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Communication between Dutch rheumatologists and occupational physicians in the occupational rehabilitation of patients with rheumatic diseases

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**CONCISE REPORT**

Communication between Dutch rheumatologists and occupational physicians in the occupational rehabilitation of patients with rheumatic diseases

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**Background:** Rheumatic diseases are a major cause of permanent work disability. In the process of occupational rehabilitation several health professionals may have a role.

**Objective:** To assess the quality and quantity of communication and cooperation between Dutch rheumatologists and occupational physicians.

**Methods:** A postal survey among 187 Dutch rheumatologists.

**Results:** 153/187 rheumatologists (82%) returned the questionnaire. They considered reducing pain and fatigue to be their major responsibility in the process of occupational rehabilitation, followed by improving work participation (68/153 (44%)) and quality of work (55/153 (36%)). Although 112/153 (73%) of the rheumatologists judged the communication and cooperation with occupational physicians as reasonable to good, 119/153 (78%) of them were willing to improve the collaboration. Perceived bottlenecks mentioned were a lack of clarity about the occupational physician’s position and activities, and the absence of practice guidelines. The most important prerequisites for improvement were found to be guarantees about the occupational physician’s professional independence and more clarity about the competence of the occupational physicians and how they used the information provided.

**Conclusion:** Dutch rheumatologists are willing to improve cooperation and communication with occupational physicians. The perceived lack of clarity about their mutual tasks appears to be a major obstacle. Thus the development of a joint education programme and a guideline for occupational rehabilitation in rheumatic diseases may be appropriate first steps towards improvement.

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Rheumatic diseases are a major cause of work disability and place a huge financial burden on the individual as well as on society. In addition, the non-economic impact of work disability on a person and his or her family is substantial. Patients with a rheumatic disease who have a health related problem in their performance at work receive non-uniform guidance as the organisation and availability of care vary among countries. This diversity is seen in the role and availability of individual health professionals as well as multidisciplinary facilities such as occupational rehabilitation teams.

In the Dutch occupational healthcare system, both occupational physicians and general practitioners or medical specialists play a part in the guidance of patients with a health related problem in their performance at work. Occupational physicians are linked to Occupational Health Services, with which all companies are legally obliged to have a contract since January 1998. At this time, 96% of companies have met this requirement. The guidance offered by occupational physicians is mainly aimed at preventing and diminishing sick leave and improving return to work.

Successful occupational rehabilitation in rheumatic diseases requires a working partnership between the patient, the occupational physician, the rheumatologist, other health professionals, and the employer. Recent studies have shown that cooperation and communication between the different physicians who participate in occupational rehabilitation need to be improved.

The objective of this study was to assess both the quality and the quantity of communication and cooperation between Dutch rheumatologists and occupational physicians and to list suggestions for improvement.

**METHODS**

All 187 Dutch rheumatologists and rheumatologists in training (further referred to as rheumatologists) who were members of the Dutch Society for Rheumatology on 1 September 1999 received a postal survey in October 1999. The survey used was based on a questionnaire developed by TNO Work and Employment, Hoofddorp, The Netherlands. This questionnaire was designed to list among general practitioners, medical specialists, and occupational physicians the frequency and reasons for contacts and the perceived bottlenecks in, and prerequisites for, improvement of cooperation. The adjusted survey for rheumatologists comprised a total of 29 questions. The first seven questions were designed specifically for rheumatologists. In the survey the following definition of a working problem was used: The experience of limitations in the performance of a paid job due to a rheumatic disease, which may lead or may have led to absenteeism from work.

**RESULTS**

A total of 153/187 (82%) rheumatologists returned the survey. The mean age of the responders was 44.4 years (SD 7.7), 65% were male and 35% worked in an academic hospital.

**Actual rheumatological practice and collaboration with occupational physicians in the case of working problems**

Overall, most rheumatologists ask their patients about their working situation regularly (77% often, 22% sometimes, and 1% never). Most rheumatologists indicated that they would actually refer their patients with a working problem to the rheumatology nurse practitioner (63%), the occupational therapist (44%), the physical therapist (34%), the social worker (22%), or a vocational rehabilitation team (25%).
contrast with the availability of the mentioned health professionals (89–100%), vocational rehabilitation teams were available to only 28% of the rheumatologists.

