arbeidsongeschikten kan een bijdrage leveren aan de oplossing van het probleem. Bij deze sociaal-medische begeleiding zijn alle artsen betrokken : huisartsen, verzekeringsgeneeskundigen, bedrijfsartsen en specialisten. In dit artikel wordt vanuit de verzekeringsgeneeskundige invalshoek aandacht besteed aan de formele gedragsregels voor artsen ten aanzien van samenwerking, recente meningsvorming hierover en praktijkervaringen. Ten slotte worden enkele aanbevelingen gedaan.

Hento, I., Kaaij, H.
Samenwerking tussen bedrijfsarts en curatieve sector : optimisme en zorg.
Tijdschrift voor bedrijfs- en verzekeringsgeneeskunde 8(2000)no. 5 p. 146-15
Op basis van een brede landelijke inventarisatie en diepte-interviews onder betrokkenen is onderzocht welke vormen van succesvolle en mislukte samenwerkingsverbanden tussen bedrijfsartsen en de curatieve sector in Nederland voorkomen en wat

de ervaringen zijn van participanten over deze samenwerking. Het onderzoek bevestigt dat er nog heel wat te verbeteren valt met betrekking tot de samenwerking tussen bedrijfsartsen en de curatieve sector. De samenwerking tussen bedrijfsartsen en huisarts blijkt bescheiden van inhoud en intensiteit. Tegelijkertijd blijkt er een aantal veelal geformaliseerde samenwerkingsverbanden te bestaan met name tussen bedrijfsarts en de psychologische zorgverlening. Effectieve (structurele, langerdurende) samenwerking komt feitelijk alleen tot stand als de betrokken professionals van de meerwaarde van die samenwerking in de praktijk overtuigd zijn. Dat kan alleen door elkaar persoonlijk te ontmoeten, elkaars werkwijze, opvattingen en (on)mogelijkheden te leren kennen en op basis daarvan werkafspraken te maken. Formalisering van deze afspraken door middel van contracten of protocollen kan hierbij een ondersteunende rol spelen.

Bollen, S.H., Klink, J.J.L. van der, Terluin, B., Wijers, J.H.
Snel weer aan het werk : de rol van artsen bij de aanpak van verzuim om psychische redenen.
Medisch contact 57(2002)no. 11 p. 420-422

De Commissie Psychische Arbeidsongeschiktheid (Donner-I) presenteerde onlangs een leidraad voor het omgaan met ziekteverzuim om psychische redenen. De commissie gaat ervan uit dat in de meeste gevallen herstel en reïntegratie mogelijk is. Kern van de leidraad is een stappenplan ter ondersteuning van werkgever en werknemer. Een doeltreffende aanpak behelst contact houden, tijdige en adequate begeleiding en behandeling, activering thuis en op het werk. Hierbij kunnen verschillende deskundigen worden ingeschakeld. Zo maakt de bedrijfsarts een probleemanalyse en ondersteunt de betrokkenen bij zijn "hersteltaken"; de huisarts zorgt mede voor begeleiding, vooral bij privé-problemen. De psychiater geeft ondersteuning bij diagnostiek en behandeling, en de verzekeringsarts (en arbeidsdeskundige) gaat de kwaliteit van de reïntegratie-inspanningen na. Randvoorwaarden voor succesvolle implementatie en de voorgestane cultuurwijziging zijn een goede afstemming en samenwerking tussen alle actoren, voorlichting en korte trajecten of trainingen om deskundigheid te bevorderen.

Poulssen-Mestrom, M.E.S.
Successen in Hollandse en Brabantse samenwerkingsprojecten.
Tijdschrift voor bedrijfs- en verzekeringsgeneeskunde 10(2002)no. 5 p. 148-1

Werknemers met psychische klachten in de arbeidssituatie vormen, naast de mensen met klachten aan het bewegingsapparaat, de grootste groep WAO-instromers. Deze groep is er zeker bij gebaat wanneer bedrijfsartsen en huisartsen een eenduidige aanpak voorstaan. In de regio Zuid-Oost Brabant en de in regio Haarlemmermeer / Kennemerland hebben huisartsen en bedrijfsartsen "psychische klachten in de arbeidssituatie" bij de kop gevat en onderwerp gemaakt van hun streven
naar een betere samenwerking. De spontane samenwerking die in beide regio's vanuit een eigen behoefte op gang was gekomen, wordt concreet in de projecten "Samen werkt beter bij arbocuratieve zorg".

Masschelein, R., Donceel, P., Mortelmans, A.K., Moens, G.
Samenwerking tussen de bedrijfsarts, verzekeringsarts en curatieve arts : resultaten van een cross-sectioneel onderzoek bij Belgische bedrijfsartsen.
Tijdschrift voor gezondheidswetenschappen 82(2004)no. 2 p. 104-111

De praktijk laat vermoeden dat gebrekkig overleg tussen bedrijfsarts, verzekeringsarts en curatieve arts de reïntegratie van arbeidsongeschikte werknemers vertraagt. Een cross-sectioneel onderzoek onder bedrijfsartsen werd opgezet om: (1) de frequentie van contacten van bedrijfsartsen met curatieve artsen en met verzekeringsartsen te meten; (2) de aard en inhoud ervan te beschrijven; (3) de tevredenheid erover te onderzoeken; (4) obstakels op te sporen en voorstellen tot verbetering te formuleren. Van de bedrijfsartsen (n=50) heeft 59% wekelijks overleg met curatieve artsen, 6% met verzekeringsartsen. De bedrijfsarts neemt hierbij doorgaans het initiatief. Van de curatieve arts vraagt hij informatie over de gezondheidsklachten. Met de verzekeringsarts wordt een gezamenlijk werkhervattingsplan nagestreefd. Over de samenwerking met curatieve artsen is 95% tevreden, over die met verzekeringsartsen 62%. Praktische knelpunten zijn een beperkt inzicht in de taken van de
bedrijfsarts en diens beperkte bereikbaarheid. Gemeenschappelijke (na)scholing, een gestructureerde uitwisseling van contactgegevens en het opstellen en beter communiceren van richtlijnen wordt aanbevolen.

Verbeek, J.H.A.M., Barneveld, T.A. van, Valk, M.
Werkende patiënten : te weinig aandacht voor "arbeid" in klinische richtlijnen.
Medisch contact 59(2004)no. 20 p. 810-812

De factor "arbeid" speelt een belangrijke rol bij het ontstaan en de gevolgen van ziekte. Klinische richtlijnen besteden echter nauwelijks aandacht aan het werk van de patiënt. Noch in NHG-Standaarden, noch in CBO-richtlijnen worden werkgerelateerde aspecten verder uitgewerkt.
Arbeidsongeschiktheid en beroepsziekten kunnen efficiënter aangepakt worden door in richtlijnen aandacht te schenken aan werkgerelateerde interventies. Een NVAB/CBO-projectgroep heeft een algemene strategie voor opname van werkgerelateerde interventies in CBO-richtlijnen ontwikkeld en toegepast in voorbeeldprojecten.

Thornton, P., Sainsbury, R., Barnes, H.
Helping disabled people to work : a cross-national study of social security and employment provisions: a report for the social security advisory committee.
London, The Stationery Office, 1997

In October 1996, the Social Policy Research Unit was commissioned by the Social Security Advisory Committee, through the Department of Social Security, to carry out an international comparison of
approaches to supplementing the income from work and supporting the employment of disabled people with partial capacity for work. The UK had introduced a new form of partial capacity provision into the social security system in 1992, previously the only opportunities to work and claim incapacity benefit were very restricted. The chosen approach, an in-work social security benefit to supplement to low earnings (Disability Working Allowance), had not met policy expectations. The study was commissioned by the Social Security Advisory Committee to compare the UK experience with alternative approaches to 'partial capacity provision' in Australia, Finland, France, Germany, the Netherlands and Sweden.

Prins, R., Veerman, T.J., Giezen, A.M. van der
Werkhervatting na rugklachten : een internationale studie: probleemstelling, opzet en uitvoering van de eerste fase. Deelrapport 1.
Zoetermeer, College van Toezicht Sociale Verzekeringen (CTSV), 1996, 141 p.

Verslag van de voorbereidingen en de eerste fase van een internationaal onderzoek naar werkhervatting van patiënten die wegens lage rugklachten drie maanden zijn ziekgemeld. Aan het onderzoek doen zeven landen mee. In ieder land wordt een vergelijkbare groep van enkele honderden werknemers met lage rugklachten gevolgd gedurende een periode van twee jaar. Het project beoogt inzicht te krijgen in de activiteiten (interventies) die vanuit gezondheidszorg, uitvoeringsorgaan, werkgever en de werknemer zelf worden ondernomen met het oog op hervatting. Het onderzoek maakt deel uit van een internationale vergelijkende studie, getiteld "Work Incapacity and Reintegration", onder auspiciën van de International Social Security Association. In deze eerste rapportage wordt een uitvoerige beschrijving gegeven van de achtergrond, doelstelling en inrichting
van het totale project (nationaal en internationaal) en de precieze opzet van het Nederlandse project.

Giezen, A.M. van der, Veerman, T.J., Prins, R.
Werkhervatting na rugklachten : drie maanden in de ziektewet: ervaringen van werknemers en hun bedrijfsartsen. Deelrapport 2.
Zoetermeer, College van Toezicht Sociale Verzekeringen (CTSV), 1996, 128 p.

Deelrapportage van het internationale project "Work Incapacity and Reintegration". In dit tweede deelrapport wordt verslag gedaan van de eerste enquête-ronde onder de werknemers en hun bedrijfsartsen.

Einerhand, M.G.K., Knol, G., Prins, R.
Sickness and invalidity arrangements : facts and figures from six European countries.
Den Haag, VUGA, 1995, 308 p.

This study examines the scale, nature and background of differences in short term and long term work incapacity between the working age populations in Belgium, Denmark, Germany, Great Britain, The Netherlands and Sweden in the period 1980-1990 and surveys the major elements of the income replacement schemes for work incapacity due to sickness, injury and disablement in these countries. In this context attention is also paid to the demographic development, the working conditions, the rehabilitation and employment of disabled, the unemployment and (early) retirement arrangements, the employment to population ratio and the arrangements for civil workers.

Prins, R., Cuelenaere, B., Veerman, T.J.
In distant mirrors : work incapacity and return to work : a study of low back pain patients in the Netherlands and five other countries.
Zoetermeer, CTSV, 1999, 122 p.

Under the auspices of the ISSA (International Social Security Association), a group of social security organisations, and social or health departments in six countries (Denmark, Germany, Israel, The
Netherlands, Sweden and the United States) agreed to conduct a cross-national study on work incapacity and reintegration. The purpose of this study was to learn how work resumption of persons with work incapacity could be improved.

