PERMANENT ACCOMMODATION AND OCCUPATIONAL HEALTH PHYSICIAN COOPERATION

By Tamara Keenan and Liz Scott

Permanent Accommodation decisions can have far-reaching implications beyond just the individual employer and the employee's role at work. There are many workplace, psychological, and social aspects to be considered. The topic of permanent accommodation in the workplace, roles and responsibilities of the key participants including the occupational health nurse (OHN) and occupational health physician (OP), and employee social impacts, are key to the series of very important steps in accommodation decisions. Applying a label of 'permanently disabled' should not be taken lightly or without a full and thorough investigation. There are many parties involved in the confirmation of permanent restrictions including the primary physician, specialist, physiotherapist or psychotherapist, occupational health nurse, return to work professional, occupational health physician, and sometimes legislators.

Permanent Accommodation

There are occasions that may require accommodation either on a temporary or permanent basis.

Temporary accommodations are better called transitional return to work to prevent confusion in the terminology and should always have a well-defined return to regular work plan in place. The use of permanent accommodation should be reserved for those who have achieved maximum medical recovery (MMR).

Permanent Accommodation can assist in the sustainment of employment for people with disabilities. Accommodation decisions are a function of a complex array of factors. Key among these factors is the need for access to the workplace job demands, activities of daily living, underlying objective medical information, and workplace barriers (Chandola & Rouxel, 2021; Gates, 2000). Consideration also needs to be given to social and financial elements. An approach to accommodation that does not consider the social context ignores the consequences on individual self-esteem, self-efficacy, and well-being. It has been shown that 'labels' can have negative long lasting impacts (Bandura, 1988; Chandola & Rouxel, 2021; Corbière et al., 2019; Dong et al., 2020; Klevanger et al., 2018). When someone is labeled as a person with a disability, they may start to personify that label. Labeling can also alter the treatment of the individual. When medical professionals perceive the condition to be chronic in nature, a different view of the patient is often adopted (Cullen et al., 2018; Labriola et al., 2007; Løvvik et al., 2014; Stratil et al., 2018; Wilski & Tasiemski, 2016). In the workplace, labels and accommodation may also have a broad-reaching impact on relationships with co-workers. This has repercussions for individual job performance, job satisfaction, and work retention, as well as overall work group productivity.

In Canada, laws aim to protect workers living with a disability and require organizations to make reasonable accommodations for workers with a disability. Workplace accommodation is defined as modifications and adjustments to a job or the work environment when barriers have not or cannot be removed (Conference Board of Canada, 2012, p. 24). Permanent accommodation, when designed and implemented appropriately, is an effective means of supporting and maintaining the sustainability of employment for persons with disabilities. Permanent accommodation depends on the objective needs of individual employees, objective functional information, the essential job demands, and the design of the workplace (Chandola & Rouxel, 2021; Lagerveld et al., 2017; Nancarrow et al., 2013; Telwatte et al., 2017). Availability of flexible workplace policies and practices, modified work duties, assistive devices and technology, environmental/physical adaptations, as well as training and support all make a difference (Nevala, Pehkonen, Koskela, Ruusuvuori, & Anttila, 2015; Padkapayeva et al., 2016). However, accommodations can be problematic when employers and healthcare practitioners take a narrow focus on individual employee limitations / capabilities, rather than overall workplace context and culture (Gates, 2000; Sanford & Milchus, 2006).

Barriers may exist at the organizational level (negative organizational attitudes towards employees with chronic con-

ditions), the employee level (employee reluctance to collaborate with employers in dealing with work-related barriers), and the healthcare provider level (lack of accuracy, objective findings, or workplace understanding) (Björk Brämberg et al., 2019; Nevala et al., 2015; Stratil et al., 2018).

Workplace parties, clear policies, and procedures, and outlined roles and responsibilities, can be instrumental in successful accommodations. Clear accountability structures and collaboration between occupational physicians and occupational health nurse participants are vital to success (Bosma et al., 2021; Mustard et al., 2017; Nancarrow et al., 2013; Stratil et al., 2018).

Policy and Procedures

In order to mitigate barriers and guide permanent accommodation design there is a need to have clear policies, procedures, and practices in place to guide the accommodation process. Communication in the workplace also creates favourable results (Corbière et al., 2019; Gates, 2000; Mustard et al., 2017).

In designing the policies and procedures it is important to make them workplace-based with the integration of health care practitioners to provide guidance on capabilities. It may be of interest to understand the impact of leading with legislation (Halonen et al., 2016; Lefever et al., 2018; Nielssen et al., 2019). In a study conducted surrounding the outcome of formal versus informal request, it was found that the odds of acquiring the requested accommodation was significantly higher - relative to other strategies - for requests made informally without mentioning legislative mandates (Dong et al, 2020).

Another important consideration when building a permanent accommodation policy and procedures is the importance of having a process in place that includes the workplace parties. In a recent study, an intervention was designed to take into account the social nature of the accommodation process (Dong et al., 2020). They used 12 workers who were on short-term disability leave with a psychiatric diagnosis plus their work groups. The use of a psychoeducational model, includes an intervention to educate the work group about what it means to work with a disability; provides a safe environment where the worker with a disability and coworkers can share concerns about the impact of the accommodation on the group; information about the accommodation process; and specific strategies to help the worker with a disability best meet essential job requirements (Dong et al., 2020).