Rheumatologists indicated that reducing pain and fatigue was considered to be fully (66%) or partially (32%) part of their task. Improving work participation and quality of work, shortening ill health and giving guidance on ill health retirement were indicated as fully part of their task by 44% of the rheumatologists.

Table 1 presents the frequency of contacts between rheumatologists and occupational physicians, the way contact is made and by whom, and the overall judgment of the contacts and the reasons for contacting the rheumatologist by the occupational physician. Only 18% of the rheumatologists were familiar with the contents of the guidelines of the Royal Dutch Medical Association (KNMG) about the exchange of sociomedical information, 42% had heard about them, and 40% were not familiar with them. Of the 18% of the rheumatologists who were familiar with the guidelines, 57% said they worked well in daily practice.

Figure 1 presents four of 11 probable bottlenecks, which were mentioned as important by more than half of the responders. The other seven bottlenecks presented which were considered to be important bottlenecks by fewer than 35% of the rheumatologists were not knowing the occupational physicians personally, the fear of a patient pressing charges when information is provided orally without prior consent or when the occupational physician is passing on the provided information to a third party, a lack of financial compensation for written information, the occupational physician’s only goal is to get the patient back to work as soon as possible, rheumatologists have a general lack of knowledge about work related disorders, commercialisation of Occupational Health Services, and lack of a relationship based on mutual trust between occupational physicians and their patients.

<table>
<thead>
<tr>
<th>Table 1 Contact between rheumatologists and occupational physicians. Results are shown as percentages</th>
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<tbody>
<tr>
<td>Contacts between rheumatologists and occupational physicians</td>
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<tr>
<td>Frequency of contacts over the past 4 weeks, median (range) (n=153)</td>
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<tr>
<td>Initiative for making contact by the rheumatologists (n=153):</td>
</tr>
<tr>
<td>Never</td>
</tr>
<tr>
<td>Seldom</td>
</tr>
<tr>
<td>Often</td>
</tr>
<tr>
<td>Always</td>
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<tr>
<td>Contact is made by rheumatologists (n=85) by:</td>
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<tr>
<td>Telephone only</td>
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<tr>
<td>Mail only</td>
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<tr>
<td>More by telephone than by mail</td>
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<tr>
<td>More by mail than by telephone</td>
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<tr>
<td>Both in equal proportions</td>
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<tr>
<td>Reasons given by rheumatologists for occupational physicians to contact them (n=153):</td>
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<tr>
<td>To get more information about patients’ complaints</td>
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<tr>
<td>To get a prognosis about the duration of work incapacity</td>
</tr>
<tr>
<td>To get more information about current treatment</td>
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<tr>
<td>To get information about disabilities of the patient related to return to work</td>
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<tr>
<td>To get additional information needed for a medical examination</td>
</tr>
<tr>
<td>To plan a joint strategy for treatment and vocational rehabilitation</td>
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<tr>
<td>To get additional information needed for filling in a report</td>
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<tr>
<td>To make an annotation about current treatment by the rheumatologist</td>
</tr>
<tr>
<td>To shorten the waiting list</td>
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<tr>
<td>To suggest a second opinion</td>
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<tr>
<td>Overall judgment of the contacts with occupational physicians (n=140):</td>
</tr>
<tr>
<td>Good</td>
</tr>
<tr>
<td>Reasonable</td>
</tr>
<tr>
<td>Fair</td>
</tr>
<tr>
<td>Bad</td>
</tr>
</tbody>
</table>

Figure 1 Perceived bottlenecks in the communication. Eleven probable bottlenecks were listed. Four bottlenecks mentioned by more than half of the responders to be important are presented here: 1, information provided may be used with the aim of rehabilitation but also for legislation of absenteeism; 2, occupational physicians may serve employers more than employees; 3, lack of clarity about occupational physicians’ tasks; 4, no guidelines about cooperation in the process of vocational rehabilitation.
improve cooperation with other doctors. Of 232 occupational physicians also indicated a willingness to
examined in a previous study.
the opinions of occupational physicians have already been
about their mutual tasks appears to be a major obstacle.
This study indicates that Dutch rheumatologists feel it is nec-
ecessary to improve cooperation and communication with occu-
pational physicians. However, the perceived lack of clarity
provided; 6, guidelines about indication for cooperation,
communication, and job delineation within the vocational
rehabilitation process.