Kearney, J.R.
The work incapacity and reintegration study : results of the initial survey conducted in the United States.
Social security bulletin 60(1997)no. 3 p. 21-32

The United States and six other countries (Germany, Denmark Norway, Sweden, Israel and the Netherlands) are participating in a cross-national study of work incapacity and reintegration under the
auspices of the International Social Security Association. The purpose of the study is to identify those medical and nonmedical interventions that are most successful in helping persons disabled due to back condition return to work. The study involves a baseline survey and two follow-up surveys over approximately 2 years. This article reports on the findings from the baseline survey conducted in the United States. It compares the responses of persons from four study groups (the Social Security Administration's Disability Insurance (DI) beneficiaries and Supplemental Security Income (SSI) recipients, and temporary disability insurance (TDI) recipients from two States - California and New Jersey). The article discusses the potential influence of certain characteristics on the capacity for work reintegration. Study findings suggest that the characteristics of TDI recipients with back disorders may differ in some respects from those of recently entitled DI or SSI beneficiaries with similar impairments,
and that there may be some correlation between work resumption and factors such as education, work-related demands, and the presence of other chronic diseases.

Shervington, J., Balla, J.
WorkAbilty Mark III : functional assessment of workplace capabilities.
Work : a journal of prevention, assessment & rehabilitation 7(1996)no. 3 p.

Standardised measurement of workplace performance or the functional assessment of an individual's capabilities, especially by occupational therapists, is often critical before injured workers are returned to work, placed in new jobs, or evaluated for job incapacity. A direct link between a clinician's systematic findings and the detailed requirements of the workplace is desirable. There are a range of
vocational evaluation systems available. This study examines how one of these systems, WorkAbility Mark III, incorporates a work measurement technique of industrial engineering into occupational
therapy practice. The results of this study suggest that functional assessment with WorkAbility Mark III tests and uses six activity groups of workplace elements throughout the work assessment process;
and that computer technology in this area of occupational rehabilitation can assist the clinician in his or her assessment, planning, intervention, and evaluation.

H. Persbericht dinsdag 6 september 2004

Samenhang en samenwerking bij begeleiding zieke werknemers onvoldoende

De samenwerking tussen behandelende artsen, bedrijfsartsen en hulpverleners bij de begeleiding van zieke werknemers en arbeidsgehandicapten laat te wensen over. Naast gebrekkige afstemming, zijn de verschillende professionals het vaak onderling niet eens over de vraag hoe en wanneer een uitgevallen werknemer het werk het beste kan hervatten. Hierdoor is er geen sprake van een samenhangende aanpak en zijn de adviezen van de artsen en begeleiders nogal eens strijdig waardoor het voor zieke werknemers moeilijk is te bepalen wat zij het beste kunnen doen.
Dit blijkt uit een beeldvormingsonderzoek onder professionals dat Research voor Beleid in het voorjaar van 2004 heeft uitgevoerd in opdracht van de Commissie het Werkend Perspectief en dat vandaag naar de organisaties van de verschillende beroepsgroepen en aan het UWV en CWI is gestuurd. Hoewel het om percepties gaat, is de kritiek onderling van die omvang, dat de onderzoekers concluderen dat afstemming en

een samenhangend beleid hoogst noodzakelijk is. Omdat de kansen op werk voor deze groep toch al beperkt zijn en omdat het aantoonbaar bijdraagt aan de toegang en behoud van werk voor mensen met een arbeidshandicap. Uit een eerder uitgevoerd vergelijkbaar beeldvormingsonderzoek onder werkgevers en werknemers blijkt namelijk dat werkgevers huiverig zijn om arbeidsgehandicapten aan te nemen uit angst voor hogere kosten, meer ziekteverzuim en lagere productiviteit. Professionals kunnen helpen die angst weg te nemen..

Door informatie over te dragen en meer kennis te delen kunnen zieke werknemers en arbeidsgehandicapten beter begeleid worden. De Commissie het Werkend Perspectief gaat daarom met de verschillende beroepsverenigingen in gesprek om de conclusies te bespreken en te bekijken wat de meest geschikte aanpak is. Hierbij wordt gedacht aan symposia, discussiebijeenkomsten en een beroepsoverstijgende richtlijn.

Enkele conclusies uit het onderzoek:

- Driekwart van de bedrijfsartsen en verzekeringsartsen vindt dat de curatieve sector te weinig verband legt tussen gezondheidsklachten en factoren op het werk.
- Ongeveer 40% van de bedrijfsartsen vindt dat de curatieve sector de werkhervatting in de weg staat.
- De curatieve sector vindt dat bedrijfsartsen te optimistisch zijn over de termijn waarop de werknemer weer aan het werk kan (25-50%). Ongeveer een kwart van hen vindt dat de snelle werkhervatting de behandeling in de weg staat.
- Ruim 40% van de psychiaters en psychologen vindt dat de bedrijfsartsen te weinig kennis hebben van de aanpak van verzuim wegens psychische klachten, terwijl juist ruim eenderde van de WAO-instroom veroorzaakt wordt door dit soort klachten.
- Meer dan de helft van de behandelaars in de tweede lijn vindt dat mensen met arbeidsgerelateerde problematiek regelmatig te laat naar hen worden doorverwezen.
- Ongeveer de helft van de verzekeringsartsen en reïntegratieconsulenten vindt dat veel mensen met relatief geringe aanpassingen had kunnen blijven functioneren.
- Ook de ondersteuning bij het zoeken naar werk kan beter. Een substantieel deel van de CWI-adviseurs (77%) en consulenten van reïntegratiebureaus (32%) vindt de informatie over aandoening en belastbaarheid van arbeidsgehandicapten bij de intake meestal onvoldoende. Daardoor kunnen zij hen en hun toekomstige werkgevers niet goed adviseren en begeleiden.
- Bedrijfsartsen zijn volgens verzekeringsartsen (30%) en reïntegratieconsulenten (55%) te optimistisch over terugkeer bij de eigen werkgever. Er zou eerder gekeken moeten worden naar reïntegratie bij andere werkgevers.
- Daarnaast worstelt de helft van reïntegratieconsulenten met de opdracht van de uitvoeringsinstanties om tot een snelle werkhervatting te komen. Zij hebben de indruk dat deze opdracht een duurzame reïntegratie in de weg staat.
- Een groot deel van de professionals vindt dat verzuim om psychosociale factoren te veel gemedicaliseerd wordt.

Leidraad Donner

Een opvallende conclusie van het onderzoek is dat de Leidraad van Donner, een aanpak voor verzuim wegens psychische problemen goed bekend is. In deze Leidraad wordt een tweesporenbeleid geadviseerd: door weer aan het werk te gaan, werkt de werknemer aan zijn of haar herstel. Het merendeel van de bedrijfsartsen en verzekeringsartsen is positief over de toepasbaarheid en de effecten van deze Leidraad. Ook grote groepen behandelaars zijn positief.

In tegenstelling tot het onderzoek onder werkgevers en werknemers blijkt de kennis over wet- en regelgeving bij professionals redelijk goed te zijn. De Wet Gelijke Behandeling is minder bekend. Daarnaast blijken reïntegratieconsulenten en CWI-adviseurs niet goed op de hoogte van de Wet Medische Keuringen.

I. Van het ReGa-project (KU Leuven)

Mortelmans ak. Een prospectieve studie ter bevordering van effectieve werkhervatting door een multidisciplinaire aanpak van arbeidsongeschiktheid. Het rega-project. Medecine du travail. Arbeidsgezondheidszorg & ergonomie 2002; 39: 45.

Mortelmans ak, moens g, donceel p, lahaye d. Samenwerking arbeidsgeneesheer, verzekeringsarts en behandelende arts in belgië en nederland. Deel 1: vergelijkbare problemen. Tijdschrift voor bedrijfs- en verzekerings-geneeskunde 2002; 10: 375-8.

Mortelmans ak, donceel p, masschelein r, lahaye d. Artsenoverleg over werkhervatting van langdurig arbeidsongeschikten. Tijdschrift voor geneeskunde 2003; 59: 305-14.

Mortelmans ak, donceel p, lahaye d. Samenwerking arbeidsgeneesheer, verzekeringsarts en behandelende arts in belgië en nederland. Deel 2: vergelijkbare initiatieven. Tijdschrift voor bedrijfs- en verzekeringsgeneeskunde 2003; 11: 21-3.

Mortelmans ak, masschelein r, lahaye d. Samenwerking tussen de bedrijfsarts en de behandelende arts: recente gegevens. Medecine du travail. Arbeidsgezondheidszorg & ergonomie 2003; 4: 157-66.

Mortelmans ak, masschelein r, moens g. Samenwerking tussen bedrijfsarts, verzekeringsarts en behandelende arts. Resultaten van een cross-sectioneel onderzoek bij belgische bedrijfsartsen. Tijdschrift voor gezondheidswetenschappen 2004; 2: 104-12.

J. Submitted for publication

Paul van Dijk, Wouter Hogervorst, Peter Buijs, Frank van Dijk. The role of the GP in imminent long-lasting sickness absence.

PC Buijs, MD PhD; JR Anema, MD[#] ; M Evers, MSc[#]; (FJHvDijk, JJLvdKlink)
A protocol for managing work related psychological complaints by GPs in cooperation with Ops: a pilot
28-6-versie(4191words, inclus. Figs/tabels)

4a The process of concept mapping

Uit: William Trochim (Cornell University New York). An Introduction to Concept Mapping for planning and evaluation. Evaluation and Program Planning 1989; 12: 1-16.

Concept mapping is a structured process, focused on a topic or construct of interest, involving input from one or more participants, that produces an interpretable pictorial view (concept map) of their ideas and concepts and how these are interrelated.
Concept mapping helps people to think more effectively as a group without losing their individuality. It helps groups to manage the complexity of their ideas without trivializing them or losing detail.

A concept mapping process involves six steps that can take place in a single day or can be spread out over weeks or months depending on the situation.

1. The first step is the **Preparation Step**. There are three things done here. The facilitator of the mapping process works with the initiator(s) (i.e., whoever requests the process initially) to identify who the participants will be. A mapping process can have hundreds or even thousands of stakeholders participating, although we usually have a relatively small group of between 10 and 20 stakeholders involved.
Second, the initiator works with the stakeholders to develop the focus for the project. For instance, the group might decide to focus on defining a program or treatment. Or, they might choose to map all of the outcomes they might expect to see as a result. Finally, the group decides on an appropriate schedule for the mapping.

2. In the **Generation Step** the stakeholders develop a large set of statements that address the focus. For instance, they might generate statements that describe all of the specific activities that will constitute a specific social program. Or, they might generate statements describing specific outcomes that might occur as a result of participating in a program. A wide variety of methods can be used to accomplish this including traditional brainstorming, brainwriting, nominal group techniques, focus groups, qualitative text analysis, and so on. The group can generate up to 200 statements in a concept mapping project.

