**HEALTH AND WORK: WHAT PHYSICIANS NEED TO KNOW**

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**Introduction**

As physicians, most of us have fulfilling jobs which provide structure and meaning in our lives, status in our communities, pay our bills and reward us intrinsically. The importance and relevance of work to health and wellbeing extends across all of society. Work can facilitate social mobility, promote inclusivity and should be regarded as a basic human right: in fact, work is central to human existence1. Its importance and relevance to health is most clearly highlighted amongst workless people, who have: a higher prevalence of mental illness; worse poverty; considerably increased risk of self-harm2 and a 20-30% greater risk of suicide3. Worklessness translates into higher rates of mortality4 equating to an estimated 5-10 years’ shorter life expectancy. Reliance on welfare benefits is stigmatising, can adversely impact physical and mental health and widens health inequalities. All physicians have a responsibility to consider the relationship between work and health for their patients in order to: (a) identify whether work is causing or contributing harm to health; (b) support those with ill-health to remain in work or return to work if they so choose; and (c) recommend sickness absence or changes in work status appropriately.

**Work as the cause of harm to health**

Industrial and then Occupational Medicine developed as a specialty in response to workplace hazards that caused harm to health. Asbestosis, silicosis, berylliosis, phossy jaw, mesothelioma, leptospirosis, infection with bloodborne viruses, occupational deafness, vibration white finger, chloracne and a wide range of other occupational diseases are recognised5. In many cases, the underlying exposures are identified and have either been eliminated or strategies for their control have been mandated (protective equipment, vaccination, health surveillance) with statutory responsibility for these controls falling to employers, regulated by law. This might create the perception that work-related disease has been eradicated. Unfortunately, the reality is different: according to data from the European Union, 2.02 million people die from work-related diseases (not accidents) every year and these diseases cost at least 145 billion Euros annually6.

Although new workplace hazards will continue to be identified7,8 the vast majority of the health conditions which are now work-related (defined as caused, or made worse by, work) are not found only in the workplace e.g. mental ill-health, stress, asthma, musculoskeletal disorders9. When the disease or health outcome is not unique to the workplace, it can be more difficult to recognise and to ascribe causation and indeed to apply control measures. Whilst a detailed knowledge of all occupational diseases is outside the scope of most physicians, they should all be aware of the diseases within their specialty that might be work-related and should be competent to take a brief occupational history from all patients (Table 1). Moreover, physicians should be aware of the wide range of conditions which are “prescribed diseases” (e.g. carpal tunnel syndrome, mesothelioma, hand-arm vibration syndrome) meaning that no-fault compensation can be paid to people with evidence of the exposure(s) and of the disease and resulting disablement through the Industrial Injuries Disablement Benefit scheme10.

**Promoting work retention for patients with long-term health conditions**

Once a “patient” enters a consulting room or is admitted to hospital, it is easy for their working status to be ignored or forgotten. Stroke is the same from a medical perspective whether it is occurring in a farmer or an accountant. However, the subsequent rehabilitation of that individual can be markedly different, depending upon a range of factors including an assessment of the functional requirements to be able to do their job. After an epileptic seizure, an office worker who can use public transport is relatively easily able to return to their usual work whilst a professional driver cannot work in that capacity for at least 12 months11. There is plenty of evidence that, outside of occupational medicine, few doctors consider the work impacts of the diagnoses that they make and that patients feel that they do not get the support they need for work from their specialists12,13.

As the prevalence of co-morbidities is increasing, and as governments make legislative changes to encourage people to remain in work to older ages, there is a growing number of people trying to work with at least one, and often two or more, chronic long-term diseases. Many of the common long-term conditions might not appear to impact ability to work directly e.g. diabetes, obesity, osteoarthritis and hypertension. However, these conditions can restrict the ability to meet some physical work demands and also affect work ability by causing fatigue, burnout, coexistent mental ill-health, impacting mobility, decreasing self-efficacy and confidence. Additionally, attending for hospital and primary care appointments, investigations, blood monitoring, repeat prescriptions etc. all make working more challenging. Many patients with long-term conditions use their annual leave to attend their appointments, reducing time available for their recovery. It is important to consider whether each appointment is really necessary and whether things can be scheduled all in one visit or out of working hours to show patients that their work matters, can be good for their health and can promote their rehabilitation and recovery.

