

Industrial rehabilitation of dermatitis patients

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Industrial rehabilitation is identified as an integral part of the process of patient resettlement. The organization of the Government-sponsored Employment Rehabilitation Service is described. The low incidence of dermatitis as seen by medical advisers in that Service is explained. Ways in which employment medical advisers can provide complementary support to consultant dermatologists is suggested.

Key words: contact dermatitis – employment medical adviser – incentives – industrial rehabilitation – occupational dermatitis.

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Industrial rehabilitation is a term which, even in medical circles, may convey a different meaning to different people. Rehabilitation is often used to cover both medical and industrial rehabilitation, as the two represent a continuous process – medical rehabilitation being phased out and industrial rehabilitation beginning when the employee is fit to return to a work environment. However, industrial rehabilitation is also applicable to people in good health.

In a handbook on the subject (Department of Employment 1959) industrial rehabilitation is defined as a term describing “the change which is brought about when someone who is for the time being incapable of earning his living, is able to become self supporting again”. This definition is acceptable where the previously sick or injured rehabilitee is concerned, but it does not cover the industrial rehabilitation of the

able bodied unless some qualifying phrase such as “in acceptable employment” is added.

Although industrial rehabilitation often involves a change of occupation, it may only involve a change of attitude. Perhaps the Monday morning readjustment to a work situation after the weekend break could be termed the most commonly recurring do-it-yourself industrial rehabilitation experienced by the able bodied!

Many people may want to change their job because they dislike one or other aspect of it, or think they do, to the extent that it can no longer be termed acceptable employment. Therefore, a great deal of do-it-yourself industrial rehabilitation is an unidentifiable part of what is collectively known as personnel turnover. It is perhaps important to realise this do-it-yourself component of industrial rehabilitation as we

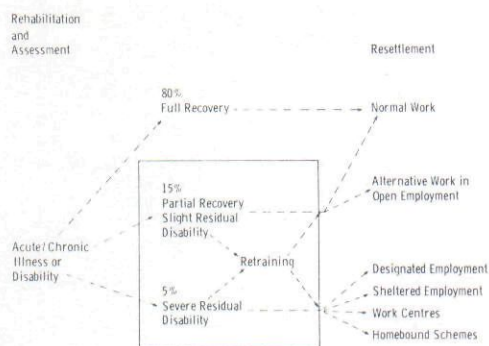


Fig. 1.

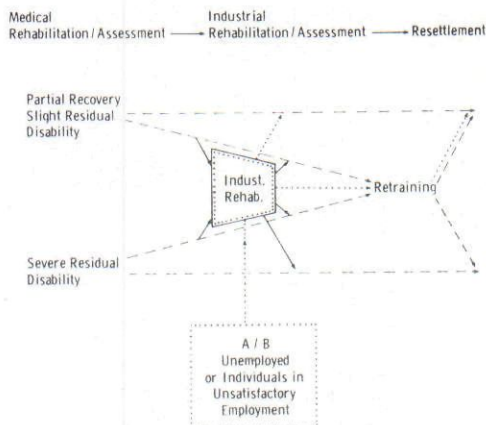


Fig. 2.

consider the industrial rehabilitation of the patient with dermatitis.

To demonstrate diagrammatically the outcome of illness or injury in terms of degree of recovery and residual disability, and therefore the linkage between medical rehabilitation and resettlement, a diagram produced by Professor Alexander Mair a few years ago is used (fig. 1.) The details of the resettlement are not of particular interest in relation to the subject matter of this article. The ringed area is shown again in fig. 2 to demonstrate the place of industrial rehabilitation as a *pre-training* or *pre-placement* means of assessment both in respect of the medical rehabilitee and the able bodied.

A brief general comment on the organization of industrial rehabilitation in Great Britain seems appropriate. There are in the United Kingdom, 26 Government Employment Rehabilitation Centres (ERCs) undertaking industrial rehabilitation; some of them are located alongside Government Training Establishments now known as Skillcentres. (As it is necessary to repeat this term Employment Rehabilitation Centre, the abbreviation ERC is used. Similarly for convenience, the abbreviation EMA for Employment Medical Adviser is used).

The centres simulate a factory environment and assessment of work capacity is

carried out under conditions similar to those that rehabilitees are likely to find when they start work again. The key staff of these centres are essentially non-medical, *i.e.* an Executive Manager, an Occupational Psychologist, a Chief Occupational Supervisor who is a technical man in charge of workshops and workshop supervisors, a Social Worker and a Disablement Resettlement Officer. The medical support is provided by Medical Advisers and Nursing Sisters of the Employment Medical Advisory Service.

The function of the EMA is to provide medical guide lines for the industrial rehabilitation of the disabled person. With vocational guidance from the Occupational Psychologist aided by psychometric tests and practical assistance from the workshop supervisors (who are craftsmen selected for their ability to deal with people), the individual's physical and mental capacity is assessed. As the individual discovers the work to which he or she is most suited and demonstrates this to him or herself, self-confidence can be restored. At the end of the course a report is made. This is discussed with the individual concerned and then sent to the local Employment Office in his

Table 1. Dundee 1973-74. Intake of rehabilitees

	Male	Female	Total
Number of Rehabilitees	498	126	624
Number presenting with dermatitis as main disability	1	0	1

or her home area with a copy to the doctor referring the case. Now I shall consider more specifically the industrial rehabilitation of dermatitis.