3. In the **Structuring Step** the participants do two things. First, each participant sorts the statements into piles of similar ones. Most times they do this by sorting a deck of cards that has one statement on each card. But they can also do this directly on a computer by dragging the statements into piles that they create. They can have as few or as many piles as they want. Each participant names each pile with a short descriptive label. Second, each participant rates each of the statements on some scale. Usually the statements are rated on a 1-to-5 scale for their relative importance, where a 1 means the statement is relatively unimportant compared to all the rest, a 3 means that it is moderately important, and a 5 means that it is extremely important.

4. The **Representation Step** is where the analysis is done -- this is the process of taking the sort and rating input and "representing" it in map form. There are two major statistical analyses that are used.
The first -- multidimensional scaling -- takes the sort data across all participants and develops the basic map where each statement is a point on the map and statements that

were piled together by more people are closer to each other on the map. The second analysis -- cluster analysis -- takes the output of the multidimensional scaling (the point map) and partitions the map into groups of statements or ideas, into clusters. If the statements describe activities of a program, the clusters show how these can be grouped into logical groups of activities. If the statements are specific outcomes, the clusters might be viewed as outcome constructs or concepts.

5. In the fifth step -- the **Interpretation Step** -- the facilitator works with the stake-holder group to help them develop their own labels and interpretations for the various maps.

6. Finally, the **Utilization Step** involves using the maps to help address the original focus. On the program side, the maps can be used as a visual framework for operation-alizing the program. on the outcome side, they can be used as the basis for developing measures and displaying results.

5 Concept mapping nationaal

A. Concept Mapping sessie ICT bedrijfsartsen (n=6)
VU (Amsterdam), 15 december 2004

Analyse

Methode: vrije statements genereren, sorteren en prioriteren.

Hoofdgroep 1: Oorzaken van BS

Gebrek aan kennis / inzicht in de rol van arbeid, in wetgeving, etc.	24
Ze vinden arbeid niet belangrijk / geven het lage prioriteit	07
Behandelaars beschouwen het niet als iets dat bij hun vak hoort	07
Aandacht voor arbeid is slecht voor de vertrouwensrelatie	05
Ze vermijden het thema arbeid bewust	04
Arbeid past niet in modellen voor diagnostiek en behandeling	03
Voor de factor arbeid zijn bedrijfsartsen	01
De patiënt verwacht niet dat je erover begint	01
Tijdgebrek	01
Angst voor voorrangszorg bij aandacht voor werk	01

Hoofdgroep 2: Redenen om BS aan te pakken

Belang van werk voor genezing en gezondheid	11
Het werk wordt leuker	03
De resultaten worden beter	03

Hoofdgroep 3: Oplossingen

Samenwerken en afstemmen	09
Opleiding verbeteren	06
Multidisciplinaire richtlijnen	05
Arbeidsanamnese door behandelend arts	03

B. Concept Mapping sessie met huisartsen-in-opleiding (n=19)
VU (Amsterdam), 18 maart 2005

Analyse van individuele uitspraken

Methode: individuele aanvulling van 11 statements

1. Huisartsen vragen zelden naar de beroepsmatige activiteiten van hun patiënten, omdat …..

Oneens met de stelling:	6
Ze vinden het minder belangrijk:	3
Gebrek aan kennis van bedrijfsgeneeskunde:	3
Ze vinden het niet op hun weg liggen	2
Tijdgebrek:	2
De patiënt vraagt er niet om:	2

Ze denken er niet aan:	1

2. Werkfactoren moeten worden beschouwd als belangrijke determinanten van ziekte, in het bijzonder …..

Bij ongunstige psychosociale factoren en stress:	16
Bij zware fysieke belasting en klachten van het bewegingsapparaat:	8
Als ze de genezing belemmeren:	1
In lagere sociaal-economische klassen:	1
Bij werkverzuim:	1

3. Nascholingsprogramma's kunnen behandelend artsen motiveren om de invloed van werk op de gezondheid in ogenschouw te nemen, indien …..

Als er wetenschappelijk bewijs van de mate van invloed van werk op de gezondheid wordt gegeven:	3
Als daarmee invloed op de werkvloer kan worden bereikt:	3
Als ze gebaseerd zijn op samenwerking:	2
Als bedrijfsartsen een onafhankelijke opstelling kiezen:	1
Als er een leidraad wordt verstrekt:	1
Als het kleinschalige (regionale) nascholing is:	1
Als de programma's direct toepasbaar zijn:	1
Als het thema pakkend en concreet wordt neergezet:	1

4. In de medische opleiding is / heeft de bedrijfsgeneeskunde ……

Marginaal aanwezig:	14
Een saai imago / een niet inspirerend onderdeel:	4
Geen interesse / prioriteit bij studenten:	3
Een vast onderdeel:	1
Moet worden geïntegreerd in de curatieve geneeskunde:	1

5. Veel werknemers met werkgerelateerde gezondheidsproblemen gaan bij voorkeur naar hun huisarts, omdat ……

De huisarts kan hun belangen beter dienen vanwege de vertrouwensrelatie:	12
De bedrijfsarts is controleur / heeft een dubbele pet / is niet te vertrouwen:	7
De werkgever kan ongunstig reageren:	2
De huisarts kan werkgerelateerde klachten van tijdelijke aard goed oplossen:	1
Het verband tussen klachten en werk is niet altijd duidelijk voor de patiënt:	1
De bedrijfsarts (diens persoon en functie) is onbekend bij de werknemer:	1

6. Behandelend artsen herkennen beroepsziekten vaak niet, omdat ….

Men denkt er niet aan:	3
Men kan er niet veel mee:	3
Men kent het werk, de beroepen niet:	2
Men maakt er geen tijd voor:	2
Men is er niet voor opgeleid:	1
Men weet niet hoe dit uit te vragen:	1
Onvoldoende aandacht voor probleem achter de klacht:	1

Men ziet het verband niet:	1
De patiënt legt het verband niet:	1

7. Voor werknemers is het belangrijk dat behandelend artsen aandacht schenken aan de oorzaak van hun klachten, omdat …….

Betere / meer gerichte behandeling:	9
Voorkómen van recidieven of falen van behandeling:	3
Het kan preventief werken:	2
De patiënt zal beter meewerken met de aanpak, als inzicht in de oorzaak wordt gegeven:	2
Het is soms de expliciete vraag van de patiënt:	1
De patiënt voelt zich beter begrepen / gesteund:	1
De werknemer kan door werkaanpassing weer sneller aan het werk:	1

8. Het certificeren van ziekteverzuim helpt artsen niet om rekening te houden met de invloed van werk, omdat …….

Certificering betekent nog niet dat werkfactoren als oorzaak aan bod komen:	1
Het is tijdrovend werk:	1
Patiënt zal de relatie met het werk vaker naar voren brengen:	1
Reuze klus; wie betaalt?	1
Oneigenlijk gebruik van arts; het werk is een derde partij die de vertrouwelijke behandelrelatie kan verstoren:	1

9. Behandelend artsen beschouwen arbeidsreïntegratie niet als een doel, omdat ….

Ze vinden het een taak voor de bedrijfsarts of reïntegratiedeskundige:	5
Ze zijn er niet voor opgeleid / het is niet hun vakgebied:	5
Behandelaar verwacht dat werkhervatting logisch volgt op fysiek herstel:	2
Behandelaars zijn ziektegericht; reïntegratie valt daarbuiten of daarna:	2
Ze vinden het een neven-effect van genezing:	2
Ze hebben onvoldoende inzicht in de werksituatie:	1
Niet duidelijk dat werk mensen beter maakt, als er zoveel ziek van worden:	1

10. Medische specialisten houden geen rekening met de effecten van hun behandeling op de arbeidsgeschiktheid van hun patiënten, omdat …..

Ze zijn exclusief gericht op ziekte en behandeling:	4
Het is niet hun kerntaak / prioriteit:	4
Ze denken daar niet aan:	1
Tijdsbeperkingen:	1
Behandelresultaten worden in medische termen uitgedrukt (genezing):	1

<u>C. Concept Mapping sessie met huisartsen-in-opleiding (n=19)</u>
<u>VU (Amsterdam), 18 maart 2005</u>

Analyse en selectie van groepsuitspraken

Methode: groepsdiscussie n.a.v. individuele aanvulling van statements
Selectie m.b.t. relevantie voor het bestaan van een ‘Blind Spot for Work’

1. Huisartsen vragen zelden naar de beroepsmatige activiteiten van hun patiënten, omdat …..

De dokter begint er niet over / is er niet in getraind.
Het is geen belang van de patiënt.
Het is niet de hulpvraag van de patiënt.
De patiënt kiest een symptoom als ingang.
Bij bepaalde aandoeningen vragen huisartsen wel naar het werk.

2. Werkfactoren moeten worden beschouwd als belangrijke determinanten van ziekte, in het bijzonder …..

Lichamelijke stress: gemakkelijk te linken (werk ~ klachten).
Psychische stress: kwestie van gewaardeerd worden / stresspercepție.
Spanning / ontevredenheid / waardering.
Zware lichamelijke arbeid.
De perceptie van het werk: blij zijn dat je werk hebt. Werk hoeft niet leuk te zijn: het is vaak een zaak van 'brood op de plank'.

3. Nascholingsprogramma's kunnen behandelend artsen motiveren om de invloed van werk op de gezondheid in ogenschouw te nemen, indien …..

Ze moeten gericht zijn op bewustwording; een goed middel is casuïstiek.
Ze moeten praktisch zijn: kwestie van richtlijnen opstellen en interventiemogelijkheden benoemen.
Doel is de samenwerking met ARBO, omdat de nascholing en een eventuele leidraad het nut van samenwerking duidelijk maakt.
Er moeten eisen worden gesteld aangaande de onafhankelijkheid van de ARBO-arts.

4. In de medische opleiding is / heeft de bedrijfsgeneeskunde ……

Te weinig aandacht bij de docenten / curriculumbeheerders.
Te weinig interesse bij de studenten.

5. Veel werknemers met werkgerelateerde gezondheidsproblemen gaan bij voorkeur naar hun huisarts, omdat ……

De huisarts is onafhankelijk, geniet vertrouwen.
De patiënt heeft een bestaande relatie met zijn huisarts.
Beeldvorming bij de patiënt inzake persoon en functie van de bedrijfsarts is niet positief.
Misbruik van de arts als legitimatie.

7. Voor werknemers is het belangrijk dat behandelend artsen aandacht schenken aan de oorzaak van hun klachten, omdat …….

Dit geeft een ingang om inzicht te geven in het genezingsproces.
Preventieve werking.

9. Behandelend artsen beschouwen arbeidsreïntegratie niet als een doel, omdat ….

Deskundigheid ontbreekt.
Werk is oorzaak van de ziekte.
Deskundigheid, opleiding, interesse ontbreken.
Werk is oorzakelijk.

