BLIND SPOT FOR WORK IN HEALTH CARE:
ONLY A DUTCH PROBLEM?
A Working Document / POSITION PAPER

'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[i]

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[ii] and has induced a lot of initiatives and actions, especially from the early nineties on[iii] – 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[iv] 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[v].
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 defining 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.

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[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.

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