In our ERC records we recognize a main presenting disability, major subsidiary disabilities and other disabilities. From the records of rehabilitees attending the Dundee ERC during 1973/74 (Table 1), out of a total of 624 there was only one rehabilitee with dermatitis as a main presenting disability, although in about twelve others a skin condition was given as a major subsidiary or other disability. Further confirmation of the insignificant incidence of dermatitis as a presenting disability at ERCs is seen from other figures (Department of Employment Gazette, 1974). Skin diseases do not appear as a specific entity on the original table, being submerged in the miscellaneous "other group". The original table is too big to show here, but Table 2 compares the incidence of skin disease with the most important groups in the Department of Employment Gazette and draws comparisons between Dundee and the national figures. The low incidence of skin disease, far less dermatitis, as a presenting diagnosis is obvious. (A high incidence of cardiovascular disease in Dundee compared with the national figure is perhaps an artefact, *i.e.* Professor Mair and my predecessor Dr. C. A. Gourley conducted a special survey of this group.)

Table 2. Skin Diseases Compared with Main Disability Groups.

	Expressed as a %	
	Dundee 1973	National 1973*
Injuries, Diseases and Deformities of Skeletal System	25.7	23.1
Psychoneurosis, Personality Disorders, Mental Subnormality and Psychosis	24.8	24.3
Organic Nervous Disease including Epilepsy	9.9	10.8
Cardiovascular Disease	14.6	9.9
Respiratory Diseases	7.4	6.0
Diseases of Digestive System	4.6	2.7
Skin Diseases	0.6 ⁺	●
	(2)	

* E.R.C. Admissions, Extracted from Dept. Of Employment Gazette, November 1974.

⁺ One Dermatitis; One Psoriasis

● Not mentioned as separate entity.

In the middle sixties, a survey of cases of asthmatic/bronchitis and dermatitis seen at the ERCs in the then Birmingham Division of the Factory Inspectorate showed the incidence of dermatitis as a presenting diagnosis to be of the same low order (Kipling 1964).

So we have consistent evidence of a low incidence of dermatitis as a main disability in rehabilitees attending ERCs. This is strangely inconsistent with the comparative frequency of occupational dermatitis; and so the question is: what happens to the patient with dermatitis who requires industrial rehabilitation? This question will be considered from two points of view; first, the consumer, that is the patient, and second, from the view point of those involved in the primary and consultant care of the patient with dermatitis. From the point of view of the potential rehabilitee, in Table

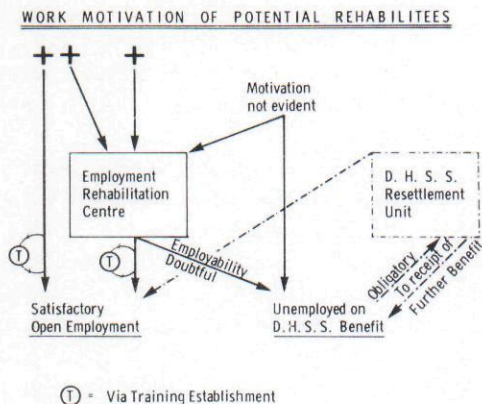


Fig. 3.

2 it will be noted from the disabilities most commonly presented by rehabilitees that the majority are recovering from disabling physical injuries or severe physical or mental illness. Is this a disabled population into which the patient with dermatitis fits? I think not.

Then there is the question of motivation to return to work, which in terms of industrial rehabilitation is diagrammatically presented in fig. 3. The more highly motivated are in the do-it-yourself category and usual-

ly do not need any assistance in finding satisfactory new employment. On the contrary, when motivation to return to work is not evident, the individual may not wish to attend an ERC. Does the majority of potential rehabilitees with dermatitis, who do not attend an ERC, come into those categories, *i.e.* motivation ++ or no evidence of motivation? I have the clinical impression that this is so. Attendance at the ERC is, of course, voluntary. The Department of Health and Social Security Resettlement Units are essentially for non-medical problems of unemployment of over one year's duration and under certain circumstances attendance is obligatory. I mention this largely to accentuate the voluntary nature of attendance at an ERC.

The subject of motivation automatically raises the financial incentive to attend an ERC. Table 3 shows the permissible allowances (as on 30 March, 1975) granted to a rehabilitee and compares them with the social security benefits paid when the individual is unemployed or sick. It is realised that to attend an ERC, the individual must be given a final certificate by his General Practitioner that he is fit to return to work,

Table 3.

	Sickness Benefit	ERC Allowance	Invalidity Benefit
Basic Wife's Earnings	£18.40 p.w. up to £5.30 p.w.	£19.65 p.w. no limit	£26.95 p.w.* to £13.09 p.w.
● Earnings Related Supplement	+ve	+ve	-ve

* Paid if disability continues for over 6 months

● Range

Income £501 p.a.	Supplement £0.01 p.w.
↓	↓
£2,400 p.a. or above	£9.37 p.w.