D. Concept Mapping sessies met huisarts-opleiders (n=12)
VU (Amsterdam), 22 en 24 maart 2005

Analyse en selectie van individuele uitspraken

Methode: individuele aanvulling van 11 statements
Selectie m.b.t. relevantie voor het bestaan van een 'Blind Spot for Work'

(1) Bij het voorschrijven van geneesmiddelen houd ik als huisarts wel / geen rekening met het werk dat mijn patiënt doet, want …….

9x wel, 1x zelden

Wel:
Het moet sowieso "maatwerk" zijn. – Ik heb wel blinde vlekken.
Ik wil niet dat mensen risico's lopen tijdens hun werk door mijn medicatie.
'Beperk arbeidsongeschikt zijn' is vaak de vraag van de patiënt.
Afhankelijk van soort geneesmiddel. Wel bij bv. insuline; tranquilizer.

Zelden:
Het heeft vaak geen raakvlakken met werk.

(2) Als ik als huisarts ook de ziektewetcontrole erbij zou doen, zou dat mij van nut zijn bij de behandeling van de patiënt, omdat ……..

de factor werk en de invloed daarvan op het welbevinden altijd boven water komt. Maar het veroorzaakt wel een spanningsveld en is daarom ongewenst.
ik gedwongen werd mij meer te verdiepen in het werk van patiënt.

(3) Als huisarts herken ik beroepsziekten nooit / soms / vaak, want ……..

7x soms, 5x vaak

Vaak. Ik ben er wel attent op. Denk aan epicondylitis of tendinitis i.h.a., rug- en nekklachten etc., slaapproblemen. Wel blinde vlekken.
Soms. De fysieke / psychische balans in het werk is niet altijd duidelijk.
Vaak. Patiënt geeft dat vaak al aan.
Soms. Ik weet niet altijd wat mijn patiënt precies voor werk doet (= wat zijn werk inhoudt). Ik weet niet of ik voldoende afweet van beroepsziekte.
Soms. Ik vind werk een belangrijk onderdeel van het functioneren van een persoon, dus daar vraag ik vaker naar.

(4) Als huisarts vraag ik nooit / soms / vaak naar hoe het op het werk gaat, omdat …….
4x soms, 8x vaak

Vaak. Omdat mij dat informatie verschaft hoe hij/zij de ziekte beleeft.

Vaak. Omdat satisfactie op het werk of onvrede over het werk belangrijk is bij het welbevinden van patiënt (kwaliteit van leven).
Vaak. Veel ellende ontstaat op het strijdveld van eisen van het bedrijf en vermogen van werknemers.
Soms. Alleen als er aanleiding toe is; ik moet mijn tijd zorgvuldig besteden.

(5) Werknemers met klachten van hun werk gaan daarmee bij voorkeur naar hun huisarts, want …….

… deze is onafhankelijk t.o.v. werk; heeft geen dubbele agenda.
… hij is vertrouwenspersoon; hij is vertrouwd; hij is niet aan het bedrijf verbonden en dus minder kans op "partijdigheid".
… op het werk / bij arboarts geen gehoor.
… velen zijn niet op de hoogte van de functie van een bedrijfsarts of weten de toegang niet / worden tegengehouden. Partijdigheid.
… dat is de eerste aangewezen om te starten in het medisch circuit in Nederland.
… die is gemakkelijker bereikbaar.
… die kan therapie / medicijnen verstrekken. En: voor ZW is (zich) stellen onder medische zorg (een) voorwaarde.

(6) Over de aandacht die de factor arbeid krijgt in het medisch basiscurriculum wil ik het volgende opmerken: …….

Bij mijn weten is deze zeer gering.
Te weinig.
Ik heb er nooit wat over gehoord, voorzover ik me dat herinner (diploma in 1975).

(7) Aandacht van de huisarts voor het werk dat de patiënt doet leidt naar mijn ervaring wel / niet tot een grotere tevredenheid van de patiënt, omdat ……

4x wel

Wel, omdat dit de centrale rol van de huisarts bevestigt.
Wel, omdat goede arbeidsomstandigheden belangrijk zijn voor de patiënt (8 van de 24 uur) en aandacht op prijs gesteld wordt. Huisarts heeft geen banden of verplichtingen naar werk (beroepsgeheim), kan van de andere kant zo nodig een positieve schakel zijn naar het werk.

(8) Werkhervatting en functioneel herstel zijn voor mij als huisarts wel / geen doel van mijn behandeling, want …….

8x wel, 1x soms, 3x geen

Geen, want het is niet mijn insteek. Ik kom er tot mijn schrik en verbazing wel eens bij toeval achter dat iemand al maanden niet meer werkt met een (in mijn ogen) relatief gering gezondheidsprobleem.
Geen. Ik probeer mij er meestal van te distantiëren. Je blijft toch als huisarts achter je patiënt staan, als het even kan.
Wel. Werk biedt aan velen structuur in het leven.
Wel. Ik denk dat werken in het algemeen gezond is.
Soms. Werken is sociaal belangrijk, en in die zin onderdeel van "gezond voelen".

(9) Ik vind beroepsarbeid van mijn patiënten wel / geen factor van betekenis voor hun gezondheid, want …….

12x wel
Wel. Structuur, regelmaat, voorbeeld voor kinderen, bijdrage aan maatschappij, geeft eigenwaarde, ook meer mogelijkheden op materieel gebied.
Wel. Er wordt veel tijd aan besteed. Het kan grote lichamelijke belasting inhouden. Het kan grote geestelijke belasting inhouden. Sociale contacten. Waardering / zelfvertrouwen.
Wel. Ik beschouw (beroepsarbeid) als 50% van hun leven.
Wel. Mijn eigen ervaring is dat prettig functioneren op het werk mij veel plezier bezorgt.
Wel. Werken is gezond (meestal).

(10) Een nascholingsmiddag over arbeidsgeneeskunde voor huisartsen is aan mij wel / niet besteed, omdat …….

6x wel, 4x niet

Wel, omdat ik zeker blinde vlekken heb en (nog erger) vooroordelen.
Niet, omdat er geen vraag of probleem bestaat.
Wel, omdat meer wederzijds begrip leidt tot betere samenwerking → resultaat. Die samenwerking mag niet te veel tijd kosten.
Niet, omdat het vaak over samenwerking gaat, die ik helaas niet heb.
Niet, omdat ik dat een ander vakgebied vind.

(11) Door geen aandacht aan de arbeidssituatie te schenken loop je als huisarts het risico dat …….

… bepaalde klachten blijven bestaan, zoals surmenage (burnout) en ergonomische aspecten.
… je belangrijke informatie mist.
… je ziekmakend bezig bent.
… je diagnoses over het hoofd ziet; niet aansluit bij de patiënt; de follow-up van een klacht niet kunt begrijpen.

<u>E. Concept Mapping sessies met huisarts-opleiders (n=12)</u>
<u>VU (Amsterdam), 22 en 24 maart 2005</u>

Analyse en selectie van groepsuitspraken

Methode: sorteren van uitspraken en groepsdiscussie
Selectie m.b.t. relevantie voor het bestaan van een ‘Blind Spot for Work’

<u>Onderscheiden clusters van statements, 22 maart 2005:</u>

Blinde vlekken in werkgerelateerde klachten
Werk is belangrijk voor patiënt
Werkbemoeienis door huisarts is ongewenst vanwege spanningsveld
Kennis van het werk is voor de huisarts belangrijk
Centrale positie van de huisarts
Aandacht voor het werk van patiënt is belangrijk voor huisarts

Beeldvorming over bedrijfsartsen

Observaties tijdens de groepsdiscussie over de statements, 24 maart 2005:

(1) Bij het voorschrijven van geneesmiddelen houd ik als huisarts wel / geen rekening met het werk dat mijn patiënt doet, want …….

De indicatie voor medicatie kan zelfs geheel door het beroep worden bepaald, bv. een prednisonkuur voor een beroepszanger.
Mensen moeten niet de dupe worden van mijn beleid.

(3) Als huisarts herken ik beroepsziekten nooit / soms / vaak, want ……..

Je weet nu eenmaal niet wat je mist.
"Psychosociaal" herken ik wel.
Wat is een beroepsziekte?
De secretaresse vult het beroep in, maar de term zegt vaak niets: "classificeerder".

(4) Als huisarts vraag ik nooit / soms / vaak naar hoe het op het werk gaat, omdat …….

je moet afchecken wat het belang van de patiënt is.
Sommige patiënten moeten op het spreekuur komen omdat ze zich ziek hebben gemeld.
De werkgever mag niet vragen naar de reden van het verzuim.

(5) Werknemers met klachten van hun werk gaan daarmee bij voorkeur naar hun huisarts, want …….

Het wordt nagevraagd (of ze bij de huisarts geweest zijn).
Ze denken dat de bedrijfsarts partijdig is.
Ze mogen van de baas niet naar de bedrijfsarts.
De bedrijfsarts wordt niet vertrouwd.

(10) Een nascholingsmiddag over arbeidsgeneeskunde voor huisartsen is aan mij wel / niet besteed, omdat …….

Niet besteed: het is een apart vakgebied.
Ik ben niet creatief bezig met werk.
Ik zou op de nascholing het preventieve willen leren.
Stress, mobbing, wegpesten.
De Arbo-arts krijgt geen voet aan de grond bij de werkgever.
ARBO is een grote zoethouder.
Een drukker met OPS-klachten moet zelf zijn weg zoeken.
De bedrijfsarts heeft geen macht om verbeteringen te realiseren.

6 Concept mapping internationaal

A. Concept Mapping session Modena (Italy), 15 October 2004

Analysis

Applied method: completion of preformulated statements

Causes

Lack of knowledge / bad education	12
Rehabilitation is not an objective	06
Time constraint	05
No awareness	04
Lack of information about work situation	03
Low importance / priority	03
Social approach is family, not work	02
Legal obligation to go to GP first	02
Lack of trust in OPs	02
OP is not available	02
OP is not allowed to treat	01
Sick patients go to GP	01
Patient does not allow to explore the work situation	01
Patient does not ask for rehabilitation	01
GPs do not forward the information about ODs	01

Consequences

Missed diagnoses of occ. diseases	02
Problems, especially for black work / self employed / informal workers who have no OP /no access to OHS	01
GPs do not consider the possibility of occ. diseases	01
Missed opportunities for prevention	01
Improper treatment	01
Improper rehabilitation	01
Treatment OK, but complaints persist	01

Solutions

More hours for OM in regular basic medical curriculum	10
Specific CME programmes	09
Certification of sickness absence by treating physician	02
More information about objectives of OM to general population	01

B. Concept Mapping session Helsinki (Finland), 25 January 2005

Analysis

Applied method: free generation of statements; sorting; prioritisation of batches

Batch labels	**Votes for importance**
Education / CME	6 votes
Structure, communication & awareness	3 votes
Common goal / care for same patient	2 votes
Definition	1 vote
Worker empowerment	1 vote
Work demands assessment	1 vote
Adverse effects	1 vote
Money	1 vote
Research	1 vote
Solutions	1 vote
All health care levels	0 votes
Gp's unabiliy to influence	0 votes
Resources	0 votes

Batch labels with number of statements in batch between brackets.
Some typical statements selected for illustration.