> The accommodation process cannot stop at placement.

In another study the importance of process was demonstrated using an intervention mapping exercise with five key steps:

Step 1. A needs assessment to define the problem and explore participants' perceptions.

Step 2. The program outcomes, and objectives for the employees that required accommodation due to a chronic condition were specified.

Step 3. Return to work methods, and practical accommodations were designed.

Step 4. The actual intervention was completed. This included a plan to teach the organization about creating a supportive work environment.

Step 5. Integration of follow-up meetings.

The conclusions of the study proved having a process provided practical tools for the facilitation of sustainable employment for employees with chronic conditions (Bosma et al., 2021).

Another important consideration in developing the policy and procedures is the encouragement of the workplaces to focus on social and environmental barriers that can make employment difficult; not on medical diagnoses and symptoms. At the same time, health professional verification of an underlying condition and workplace activity limitations may be sought (Gignac et al., 2021). Findings suggest that the accommodation process cannot stop at placement. This requires participants to take on roles such as educators, negotiators, trainers, and evaluators (Gates, 2000).

Key Participants – Roles and Responsibilities

Workplace parties have a strong role to play in successful accommodation and transition back into the workforce. The OHN and OP have roles to play to ensure the accuracy of the objective medical information; report details of the objective capabilities, functional or psychological; and verify the suitability of the essential duties of the job or an alternate job. If there is a lack in any of the key areas, an effort needs to be made to close the gap. As an example, if the capabilities are not clear, perhaps an additional assessment is required. If the decision on maximum medical recovery is not clear,

clarity will be required. Has every reasonable attempt been made to assist the individual in returning to full function? Is the physical demands analysis complete and accurate for the job match? These are important aspects given the individual's life trajectory based on the permanency of accommodation decisions. The OHN and OP have the burden of ensuring capabilities are accurate, so the accommodation design is accurate, well thought out, and communicated properly to the workplace parties.

Health care participants should use evidence informed best practice guidelines, understand, and adhere to the policy and procedures, collaborate, and communicate. Sometimes a challenging situation emerges for the OHN when they are not confident that the OP has considered all of the complexities of the accommodation or if the recommendations are not consistent with the objectives. The OHN is put in a situation of having to have frank discussions with the OP, which is sometimes challenging due to layers of social stratification (Amick et al., 2017; Jetha et al., 2016; Stratil et al., 2018).

The rift between doctors and nurses has been glamorized over the years creating its own barrier of preconceived notions. A recent study was conducted on the facilitators and prerequisites for successful cooperation between the OP and OHN. While all participants reported a positive perception of their own professional group, there were numerous negative perceptions about other groups, especially regarding OPs. OP negative perceptions included:
1) apparent conflict of interest between employer and employee;
2) lack of commitment to patient outcomes;
3) lack of useful specialized knowledge which could have a bearing on accommodation outcomes; and
4) distrust on the part of employees and employers. (Nastasia et al., 2020; Stratil et al., 2018).

The authors also found divergent perceptions regarding roles, responsibilities, and capabilities among the specialist groups. Both negative and conflicting perceptions about roles were characterized as barriers to cooperation by participants in the study (Stratil et al., 2018).

Several studies, including systematic reviews, identified facilitators for successful inter-professional cooperation, especially concerning the cooperation of doctors and nurses. These facilitators include mutual trust, mutual respect, collegial partnerships, understanding the practice of the other group's profession, awareness, and valorization of other professionals' contributions, as well as perceived benefits of cooperation. A lack of clear understanding of the professional role and responsibility, knowledge levels, negative, and

prejudicial attitudes were mentioned as a barrier to cooperation (Nancarrow et al., 2013).

Characteristics underpinning effective interdisciplinary team work include: clarity on the objective, common level of understanding, positive leadership and management attributes, communication strategies and structures, joint training and development, appropriate resources and procedures, appropriate skill mix, individual characteristics and defined roles that support interdisciplinary team work, and respecting and understanding that the OHN and OP have the shared goal of successful reintegration of the employee to sustainable work. The use of clearly defined roles and responsibilities, reliance on policy and procedures, open discussion on roles and responsibility, and evidence based best practice will assist in the resolution of conflict surrounding the permanent accommodation discussion (Cancelliere et al., 2016; Corbière et al., 2019; Dewa et al., 2016; Stratil et al., 2018).

The use of goal driven strategies can reduce the conflict between the OP and the OHN. A clear understanding of functional capability, maximum medical recovery, job demands, and joint understanding of the goals will assist in the appropriate placement into permanent accommodation.

Conclusion

Permanent accommodation should not be taken lightly due to the impact on self-efficacy, sustainability of the workplace participation, and many health and social impacts of exit from the workforce. A clear understanding of the process and roles for the OHN and OP will assist in well-designed accommodation based on objective medical capabilities and appropriate job matching. Workplace participants also have a vital role in return to work and should be engaged to make permanent accommodation a success.

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