There are a range of national, regional and local services available to support workers with disabilities or long-term conditions to be able to remain in work. Physicians need not be the experts but should be aware of, and able to signpost to, services (Table 2).

**Employers: prevention and retention**

Employers have legal responsibility to protect the health and safety of their employees. Larger employers also need to provide access to occupational health services for their employees but in many cases, these are purchased from commercial providers and employers pay for a minimal level of service which often amounts to sickness absence management and/or telephone-based employee assistance programmes. It is important to be aware that an estimated 45% of the UK population do not have any occupational health support if they work in small and medium-sized enterprises. More enlightened employers do however invest in the health of their workforce through e.g. wellbeing programmes, campaigns around healthy eating, smoking cessation and/or promotion of physical activity. There are moral and ethical reasons for employers to do so, but there is also a financial one. There is considerable evidence that investment in the health and wellbeing of employees pays employers back considerably: reduced staff turnover (with its attendant costs); reduced working days lost to sickness absence and enhanced productivity (estimates range from £3 back for every £1 investment through to £10-£20 for each £1 investment). Despite these strong arguments for investment, there are unfortunately still a large number of employers offering poor-quality jobs at minimum wage, with zero-hour contracts that offer employees no paid sickness absence or leave.

**Fitnotes, sick leave and permanent work disability**

Sick leave is a strong predictor of permanent work disability14. It has been shown that people off sick for more than 6 months with a musculoskeletal disorder only have a 50% chance of ever returning to work and that after 2 years’ sickness, the proportion who return is virtually negligible. The reasons for this are complex: confidence and skills become eroded, working relationships break down, the job role is filled, the individual becomes accustomed to filling their time outside of work and may become embedded within the state benefit system so that they are “trapped” afraid to try and go back to work in case they find themselves without any income if the return fails.

As a result, the UK “sick note” was re-invented as the “fitnote” in 2010 (Figure 1). The aim was to prevent unnecessary sick leave by encouraging doctors to give some thought before prescribing or extending, sick leave1. Doctors are encouraged to provide additional advice to the employer about what aspects of their work the patient could still do. For example, a security officer with a recent exacerbation of COPD might not be fit to do the more physical aspects of their role but might be able to watch the security monitors if on shift with a colleague who could provide support. Unfortunately, recent data suggest that as few as 10% of all fitnotes offer any such advice15 so that they are failing to deliver their intended outcome. Whilst the majority of fitnotes are written in primary care, hospital doctors are required to provide them when it will prevent an appointment in primary care16. Some key FAQs about how to write a fitnote are shown in Table 3.

In some cases, an individual’s health, physical and mental capacity are no longer compatible with their job requirements. According to the latest available data from the Organisation of Economic and Commercial Development (OECD) countries, the UK is the country with the highest rate/head of population of new claims for work disability17. Patients finding their work demands exceeded by their capacity will seek advice about stopping work. Physicians may be unaware but only around 45% of UK workers have access to any Occupational Health (OH) services and around 15% can access an OH physician19 through their employer. Therefore, it is often their physician, alongside their GP, who are best placed to advise about work capability. As a rheumatologist I look back on how often my advice was to give up the work, thinking that I was offering support and advocacy. I now know better: this decision is complex and in general, peoples’ health is worse if they stop work than if they carry on19. Where possible, work should be adjusted to accommodate the individual’s needs whilst retaining them at work. This principle is enshrined in the UK Equality Act 2010, in which “disability” is a protected characteristic but many of our patients do not perceive themselves to be “disabled”. Working as little as 4 hours/week can be valuable to a person’s health and wellbeing. Not all jobs are good, or employers willing to make the necessary accommodations, and this is what hampers healthcare providers from ultimately having control over work disability but, in general, physicians should emphasise the benefits of work and offer support to remain in good work.

**Conclusion**

Work and health are inextricably linked. The Academy of Medical Royal Colleges committed to a consensus statement for action around health and work last year20. All physicians should be able to identify work-related disease, and offer support and advice to enable work participation for patients who wish to work.

**Key points**

* **Work gives value and purpose to lives and good work is good for health and wellbeing**
* **Worklessness is associated with poorer physical and mental health, poverty, self-harm and suicide**
* **Prolonged sickness absence increases the risk of permanent work disability**
* **Physicians need to enquire about their patients’ work and feel confident taking a relevant occupational history, detecting harm to health from work and enabling work participation despite ill-health where possible**

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