DEFINITION (2)

Blind Spot is not thinking of work by curative medical professionals.

EDUCATION (21)

Blind Spot is due to lack of academic interest in occupational medicine: "what you do not learn at school does not exist".

Modules in occupational medicine incorporated in the training of general practitioners as well as physician specialists may be part of the solution to the Blind Spot problem.

Medical education has been strongly concerned with diagnosis and treatment, instead of prevention. If prevention would be addressed, causal factors or determinants would receive emphasis.

WORKER / SOCIETY CONTROL & EMPOWERMENT (3)

Workers might not want the doctor / GP to intervene with the work-place in fear of losing job or being accused of making problems for the boss / company.

Workers' information and empowerment are conditions and critical inputs to overcome (make some progress) this issue.

ALL HEALTH CARE LEVELS / ISSUES (6)

The Blind Spot problem is not only an issue for occupational health, but applies to any area of health care where optimising functional capacity is important, e.g. geriatric medicine, paediatric medicine, psychiatric medicine.

Blind Spot is not restricted to physicians, but is also present in nurses, physiotherapists, audiologists, rheumatoid arthritis consulents, etc.

Blind Spot leads to hide occupational injuries, delay of care or treatment, and gives impairment and bad consequences on health:
- health sequelae
- higher health costs
- impairment of handicap.

ASSESSMENT OF WORK DEMANDS IS DIFFICULT (3)

Blind Spot is emphasized in modern society, due to a great variation of jobs and job titles.

KNOWLEDGE OF AND ABILITY TO INFLUENCE THE WORKPLACE (5)

The Blind Spot might be eliminated by combining primary and occupational care.

Is there any evidence that the Blind Spot is less in Finland, where there is close linkage between primary and occupational health care?

ADVERSE EFFECTS (7)

Not considering “work” by medical professionals may lead to more sickness absence and permanent work disability than in situations with optimal care.

The Blind Spot could compromise health care rendered to patients, particularly those in the productive age groups.

The Blind Spot leads to underestimation of health consequences of occupational risks and the financial consequences on social budget..

MONEY (8)

Blind Spot transfers the financial consequences of occupational disease and occupational injuries from companies (industry) to society.

Profits for GPs is connected to treatment; taking time to ask for work environment factors does not pay.

RESEARCH (5)

The Blind Spot problem could be addressed adequately if news on the causes are sought globally.
How to apply the evidence based medicine in occupational health?

RESOURCES (3)

The way to eliminate the Blind Spot is to use non-medical rehabilitation team to manage rehabilitation.

COMMON GOAL / CARE FOR SAME PATIENT (11)

The GP thinks that the OHS / occupational physician will follow-up all work-related problems.

Blind Spot is due to:

- lack of GP's taking total responsibility for their patients. They only care for the core of the disease / disorder the patient is presenting in each consultation.

Blind Spot: it could be eliminated by establishing a common goal for all health care – that of maximising functional capacity as a key outcome measure.

Occupational health physicians and researchers should approach curative colleagues for co-operation based on the shared goal of good quality of care which includes "work".

STRUCTURE, COMMUNICATION & AWARENESS (7)

Blind Spot is due to lack of governmental / public interest in occupational medicine – allowing the state of the day to continue.

AW Blind Spot is due to the general public focus on heroic care – versus the dreary non-heroic work of prevention (where prevention has the disadvantage not being able to count its successes directly).

AW Blind Spot is due to the organizational splitting apart of curative and group preventive medicine – in governmental organizations.

7 Interviews met sleutelpersonen

A. René Mendes, Belo Horizonte, Brazil, 25 januari 2005

Prof. Mendes heeft zich vanaf de start van het project zeer geïnteresseerd getoond in het onderwerp 'Blind Spot for Work in Health Care'. Hij bezocht de ICOH-congressen in Modena (oktober 2004) en Helsinki (januari 2005) in zijn hoedanigheid van president van de Braziliaanse National Association of Occupational Medicine - ANAMT (2001-2004; 2004-2007), en als lid van de ICOH Board (2003-2006).

In Brazilië krijgt workers' empowerment momenteel hoge prioriteit. Werknemers worden aangemoedigd en geïnstrueerd om zelf meer invloed uit te oefenen op hun werksituatie en de zorg voor veiligheid en gezondheid op het werk. Als een werknemer met een arbeidsgerelateerde aandoening attent is op een Blind Spot bij zijn behandelend arts, kan dat het proces van diagnostiek en behandeling bevorderen en het resultaat verbeteren. Ook de medische stand wordt op dit punt voorgelicht: van overheidswege is een leerboek van 700 pagina's met informatie over de regelingen voor veiligheid en gezondheid op het werk verspreid onder meer dan 100.000 curatief werkzame artsen in Brazilië.

B. Raf Masschelein, Leuven, België, 3 februari 2005

(1) Naam geïnterviewde persoon: Prof. dr R. Masschelein

(2) Functie: hoogleraar

(3) Werkzaam bij: KU Leuven

(4) Dekkingsgraad BGZ in eigen land: normalerwijze 95 %. Zelfstandigen vallen er niet onder. Onduidelijke definitie van het begrip onderneming. In Bouw veel verloop van ondernemingen.

(5) Herkent Blind Spot in eigen land:
- in de eerste lijn (huisarts): ja (er is een thesis over)
- in de tweede lijn (ziekenhuisarts): ja, varieert per specialisme; minder bij bv dermatologen

(6) Is men zich het probleem bewust
- in de eerste lijn (huisarts)
- in de tweede lijn (ziekenhuisarts): eerste en tweede lijn: ten dele wel; patiënt prikkelt hen niet daartoe, soms wel de verzekeraar; het afgeven van een ziekte-attest leidt de aandacht wel naar het werk
- in de bedrijfsgezondheidszorg: ja

(7) Zijn er in eigen land acties ondernomen (of oplossingen gevonden) om de Blind Spot tegen te gaan?
- in de eerste lijn (huisarts)
- in de tweede lijn (ziekenhuisarts)
- in de bedrijfsgezondheidszorg: er is aandacht aan besteed bij de bedrijfsartsen, in verenigingsverband

- door de beroepsverenigingen: ja, contacten tussen verenigingen van huis- en bedrijfsartsen
- door onderzoeksinstellingen
- door opleidingsinstellingen: de nascholing kiest soms een werkgerelateerd thema
- door verzekeraars
- door de overheid: verzekeraars en overheid niet of nauwelijks; het wordt niet als een prioriteitsgebied gezien
- door sociale partners: weinig aandacht; bij het wettelijk 'voortgezet toezicht'

(8) Van welke aard zijn deze acties?
Universiteiten en beroepsverenigingen besteden er aandacht aan bij de nascholing, maar nog niet systematisch.

(9) Is de geïnterviewde persoonlijk bij één of meer acties / oplossingen betrokken?
REGA-project: KU Leuven, IDEWE en CM zijn partners. Katrien Mortelmans (KU Leuven) werkt eraan.

(10) Dragen de acties naar de mening van de geïnterviewde werkelijk bij tot eliminering van de Blind Spot, of gaat het meer om samenwerken / verwijzen?

(11) Korte beschrijving van de acties
REGA bestudeert de perceptie en communicatie tussen huisarts en bedrijfsarts. Mortelmans doet ook onderzoek naar de optimale vorm van informatie-uitwisseling. Zij gaat na wat hierover in de wet staat. De Franstaligen hebben niets op dit gebied. Er is een blind spot voor preventie bij de huisartsen in Wallonië! Bij Franstalige huisartsen is een grotere gevoeligheid voor de vraag waar de patiënt ingeval van beroepsziekte of werkgerelateerde aandoening zijn uitkering kan halen.

(12) Zijn / worden de acties / oplossingen geëvalueerd / getoetst op effectiviteit?
Door wie, wanneer?

(13) Vraag naar rapportages, publikaties, relevante web sites.
REGA: deelverslagen (Mortelmans), vooral geconcentreerd op samenwerking BA – VA.
Er zijn plannen van IDEWE om een vervolg aan het REGA-project te geven.
De Vlammse wetenschappelijke vereniging voor huisartsen zou wel belangstelling hebben. De VWVA heeft contacten hiermee, gericht op samenwerking.

<u>C. Alain Cantineau, Straatsburg, Frankrijk, 1 april 2005</u>

(1) Naam geïnterviewde persoon: Prof. dr A. Cantineau

(2) Functie: hoogleraar

(3) Werkzaam bij: Université Louis Pasteur, Médecine et Santé au Travail
Hôpital Civil, Service de Pathologie Professionnelle, Strasbourg, France

(4) Dekkingsgraad BGZ in eigen land: industriële bedrijven bijna 100%; dienstverlening en overheid ongeveer 50%. Bedrijven moeten eens per 2 jaar worden bezocht. Visite annuelle minstens eens per 5 jaar, afhankelijk van de risico's.

(5) Herkent Blind Spot in eigen land:
- in de eerste lijn (huisarts): sommigen; niet nader te preciseren
- in de tweede lijn (ziekenhuisarts): sommige specialisten, afhankelijk van het specialisme: longartsen, reumatologen en dermatologen wat meer / vaker

(6) Is men zich het probleem bewust
- in de eerste lijn (huisarts): oudere huisartsen weinig; jongeren meer, maar weten niet hoe ermee om te gaan; vb: patiënten zeggen: het is een beroepsletsel vanwege de compensatie / uitkering
- in de tweede lijn (ziekenhuisarts)
- in de bedrijfsgezondheidszorg: bedrijfsartsen zijn zich het probleem zeer wel bewust

(7) Zijn er in eigen land acties ondernomen (of oplossingen gevonden) om de Blind Spot tegen te gaan?
- in de eerste lijn (huisarts)
- in de tweede lijn (ziekenhuisarts)
- in de bedrijfsgezondheidszorg
- door de beroepsverenigingen: de beroepsvereniging voor occupational medicine[6] heeft contacten met de zustervereningingen van cardiologen, radiologen, pulmonologen; er is in het algemeen sprake van een verbetering van de relatie met de medisch specialisten
- door onderzoeksinstellingen
- door opleidingsinstellingen: in de medische basisopleiding is er heel weinig aandacht voor occupational medicine (het was vroeger 20 uur in 4 jaar; nu nog slechts 3 uur); in de postgraduate scholing van huisartsen[7] ontbreekt het vrijwel helemaal; huisartsen kennen een verplichte nascholing; AC geeft een korte cursus over sociale zekerheid aan huisartsen
- door de overheid: ja, zie 11
- door sociale partners: de werkgevers bekommeren zich niet om dit probleem

(8) Van welke aard zijn deze acties?