All subject to increase on 1/4/75, but differential likely to remain similar

and thereby that person ceases to be eligible for sickness benefit. The potential rehabilitee in the example, a married man with two children is normally eligible on entering the ERC for an allowance slightly higher than his social security benefits. As with sickness benefit, there is no limit imposed as to his wife's earnings. He or she is also eligible for earnings related supplement. However, if he is unfit for work for more than six months, his invalidity benefit for which he then becomes eligible may make the ERC allowance unattractive. Under such circumstances the decision to attend or not to attend the ERC will depend on the individual's motivation to go back to work.

At the Contact Dermatitis Investigation Unit at Belvidere Hospital in Glasgow, this invalidity benefit differential did, on several occasions, result in potential rehabilitees declining attendance at an ERC. One other point in connection with the consumer is that most individuals with dermatitis are very much aware that a known history of dermatitis is liable to create unfortunate difficulties in finding a job. Therefore, it is inevitable that a considerable amount of concealment or at least low profile presentation of the history of dermatitis occurs, and this is somewhat incompatible with the scrutiny of attendance at an ERC.

Now here are a few comments from the other view point, that is those responsible for the primary and consultant care.

First, in any consideration of 'who does what' in Industrial Rehabilitation, due recognition must be paid to what is done by works medical and nursing staff. Dr. D. S. Wilkinson, in his talk at the Society of Occupational Medicine in London in March, 1975, impressed on us the importance he associated with the dermatitis patient being seen early. Undoubtedly the dermatologically orientated works medical and nursing staff often fill this role and practise what can only be called early industrial rehabili-

tation. That can apply equally to the General Practitioner. However, direct communication between the General Practitioner and the employer is not often easily established.

When a patient is certificated as having a Prescribed Industrial Disease, the EMAS office receives a copy of the Department of Health and Social Security notification. Over a period of about 16 months, some 134 cases of Prescribed Disease 42 (Skin) were followed up in the area covered by an EMA. Not one such case was referred for industrial rehabilitation to an ERC.

Looking back on various contact dermatitis clinic experiences with Dr. W. Frain-Bell in Dundee, with Dr. E. Cronin and Dr. C. D. Calnan's clinic at the Institute of Dermatology in London and with Dr. S. L. Husain at the Belvidere Hospital in Glasgow, it seems that the industrial rehabilitation of dermatitis is rather unique in the degree to which the clinical consultant must be involved. In dermatitis, the sequence of treatment (the early suppression of the skin reaction), the investigation of potential causal factors and the subsequent rehabilitation must, of necessity, be compounded into one to achieve clinical stability, the pre-requisite to effective industrial rehabilitation. In terms of knowledge of cause and prevention of clinical relapse, this compounding in dermatitis demands that the consultant dermatologist treating the patient must be involved in the details of industrial rehabilitation. The potential occupational industrial exposure is the dermatologist's concern alongside the other environmental spaces at home or during leisure activities.

In the absence of a satisfactory alternative rehabilitation system, the industrial rehabilitation of problem dermatitis patients has until now been undertaken, and must continue to be undertaken, largely by the consultant dermatologist through his out-patient clinic. Perhaps the concept of the

EMAS has created a new situation which in terms of industrial relations might be referred to as one requiring some job demarcation! In fact, the consultant dermatologist now has in his EMA colleague, a useful field ally whose neutral non-aligned interest in the employer/employee inter-phase, and his ready access to the place of work, allows him to become a useful pathfinder, through whom such information on the patient's work space – of critical importance medically – can be readily passed to the consultant. The present Health and Safety at Work Act appears to make this more possible.

If some of the difficulties discussed here can be overcome, what in particular at this time can an ERC do in the industrial rehabilitation of the patient with dermatitis? As stated the EMA's function is to provide medical guide-lines. However, with continual changes in chemical technology it is almost inevitable that the Consultant investigating the contact dermatitis may be one step or more behind. Dr. C. D. Calnan (1975) seemed to provide an interesting example of how this can arise when he mentioned his finding that certain grades of the commonly used solvent trichlorethylene were found to contain epichlorhydrin as a stabilizer.

The medical guide-lines in the industrial rehabilitation of patients with dermatitis are liable to be strewn with uncertainties. Can ERCs offer any help in selected cases? As a part of their administrative armament,

ERCs have a recognized trial mechanism – called job rehearsal. Under this umbrella rehabilitees can work for a few weeks at a selected job with a potential employer without being in the employment of the employer: that is, the rehabilitee remains on ERC allowances. Provided the trial is a success, he can then take up employment in the normal way, having established the sort of proof a hesitant, reluctant employer or employee requires. If this rehabilitation mechanism can be shown to be of use in the rehabilitation of patients with dermatitis, and there seems every likelihood that it can, perhaps on the next occasion an EMA has the honour of speaking at some such symposium, he will be able to provide more evidence of the industrial rehabilitation of dermatitis at ERCs than has been provided (Table 1).

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