

## **The Worker as a Patient - Hearing the Worker's Voice in Medical Research**

Providing information and advice about occupational health and safety is one way to promote a safe and healthy work environment. This is exactly the role that the Canadian Centre for Occupational Health and Safety (CCOHS) fills. This essay will focus on "the step before", since it is research into occupational health and safety issues that helps to identify and define, at a fundamental level, what is the best advice to give a worker.

Although research into the measurement of health care quality and outcomes in the field of occupational illness is in its infancy globally, and particularly in Canada, the importance of considering patient preferences for the achievement of certain outcomes has long been recognized (Brook et al, 1977). Outcomes no longer only encompass clinical endpoints eg. mortality, but also include other components such as functional status, general well-being, and satisfaction with care (Tarlov et al, 1989). Well-being (the subjective assessment of quality of life and health), and functional status (the capacity to perform tasks and activities) are primary concerns of patients, their families, and clinicians (Wells et al, 1989). Because functional status and well-being are highly valued by patients they are essential outcomes in addition to measures of clinical endpoints.

A fundamental challenge in measuring and improving quality in occupational health care is the differing perspectives of system participants (Deitchman et al, 2001). Usually the medical model deals with a 2-stakeholder system: the patient and the physician. In the case of workplace-related illness and injury, the reality is that there are not only 2 stakeholders; it is definitely a multi-stakeholder model including the patient, physician, compensation or insurance provider board, and the workplace.

Much research has been done to elaborate the patient-physician relationship, and the fact that patient and physician views and opinions often differ (Laine et al, 1996, Brown, et al, 2000; Johnston et al, 1995). Some work has touched upon the impact on outcome when there are noncongruent perceptions or attitudes between these two stakeholders (Starfield et al, 1981; Stewart, 1995). Consensus may not even exist within the physician group.

On the other hand, there has been little done to clarify the patient-physician relationship in a work-injured or ill population (Plomp, 1993); progressively less on the workplace-patient relationship and the insurer-patient relationship, and a virtual paucity of research toward understanding the complex inter-relationship among the variety of stakeholders.

Nonetheless, usually it is clinicians and researchers who develop the various models for defining quality and outcome, based on theory, or group consensus. However, there is no assurance that their judgments validly reflect those that might be made by other stakeholders (Brook et al, 1977).

Sometimes this process includes patient viewpoints, for example, by conducting focus groups. Whether the other stakeholders i.e. insurance boards or workplaces use the same schema or model to define a "good outcome" is virtually unknown. Employers and insurers may think of "quality" care in terms of cost savings. For workers, access to care or restoration of physical function may be most important. Feuerstein et al (1993) suggest employers may be primarily interested in return to productive work as an outcome.

Gartland (1988) notes that insurers, employers, and public policymakers believe that treatments providing temporary symptomatic improvement often used by the medical community are inappropriate because they do not impact outcomes such as work status or job retention.

Thus the different stakeholders could have entirely different views of what would indicate ideal system performance despite the presumed position that all stakeholders have the 'best interest of the worker' at heart. Outcome and system performance can therefore only be assessed if such disparate views are confirmed and then reconciled. Some qualitative thinkers might argue that reconciliation is unachievable so perhaps a better goal would be recognition of differences.

So who is interested in which outcome measure? What is the impact on health care when stakeholders in an occupational health setting hold different views of what constitutes quality care, or of what defines a good outcome? The answers remain unknown. In general, what constitutes high quality medical care and good outcome for a work-related illness or injury remains to be clarified.

Overall, the key point that this discussion underscores is the need for the inclusion of workers' viewpoints in medical research. Including workers in research not only as subjects, but also as decision-makers in the process of conducting research makes a strong statement about the importance of worker's opinions which I think honorably reflects the values of Mr. Dick Martin.

I am an Occupational Medicine resident. I enjoy research and I plan to investigate occupational health care delivery as a significant part of my career. Mr. Martin shared many qualities that any fine physician would be proud to also exemplify. In a USWA tribute, Manitoba Federation of Labour President, and former Steelworkers' Local 6166 member, Rob Hilliard (USWA website) was quoted as saying, "He (Mr. Martin) always put people first ... he was a caring and sincere individual... If he thought even one worker could benefit from his efforts, he would go out of his way to help". Mr. Martin was instrumental in establishing the MFL Occupational Health Centre.

Without the answers the questions asked above, the conceptual framework for advancements in understanding quality and outcomes in Occupational Medicine is not adequately laid. Answers to these questions may provide a theoretical explanation for the lack of improvement in clinical outcome in many occupational illnesses. This may translate into better patient care by serving as a starting point for discussion around consensus building the stakeholders such that all are actually working towards the same goal.

Mr. Martin was no stranger to consensus building. He has been called, "a politician and a strategic thinker who has an incredible knack for finding common ground," by Burrows, a member of United Fishermen and Allied Workers Union (UFAWU)/Canadian Auto Workers (CAW) and the CLC Environmental Committee. While he was the CLC officer responsible for health and safety, Martin helped in the legislation of a national WHMIS right to know standard. Mr. Martin felt that, "... this was a major accomplishment. Getting federal *and* provincial governments along with labour *and* management to agree to this legislation was quite a feat." (WHSC website)

The result of the inclusion of workers in even the most fundamental research can foster consensus-building among stakeholders and the clarification of common goals; objectives with which Mr. Martin would certainly have been satisfied.

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