(9) Is de geïnterviewde persoonlijk bij één of meer acties / oplossingen betrokken?

(10) Dragen de acties naar de mening van de geïnterviewde werkelijk bij tot eliminering van de Blind Spot, of gaat het meer om samenwerken / verwijzen?

Bij ziekteverzuim gaat het meer om verwijzen. Huisartsen en specialisten certificeren het ziekteverzuim tot 1 maand (psychiater tot 3 maanden). Zij sturen de patiënt / werknemer na één maand (of eerder indien zij dat nodig vinden) naar de sociale zekerheidsinstelling. Deze laat controles uitvoeren door verzekeringsartsen, die overigens voor deze taak géén specifieke opleiding hebben gehad. Als de werknemer het met de beslissing van de sociale zekerheidsinstelling oneens is, kan hij zich tot de rechter wenden.

---

[6] In Frankrijk is occupational medicine sedert 1984 erkend als specialisme. De opleiding omvat een volledige praktijkuitoefening (‘residency’) gedurende 4 jaar.

[7] In Frankrijk is huisartsgeneeskunde onlangs als specialisme erkend. Er is een curriculum van 4 jaar (2 jaar theorie, 2 jaar praktijk). Een wetenschappelijke beroepsvereniging voor huisartsen is er niet. Aan de Universiteit van Strasbourg is wel een associate professor in huisartsgeneeskunde.

Huisartsen of specialisten verwijzen geen patiënten naar bedrijfsgezondheidsdiensten. Incidenteel wel naar een beroepsziektekliniek zoals die in Straatsburg (Service de pathologie Professionelle, naam is misleidend: beter zou zijn: ‘maladies professionnelles’)

(11) Korte beschrijving van de acties

Overheid onderneemt acties, niet in preventie, maar slechts in zorg en behandeling van beroepsziekten. De beroepsziektenverzekering wordt geheel door werkgevers gefinancierd. De vakbonden zijn tegen het huidige systeem.

Werknemers met een beroepsziekte krijgen een uitkering van de sociale verzekering (Caisse Nationale d’Assurances Maladies). Deze beheert zowel individueel gefinancierde verzekeringen (kinderen, moederschap, ouderdom) als door werkgevers gefinancierde verzekeringen (beroepsziekten en –ongevallen).

Website, zie 13.

(12) Zijn / worden de acties / oplossingen geëvalueerd / getoetst op effectiviteit?
Door wie, wanneer?

(13) Vraag naar rapportages, publikaties, relevante web sites.

Opzet van de website www.idrs.fr , ook bestemd voor huisartsen! Coördinator: Annie Leprince. Belangrijk item is hier: kanker door het beroep.

D. Ewan MacDonald, Glasgow, Scotland, 27 mei 2005

We bespreken actuele ontwikkelingen, onderzoek en overheidsbeleid op het vlak van arbeid en gezondheid in het Verenigd Koninkrijk.

Momenteel is er veel vraag naar arbeidskrachten in Groot-Brittannië, en een zeer lage werkeloosheid. Toch is er een grote economisch niet-actieve bevolkingsgroep. 20% van de bevolking is niet actief en claimt ook geen uitkering. Onder hen zijn de vroeggepensioneerden.

In de tijd van Margaret Thatcher werden werklozen vaak gelabeld als ‘arbeidsongeschikt’. Als gevolg daarvan ontvangen tegenwoordig ongeveer 2,6 miljoen mensen een of andere vorm van uitkering wegens ‘arbeidsongeschiktheid’.
De laatste 8 – 9 jaar toont de overheid voor deze categorie speciale belangstelling.
Een belangrijke functionaris in dit opzicht is Mansel Aylward van het Britse Ministerie van volksgezondheid.

In Groot-Brittannië verlaten elke week 3.000 mensen de arbeidsmarkt. Na vijf jaar zit 80% van hen nog zonder werk.

We moeten de zaken in het juiste verband plaatsen.
De gewoonten van huisartsen (“komt u over zes maanden nog maar eens terug”) dragen bij tot de negatieve spiraal en het inactiviteitsprobleem. Werk draagt bij tot een goede gezondheid, maar klaarblijkelijk realiseert men zich dat niet.

Ewan verwijst naar het ‘Healthy return project’. Hierbinnen wordt een screeningsinstrument ontwikkeld om mensen die gevaar lopen hun werk te verliezen vroegtijdig op te sporen binnen de totale groep van personen die langer dan zes weken verzuimen.

Ewan is betrokken bij een gerandomiseerd en gecontroleerd onderzoek. 3.000 vrijwilligers vanuit het hele land, die een grote kans lopen hun werk te verliezen, zijn at random verdeeld in vier groepen, die elk een verschillende vorm van zorg krijgen aangeboden:

- een gezondheidsinterventie
- een werkplek-interventie
- een gecombineerde interventie
- de gebruikelijke zorg.

Iedereen ondergaat hetzelfde onderzoek.
De case managers waren geen medici.
Slechts 15% had een consult van een bedrijfsarts nodig.
Uiteindelijk ging 70% van de personen uit de interventiegroepen weer aan het werk.

Er zijn nieuwe overheidsprojecten onder de vlag ‘pathways to work’.

De stad Glasgow voert een capacity benefit study uit onder leiding van Ewan.
Kernwoorden hiervan zijn:

- verlaat de gebaande paden
- meer algemene gezondheidszorg
- gezondheidsverbetering
- duurzame inzetbaarheid voor werk.

Het Department of Work and Pensions (DWP) is het ministerie dat verantwoordelijk is voor de zorg voor gezondheid en veiligheid op het werk. Dit voert een health return project uit.
Het is moeilijk de huisartsen erbij te betrekken. Van 102 uitgenodigde huisartsen kwamen er slechts 2 opdagen bij een door Ewan georganiseerde bijeenkomst.

Blind Spot is een enorm probleem! Arbeidsfactoren worden stelselmatig over het hoofd gezien als het gaat over de oorzaken van ziekte. Maar men ziet evenmin dat datzelfde werk heel goed kan bijdragen aan een goede gezondheid!

<u>E. Kort gesprek met Prof. Dr. Igor Svab, hoofd van de Huisartsenopleiding van de Medische Faculteit in Ljubljana, de hoofdstad van Slovenië, 5-9-2005</u>

Na de afsluiting van het 1e deel van dit project kwam alsnog een interessant land in het vizier, namelijk Slovenië. Hoewel veel minder uitgewerkt dan de meeste andere landen maken we er hier toch melding van, omdat het een land betreft uit het voormalige 'Oostblok', oftewel één van de nieuwe landen uit de Europese Unie.
Slovenië was al opgevallen vanwege haar hoge dekkingsgraad van Bedrijfsgezondheidszorg (meer dan 80%, waarmee het Europees gezien tot de top vijf behoort, samen met Finland, Nederland, Frankrijk en België), hetgeen een goede uitgangspositie zou kunnen beiden voor het tegengaan van de Blinde Vlek voor werk door meer afstemming tussen behandelend artsen en bedrijfsartsen.
Tijdens het WONCA - Congres, september 2005 op het eiland Kos - waar wij op uitnodiging ons project hebben gepresenteerd voor de Europese huisartsen - hebben we o.a. nader kunnen kennismaken met de President van WONCA Europe, Prof. Dr. Igor Svab en hoofd van de Huisartsenopleiding van de Medische Faculteit in Ljubljana, de

hoofdstad van Slovenië, en met enkele collega's. Zij bevestigden, dat de Blind Spot ook in Slovenië een probleem was, en schetsten o.a. dat de situatie voor de 'Wende' in 1990 inhield, dat - zoals in tal van andere Oost-Europese landen indertijd - bedrijfsartsen soms ook een soort huisartsen waren op het werk .
De Sloveense huisartsen hebben de afgelopen jaren hun handen vol gehad aan het adapteren aan de nieuwe situatie, vanaf het onafhankelijk worden van Slovenië. Er lijken nu meer kansen te zijn om nieuwe thema's aan te roeren, zoals Blind Spot.

Enkele nadere gegevens over Slovenië:

Undergraduate medical studies: 5 years

Occupational medicine education within basic medical studies: 2 x 20 hours of practical exercises

Specialization in occ medicine: integrated with sports and traffic medicine (een soort HOOFDSTROOM)

CME: role for Medical Chamber of Slovenija, membership is obligate

Recertification each 7 years; credit system

160 specialized OPs in Slovenija

Voor nadere informatie over de huisartsen, zie o.a. www.drmed.org of www.euract.org

Zie ook *: igor.svab@mf.uni-lj.si*

8 Werkbezoeken

Op 28 januari 2005, in het verlengde van het ICOH congres te Helsinki, brachten we een bezoek aan het Occupational Health Centre van de stad Helsinki, gelegen aan de Sturenkatu nr 8. Doel van dit bezoek was het in de praktijk toetsen van een Finse oplossing voor het Blind Spot probleem: de integratie van general health care en occupational health care binnen de eerstelijns gezondheidscentra. Gelijktijdig met een Armeense regeringsdelegatie werden wij gastvrij ontvangen en rondgeleid door de directeur, Juha Liira. Daarna volgde een discussie met de directeur en twee stafleden: de bedrijfsarts Ritva Heilimäki-Aro en de bedrijfspsycholoog David Parland.

Het centrum zelf was goed geoutilleerd voor de eerstelijnszorg, preventief zowel als curatief.
Uit de discussie bleek dat het centrum een actief beleid voerde op het vlak van de integrale zorg voor de individuele werknemers van de stad Helsinki, en daarnaast adviezen verstrekte op het vlak van gezondheid en veiligheid in het werk aan de verschillende gemeentelijke diensten.

Het centrum treedt ook op als verwijzer naar de tweedelijns klinische zorg. En hier openbaarde zich een ware Blind Spot. De artsen gaven aan dat de informatie vanuit de arbeidssituatie, die bij verwijzing werd meegestuurd, vaak niet op waarde werd geschat t.a.v. diagnostiek en behandeling van de kalchten, en soms zelfs volledig genegeerd.

Het werkbezoek illustreert dat het nuttig kan zijn om een nationale oplossing voor dit probleem ter plaatse op zijn merites te beoordelen.

9 Symposiumvoostel voor “Milano 2006”

A proposal for a contribution to the ICOH-Centennial Congress, Milano 2006:

Work-relatedness of health problems: a Blind Spot in curative care?

