Commentary

Return to Work is an Important Therapeutic Goal

Brian See, [1,2]*MBBS, MPH, DAvMed*, Sin Eng Chia, [2]*MBBS, MSc (OM), MD*, Kee Seng Chia, [2]*MBBS, MSc (OM), MD*

Introduction

Sickness absence within the Singapore workforce has risen over the past decade. The proportion of employees who took outpatient sick leave rose from 49.3% in 2005 to 60% in 2015, and the proportion that went on hospitalisation leave increased from 4.1% to 6% over the same period.[1,2] Some plausible causes for this upward trend could be our ageing population coupled with an upward shift in the effective retirement age to 65; changing societal and workplace norms for work attendance;[3] and possibly, poor awareness that work is generally beneficial to health as well as recovery from illness or injury.

Work is Good for Health

There is strong evidence that most work is good for an individual's physical and mental health.[4] It is the usual means for obtaining economic resources to maintain well-being, meets psychosocial needs in our modern society where employment is the norm, and is central to an individual's identity and social worth. A cross-sectional study of the self-reported impact of long-term sickness absence found that it had a negative influence on the financial situation of 81% of respondents, and that more than 60% experienced negative effects on their leisure activities, sleep and psychological well-being.[5] Conversely, there is evidence that job insecurity and unemployment have adverse effects on health, particularly mental health.[6,7]

Sickness absence is associated with increased job loss and unemployment, with a cohort study of 60,000 Finnish workers finding that a high rate of sickness absence increased the odds of job loss among female temporary workers, as well as older permanent workers of both sexes.[8] Another study of over 50,000 Swedish workers showed that the risk of subsequent unemployment increased with both the number of spells and the mean duration of sickness absence.[9] In Singapore, a recent study by the Workplace Safety and Health Institute (WSHI) found that 83.4% of workers who sustained work injuries took more than a month of sick leave, with 24% of them becoming unemployed.[10]

Preventing Iatrogenic Disability

'Primum non nocere' – first, do no harm. While it is certainly inappropriate for doctors to issue medical certificates (MCs) of durations that are too short for serious illnesses or injuries, we should be equally prudent in not providing longer than necessary medical certification based on a misguided belief that work impedes recovery. On the contrary, over-prescription of time off work may be harmful and could increase a patient's risk of long-term disability. For example, a cohort study of over 7000 French workers observed that the odds of future depression rose as the number of spells of medically certified sickness absence in excess of 7 days increased.[11] In the case of common musculoskeletal conditions, the probability of a worker with back pain ever returning to work diminishes as the duration of sickness absence increases, with a third to half of those still off work at 6 months remaining so at the 1-year mark.[12,13] While some might argue that these reflect a natural sorting according to severity, there is evidence that long periods of withdrawal from work leads to both physical deconditioning and a reduced ability to cope psychosocially.[14]

Providing Work-Focused Healthcare

Doctors play a key role in helping their patients remain in or return to work, and their advice can have an impact on whether individuals go on medical leave, for how long, and if steps are taken to expedite their return to work. Yet, this does not seem to be well recognised within the Singapore healthcare landscape – tellingly, only 1 of the 16 Clinical Practice Guidelines published by the Ministry of Health over the past 5 years mentions the restoration of occupational function as a treatment objective (MOH CPG 1/2012 on Depression).

We believe that there is potential for doctors to improve return-to-work outcomes in 3 ways. First, clinicians should avoid unhelpful terminologies and therapeutic approaches from the outset. In general, those who receive a diagnosis will develop beliefs about their condition, and patients who