Prerequisites for improvement of collaboration with occupational physicians
Most rheumatologists stated that it was important to improve cooperation with occupational physicians (78%). Cooperation is already sufficient according to 6% of the responders, 7% said they did not need better cooperation because all the information could be provided by the patients themselves, and 9% of the rheumatologists thought that better cooperation was only needed in the early stages of rheumatic diseases. In the survey 10 prerequisites for improvement of cooperation with occupational physicians were listed. Figure 2 presents the
six conditions for improvement which were mentioned as
important by most of the rheumatologists. The four prerequi-
sites for improvement which were mentioned by less than 43%
of the rheumatologists were the possibility for communication between rheumatologists and occupational physicians without the patient’s prior consent, a financial compensation for providing written information, a special budget to pay emergency consultation on request of the occupational physi-
cian, and the organisation of special meetings to get to know each other.

DISCUSSION
This study indicates that Dutch rheumatologists feel it is nec-
essary to improve cooperation and communication with occup-
local experiments. The results of our study emphasise the need for rheumato-
gists to join in actively with the initiatives already taken.

Authors’ affiliations
P D M de Buck, J M W Hazes,* T P M Vliet Vlieland, Department of Rheumatology and Medical Decision Making, Leiden University Medical Centre, The Netherlands
R J van Amstel, P C Buijs, J H W Maasen, TNO Work and Employment Hoofddorp, The Netherlands
J H W Maasen, Occupational Health Service Leiden University, The Netherlands
F J H van Dijk, Department of Occupational and Environmental Health, Coronel Institute, Academic Medical Centre University of Amsterdam, The Netherlands

*Current address: Department of Rheumatology, University Hospital Rotterdam, The Netherlands.
Correspondence to: Dr P D M de Buck, Leiden University Medical Centre, Department of Rheumatology, C4R, PO Box 9600, 2300 RC Leiden, The Netherlands; pdmdebuck@lumc.nl
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REFERENCES

Apart from lessening the burden of disease by treating pain
and fatigue, rheumatologists see it also as part of their task to
improve the quality of work, to decrease the duration of sickleave, and to prevent permanent work disability. In the light of
this willingness to contribute actively to the occupational
rehabilitation process, it is striking that cooperation between
rheumatologists and occupational physicians is currently
rather one sided. It appeared that for most contacts,
information is provided by rheumatologists on request of the
occupational physician only. These findings are in accordance
with the results of a previous study among other medical spe-
cialists. Whereas rheumatologists and other specialists (neu-
rologists, orthopaedic surgeons, and psychiatrists) seldom or
never take the initiative to contact an occupational physician,
rehabilitation specialists appeared to take the initiative for
contact far more often.4 11

The rather passive role of rheumatologists so far may possi-
bly be explained by a number of factors. Rheumatologists all
mention the lack of information about the occupational phy-
sician’s position and activities and the absence of guidelines or
protocols about cooperation and communication, and existing
guidelines appear to be known to only a few rheumatologists.
The bottlenecks in the communication as perceived by
rheumatologists are largely similar to the obstacles mentioned
by other medical specialists.11 13 Occupational physicians, on
the other hand, have indicated in a previous study that medi-
cal specialists have too little knowledge of Occupational
Health Services and relevant legislation, do not know what
they can expect from occupational physicians, and do not take
into account their patients’ jobs.

In the Netherlands the problem of insufficient cooperation
and communication between occupational physicians, general
practitioners, and medical specialists has been acknowledged
by several parties, including health policy makers. General
practitioners and occupational physicians subscribed to a con-
sensus statement to improve cooperation and communication.
The Dutch Government gave a financial grant for postgradu-
courses, regional projects, and implementation of guide-
lines. The results of the present and previous studies underline
the need to develop common concepts and guidelines between
medical specialists and occupational physicians also. A study
group has been formed comprising chairmen of the Society of
Medical Specialists and the Dutch Organisation of Occupa-
tional Physicians. They have agreed to develop specific educa-
tion programmes, common guidelines, and local experiments.
The results of our study emphasise the need for rheumatolo-
gists to join in actively with the initiatives already taken.

Figure 2 Ten prerequisites for improvement were listed. Six
prerequisites for improvement mentioned to be important by more
than half of the responders are presented here: 1, overall health
status of the patient must be the major issue; 2, professional
independence of occupational physicians; 3, guarantees about the
use of given information; 4, specificity about the abilities of
occupational physicians; 5, clarity about the goal of information
provided; 6, guidelines about indication for cooperation,
communication, and job delineation within the vocational
rehabilitation process.