How to revitalize Ramazzini’s legacy among treating physicians: a challenge for health care

Introduction

A problem generally felt within OHS is, that many treating physicians - GPs, medical specialists – pay too little attention to a possible work-relatedness of complaints or diseases. This Blind Spot can lead to sub-optimal or even bad care for the patients / employees, e.g. to a wrong or delayed diagnosis or an improper treatment.
In a country like Ghana, where OHS is hardly available, the only medical help workers with health problems can get is from curative care. In a country like the Netherlands, with an almost total OHS-coverage, workers prefer to visit their GP – although research shows a considerable Blind Spot and a lack of GP-OP-contacts.

It is in the interest of the health of all workers – in developed countries because of an ageing work force, in developing countries because of a lack of even basic OHS – to eliminate this Blind Spot. Crucial for finding solutions is to start a dialogue with treating physicians, based on a common goal: how to get the best health care for the working population.

The next ‘agenda’ might be helpful:

1. Making contact with international organisations of treating physicians
2. Trying to reach a common recognition of the blind spot-problem
3. Formulating OHS/ICOH contributions to help recognize work-relatedness and to identify suitable moments for contacts with OPs, if available
4. Looking for blind spots in OHS/OPs
5. Further exploration/research

Proposed programme

00:00 - 00:10	Introduction: the importance of the Blind Spot for the working population Prof. Peter Westerholm, Sweden
00:10 - 00:25	The Blind Spot and the global burden of occupational diseases WHO (Ivan Ivanov/Gerrie Eijkemans), Geneva
00.25 - 00.35	Blind Spot and developing countries Edith Clark, Ghana
00.35 - 00.45	Blind Spot and industrializing countries Prof. René Mendes, Brazil

00:45 - 01:10	What may general health care contribute? Prof. Chris v Weel, president of WONCA (international scientific society of general practitioners)
01:10 - 01:35	The role of clinical medicine: practice and desired changes Speaker via UEMS
01:35 - 01:55	Blind Spot: diagnosis and therapy: the Dutch case Peter Buijs, the Netherlands
01:55 - 02:05	Ramazzini revisited Prof. Giuliano Franco, Italy
02:05 - 02:30	Priority setting by voting Audience, managed by André Weel

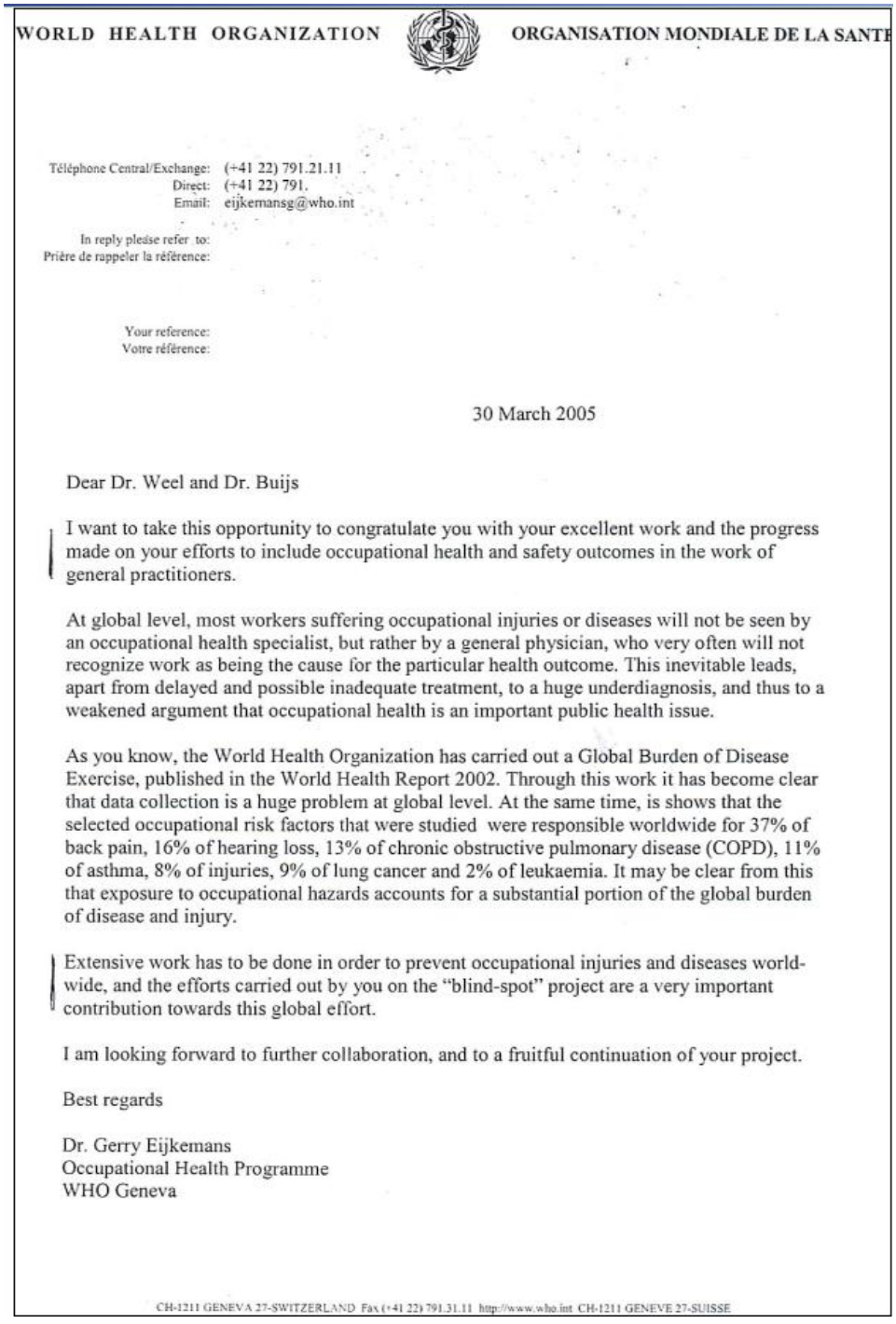
Still to be asked: Edith Clark, Giuliano Franco

27 January 2005

Peter Buijs
p.buijs@arbeid.tno.nl

André Weel
andre.weel@mediforce.nl

10 Letter of support world health organization



WORLD HEALTH ORGANIZATION ORGANISATION MONDIALE DE LA SANTE

Téléphone Central/Exchange: (+41 22) 791.21.11
Direct: (+41 22) 791.
Email: eijkemansg@who.int

In reply please refer to:
Prière de rappeler la référence:

Your reference:
Votre référence:

30 March 2005

Dear Dr. Weel and Dr. Buijs

I want to take this opportunity to congratulate you with your excellent work and the progress made on your efforts to include occupational health and safety outcomes in the work of general practitioners.

At global level, most workers suffering occupational injuries or diseases will not be seen by an occupational health specialist, but rather by a general physician, who very often will not recognize work as being the cause for the particular health outcome. This inevitable leads, apart from delayed and possible inadequate treatment, to a huge underdiagnosis, and thus to a weakened argument that occupational health is an important public health issue.

As you know, the World Health Organization has carried out a Global Burden of Disease Exercise, published in the World Health Report 2002. Through this work it has become clear that data collection is a huge problem at global level. At the same time, is shows that the selected occupational risk factors that were studied were responsible worldwide for 37% of back pain, 16% of hearing loss, 13% of chronic obstructive pulmonary disease (COPD), 11% of asthma, 8% of injuries, 9% of lung cancer and 2% of leukaemia. It may be clear from this that exposure to occupational hazards accounts for a substantial portion of the global burden of disease and injury.

Extensive work has to be done in order to prevent occupational injuries and diseases world-wide, and the efforts carried out by you on the "blind-spot" project are a very important contribution towards this global effort.

I am looking forward to further collaboration, and to a fruitful continuation of your project.

Best regards

Dr. Gerry Eijkemans
Occupational Health Programme
WHO Geneva

CH-1211 GENEVA 27-SWITZERLAND Fax (+41 22) 791.31.11 http://www.who.int CH-1211 GENEVE 27-SUISSE

Naast deze brief van de WHO ontvingen we verdere blijken van internationale ondersteuning voor ons project uit USA, Duitsland, Polen, Brazilië, Canada en de ILO (zie onder).

Van: Pransky, Glenn [mailto:Glenn.Pransky@LibertyMutual.com]
Verzonden: vr 1-4-2005 23:02
Aan: André Weel **CC:** Andre Weel; Peter Buijs
Onderwerp: RE: Update of Blind Spot Project & a request to you

I wish to encourage your continued work on Blind Spot as a critical issue in healthcare for workers. Blind Spot issues are responsible for failures to recognize and adequately work-related diseases, and appropriate disability. The public health implications are not insignificant, as failure to recognize these problems will inevitably lead to more workers developing serious and unrecognized work-related health problems. The consequences are negative impacts on individual well-being, health, as well as personal and societal economic status. The problem of Blind Spot is complex in origin, and thus has been resistant to simple solutions, even when the apparent support of all key stakeholders is present. For example, the failure of Inger Scheel's Low Back Pain Program in Norway underscores the complexity of the problem. Thus, detailed analysis and in-depth examination of a range of issues is required in order to develop appropriate solutions that will significantly impact the prevalence of blind spot-associated problems. These innovations are likely to require not only physician education at several levels, but also employer, patient, and disability system changes. Thus, I believe that Blind Spot issues are of significant importance, not only to Dutch workers, but also for others in similar situations in Western Europe and North America. Thus, there is an opportunity for you to assume leadership and focus efforts towards useful solutions in this area.
I wish you the best of luck in your endeavors in this important area.
Sincerely, Glenn Pransky, Director,Center for Disability Research, Liberty Mutual Research Institute for Safety, 71 Frankland Rd., Hopkinton MA 01748
Phone 508 497 0234 Fax 508 435 8136

From: "Schmeißer, Giso" Giso.Schmeisser@hvbg.de
To: "André Weel" <FAM.Weel@inter.NL.net>
Sent: Tuesday, April 05, 2005 5:14 PM
Subject: Blind Spot

Dear Dr. Weel,
thanks for the great efforts you have been getting out of this very important theme. It is one of the most important needs of the near future to build up strategies for connecting GPs and other therapists with the work related medical knowledge of the Occupational Physicians for the benefit of the patients and for saving money of the social security system by using synergetic effects.
So we hope that you will be able to move on this way and have the possibility to be sponsored in doing so.
Best regards, Giso Schmeisser

Dr. med. Giso Schmeisser General Practitioneer and Occupational Physician Head of Section Occupational Health Berufsgenossenschaft Institut Work and Health - BGAG - Central Agency of the Accident Insurance of the Professional Sector Koenigsbruecker Landstrasse 2
D-01109 Dresden Tel.: +49 351/457-1550 Fax: +49 351/457-1555
Unsere Seminare: www.hvbg.de/bgag-seminare Informationen:
http://www.hvbg.de/bgag

Dear Dr Weel, Dear Dr Buijs,

I am really glad that you are still able to continue your battle for the comprehensive health care for the working population. I am currently working in Turkey as an adviser for the EU- founded project "Upgrading Occupational Health and safety in Turkey". Here in my opinion adoption of the old model of total separation between curative medicine and preventative occupational medicine would even worsen the existing situation. In principle the physicians are not thought about impact of work on health since occupational medicine is not recognized specialty. Therefore postgraduate training on health and work relations of general practitioners , frequently also serving as company physicians, is very important. However , we lack sufficient example from EU countries how to prepare general practitioners to include a workplace as source of ill health and simultaneously a source of cure and better health. The new report 2004 from EUROSTAT on Work and Health Statistics in EU provides evidence that your approach reflect better challenges posed by contemporary workplaces that the old model of occupational medicine. Therefore I found your project as important contribution to necessary changes in a health care of working people.
I hope that you will be able to continue your work and provide evidence and examples of good practices in this area.