[1]Occupational Health Service, Guy's and St Thomas' NHS Foundation Trust, London, United Kingdom
[2]Saw Swee Hock School of Public Health, National University of Singapore, Singapore
Address for Correspondence: Dr Brian See, Saw Swee Hock School of Public Health, Tahir Foundation Building, National University of Singapore, 12 Science Drive 2, #10-01, Singapore 117549.
Email: ephscyb@nus.edu.sg

hold negative illness perceptions are more likely to have slower recovery times and future disability, independent of the initial objective severity of their condition.[15] To minimise such catastrophising, alarming terms such as "disc rupture" and "muscle tear" should be avoided. For the majority of common health problems, we should move from the traditional biomedical model that takes a purely mechanistic view of a broken human body with faults to be fixed, to a biopsychosocial model that aims to also identify and address patients' perceptions and beliefs, as well as possible obstacles at home or in the workplace that may impede recovery and work rehabilitation.[16] An expectation of early return to work should be encouraged, as there is evidence to suggest that such expectations improve the likelihood of and time to return to work.[17] In this regard, the Royal College of Surgeons of England, and the Royal College of Obstetricians and Gynaecologists have developed and published on their websites useful consensus-based guidelines on the usual timescales for resuming work after common procedures.

This brings us to our second point: individuals do not have to be 100% fit before returning to work. Rather, appropriate work can be therapeutic in recovery and should be viewed as an essential part of rehabilitation.[16] In supporting a patient's return to work, one should consider the patient's current and anticipated functional ability vis-à-vis his or her job demands. If there is a mismatch between the individual's functional ability and job demands, workplace adjustments may be recommended to the employer. Alternatively, should the doctor be unable to ascertain the work environment, he or she can clearly communicate the functional limitations of the individual to the employer (e.g., "unable to perform tasks that involve overhead activities" for a worker recovering from a shoulder problem) to guide the latter on possible adjustments in the context of the individual's job role. While workplace interventions may seem more relevant to physical conditions, a recent Cochrane review found moderate quality evidence to suggest that adding a work-directed intervention reduces the sickness absence duration of individuals with depression.[18]

Thirdly, Singapore's current MC-based system of sick certification is unhelpful in facilitating early return to work, as it tends to force doctors to dichotomise patients as being either completely fit or completely unfit for work. Although there is a middle-of-the-road option of certifying an individual as being fit for "light duties", the usual format of MCs does not aid doctors in communicating their patient's functional ability and limitations to employers. This has been increasingly recognised by other jurisdictions, with some moving to replace "sick notes" with "fit notes" in recent years.[19] The prescribed structure of such fit notes encourages doctors to explore with patients options for their prompt return to work, and aids in the transmission of relevant advice to employers. For instance, the recent WSHI study found that 44% of injured workers who subsequently returned to work reported fatigue symptoms, while 39% of them experienced initial difficulty in performing their original work[10]—with appropriate workplace interventions on the advice of doctors (e.g., "phased return to work"), some of these workers may have been able to return to work earlier or increase their likelihood of maintaining lasting return to work despite having residual symptoms.[20]

To strengthen the delivery of work-focused healthcare, Singapore needs doctors who understand the bidirectional relationship between health and work. In this regard, more should be done to train medical students and practising clinicians in occupational medicine; this will also benefit the ongoing total workplace safety and health drive in the country.[21] In the same vein, we should start integrating return-to-work services as a part of mainstream healthcare in tandem with the evolution of Singapore's regional health systems-based model of care. For example, return-to-work coordinators could be deployed to liaise internally with healthcare professionals and externally with employers to find return to work solutions for patients, with findings from a locally conducted randomised controlled trial supporting this approach as an effective means of improving return-to-work timings among injured workers.[22] As the cadre of doctors with qualifications in occupational medicine grows, restructured hospitals can further enhance their provision of work-focused healthcare by developing referral occupational health clinics to offer specialist fitness for work assessments undertaken by physician-led multidisciplinary teams.

Conclusion

With Singapore's re-employment age ceiling being increased to 67 from 1 July 2017 and indications that even this raised age ceiling may be abolished in time, it is imperative for doctors to recognise our role in sustaining this country's ageing local workforce by keeping them healthy when well and facilitating their early return to work when ill. Through the sum of efforts at the clinician and system levels, we will build a more work-focused healthcare system that benefits individual patients and contributes to overall national resilience.

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