Best regards,
Boguslaw Baranski, MD, PhD Occupational Health ISAG Project at the Ministry of Labour and Social Security
Phone: + 90(312) 215 08 15 Fax: + 90(312) 215 08 04 e-mail: boguslaw.baranski@isagproject.net

---

Van: René Mendes [mailto:rene.mendes@uol.com.br]
Verzonden: ma 4-4-2005 15:53
Aan: André Weel **CC:** Andre Weel; Peter Buijs
Onderwerp: Re: Update of Blind Spot Project & a request to you

Dear Peter and André:

Thank you very much for your kind message and for the attached information and material.
Thank you, also, for including my name in the proposal for the 28th ICOH Congress, to be held in Milan, June 2006.
Congratulations for your active movements in multiple "fronts".

As regards to your request, the Brazil´s National Association of Occupational Medicine (ANAMT), currently headed by me, will be pleased in sending a letter of support/request, as part of this joint multi-institutional and international efforts. Please, let me know to whom we should send it, and what would be a wise wording to target correctly the issue. I would appreciate it very much.

Best regards,

René Mendes.

Van Prof. Dr. Louis Patry, University of Montreal, Canada

Van: lpatry@santepub-mtl.qc.ca **Verzonden:** vr 15-4-2005 16:54 **Aan:** Peter Buijs
Onderwerp: Casablanca

Dear Peter, I met you at Casablanca during the Panafrican Conference in Occupational health. we had a very interesting talk. Does is it possible to get a copy of your presentation? Blind spot for work in health care. In Quebec we are facing the same problems. The family physicians are not aware by the occupational factors. We don't really know the nature and spread of this problem in Quebec. I need to learn from you. I would like also to get other references or articles on this subjects. Does is it possible to get a copy of the position paper of your international group expert group?
Thank you very much,

Best regards,

Louis Patry
1301 rue Sherbrooke est Montréal Qc Canada H2L-1M3 E-mail
lpatry@santepub-mtl.qc.ca

Ten slotte ondersteuning van de ILO, blijkend uit onderstaande mailwisseling n.a.v. de **ILO and WHO Joint Call for Prevention Strategies,** 09-05-2005

Van: Brigitte Froneberg [mailto:froneberg@ilo.org]x
Verzonden: wo 11-5-2005 11:06
Aan: Peter Buijs
CC: Dick Putten, van; iiv@euro.who.int; Andre.Weel@mediforce.nl; Frank Pot TNO KvL; eijkemansg@who.int
Onderwerp: Re: FW: Number of Work related Accidents and IllnessesContinues to Increase

Why certainly, Peter! I thought this is what your project is all about: improving the cooperation between occupational physicians and general practitioners with a view of improved preventive (and curative/rehabilitative) occupational health care.
Improved cooperation between occupational health and public health is likely to prevent not only personal suffering but also to avoid unnecessary cost to enter-

prises and the public (see text and links below). You may be hence ensured that your project goals correspond very well to the ILO/WHO joint strategy.

Best regards Brigitte Froneberg, M.D.

International Labour Organization SafeWork / Occupational & Environmental Health Case Postale 500 4, route des Morillons CH-1211 Geneva, Switzerland Tel. (+4122) 799-8373 Fax (+4122) 799-6878 Email froneberg@ilo.org Web www.ilo.org/safework/

>>> "Peter Buijs" <P.Buijs@arbeid.tno.nl> 11.05.2005 10:45 >>>
Dear friends,
Can the Blind Spot project play a role in these joint efforts of WHO and ILO? ("Improving the health of workers has led the ILO and WHO to cooperate closely on occupational safety and health issues.")

springtime greetings! Peter

Titel: Number of Work related Accidents and Illnesses Continues to Increase
Bron: ILO Datum: 09-05-2005
ILO and WHO Join in Call for Prevention Strategies

Faced with a rising toll of occupational related death, injury and sickness, the International Labour Office and the World Health Organi-zation today mark the World Day for Safety and Health at Work by highlighting the need for a preventative safety culture worldwide. According to new estimates by the ILO, the number of job related accidents and illnesses, which annually claim more than two million lives, appears to be rising because of rapid industrialization in some developing countries. What's more, a new assessment of work place accidents and illness indicates (Note 1) that the risk of occupational disease has become by far the most prevalent danger faced by people at their jobs - accounting for 1.7 million annual work related deaths and outpacing fatal accidents by four to one.
In its latest estimates, the ILO found that in addition to job related deaths, each year there are some 268 million non fatal workplace accidents in which the victims miss at least three days of work as a result, as well as 160 million new cases of work related illness. The ILO has previously estimated that workplace accidents and illness are responsible for the loss of some four per cent of the world's GDP in compensation and absence from work.

Broken down by region, the figures indicate that workplace accidents have levelled off in many industrialized and newly industrialized countries, while some countries now undergoing rapid development in Asia and Latin America are experiencing increases. For example, the ILO analysis showed that while the number of fatal and non fatal workplace accidents held steady or declined in most regions, in China the estimated number of fatal accidents rose from 73,500 in 1998 to 90,500 in 2001 (Note 2) , while accidents causing three or more days absence from work increased from 56 million to 69 million. Meanwhile, in Latin America, a rise in the total number of persons employed and growth in the construction sector, particu-

larly in Brazil and Mexico, appear to have lead to an annual increase in fatal accidents from 29,500 to 39,500 over the same time period.
"This is happening because in the newly developing countries workers are often coming out of the rural areas, with few skills and very little training in safe work practices", says Jukka Takala, Director of the ILO's Safework Programme. "Most have never worked with heavy machinery, and some have little or no experience with industrial hazards such as electricity, so they don't know how dangerous these things can be. Yet these are elements of the kinds of jobs that are available for low skilled workers in rapidly industrializing countries." "Once countries reach a more mature stage of development, there is a shift from construction to less dangerous service jobs and the accident rates begin to level off. We are seeing this now in South Korea, for example", Takala added.

The most common workplace illnesses are cancers from exposure to hazardous substances, musculoskeletal diseases, respiratory diseases, hearing loss, circulatory diseases and communicable diseases caused by exposure to pathogens. In many industrialized countries, where the number of deaths from work related accidents has been falling, deaths from occupational disease, notably asbestosis, is on the rise. Globally, asbestos alone is responsible for 100,000 occupational deaths per year. Meanwhile, in the agricultural sector, which employs half the world's workforce and is predominant in most underdeveloped countries, the use of pesticides causes some 70,000 poisoning deaths each year, and at least seven million cases of acute and long term non fatal illnesses, as stated in the assessment.

Improving the health of workers has led the ILO and WHO to cooperate closely on occupational safety and health issues. WHO helps countries to implement preventive strategies with a network of 70 Collaborating Centres, based on its Global Strategy on Occupation Health for All.

"Despite significant improvements in health and safety in many parts of the world over the past several decades, the global challenge of providing for worker health and safety is ever greater today", said Dr Kerstin Leitner, Assistant Director General for Healthy Environments and Sustainable Development at WHO. "Significant and more long lasting health gains could be achieved if greater emphasis were placed on effective policies and programmes for primary prevention. In many locations, particularly in developing countries, these are weak or virtually non existent. From a public health perspective, prevention through safety measures is better and also less expensive not only to workers individually, but to the society at large."

The three cornerstones of WHO's occupational health work focus on supporting the development and implementation of occupational health policies and action plans to countries in strengthening surveillance, estimating the occupational health burden and in developing "basic" national occupational health profiles. Another key role is to build capacity through a network of WHO Collaboration Centres in Occupational Health making current information on various risk factors (chemical, physical, ergonomic, psychosocial, biological, accidents) widely available. Finally, WHO defines a minimum package of occupational health services that each country should establish with a focus on primary prevention.

The ILO also cited new data showing that in the construction industry, at least 60,000 fatal workplace accidents occur each year worldwide - or about one death

every 10 minutes. About 17 per cent of all fatal workplace accidents occur in this sector, while construction workers also face a number of health risks, including exposure to asbestos laden dusts, silica and hazardous chemicals. In line with ILO conventions, recommendations and guidelines, the report pinpoints the need for better planning and coordination with regard to addressing safety and health issues on construction sites, as well as a greater focus on reducing work related ill health and disease. More generally, the ILO also predicted increases in the number of young people (age 15 to 24) and older people (age 60 and over) entering the workforce over the next 15 years, and warned that workers in these two age groups tend to suffer higher on the job accident rates. The report calls for the development of specially tailored accident and disease prevention programmes for workers in these two age groups.

Special World Day commemorative activities and events are expected in more than 100 countries. Both the ILO and WHO are committed to promoting and strengthening increased cooperation at the national level between ministries of labour and ministries of health as well as businesses, workers' organizations and other civil society stakeholders.

The link to World Day for Safety and Health at Work home page can be found online at www.ilo.org/public/english/protection/safework/worldday/index.htm Further information: www.ilo.org/safework

---

11 Artikelen

Het projectplan voorzag voorts in 2 artikelen, vanuit het karakter van het project bedoeld voor de internationale wetenschappelijke bladen: één probleemstellend, om de Blind Spot - issue internationaal 'op de kaart te zetten', en één over oplossingsrichtingen, m.n. gebaseerd op *concept mapping*, zoals zojuist besproken. We hebben ons bij het opstellen van het projectplan echter onvoldoende gerealiseerd, dat die artikelen eigenlijk nu pas geschreven kunnen worden, bij de afronding van deel 1 van dit project, dat immers over de verwerving van de kennis gaat, die in die artikelen beschreven moet worden. In overleg met onze contactpersoon zal het laatste artikel, dat grotendeels gereed is, volgende week worden nagezonden, spoedig gevolgd door het 1^{e} artikel.