In the move to managed health care, the interaction between the occupational health physician and employee/patient has mimicked somewhat the brevity of the medical visit experienced external to the worksite. Whereas, in former days, there was no sharply predetermined time to be devoted to the individual seeking care, today’s hurried schedules usually allow 15 min or less per visit.

Such sharp temporal demarcation allows the ailing person to declare his or her health concerns, a hasty examination by the care provider, the issue of appropriate prescriptions for medication and some counsel concerning the clinical findings, with, possibly, allusion to the patient’s inappropriate health-affecting lifestyle. In industry, there may be additional precautions offered concerning the performance of certain job functions in light of the presenting disorder.

While such a visit will meet the physical needs of the patient, rarely are basic emotional, behavioral, family or interpersonal difficulties explored. Yet, it is the underlying problem that is most bothersome to the client and which has had no inquiry. The employee leaves, still burdened by the unresolved dilemma that he or she may not even connect to the presenting ailment.

An invaluable opportunity to be of true assistance to the patient is passed, often not just because of time or schedule constraints, but because of discomfiture felt by the practitioner in the exploration and guidance required by these problems whose etiology may be completely outside the workplace.

It has been the practice of the writer, on completion of the worker’s visit, to utilize some extra moments to inquire ‘How are things at home?’ or ‘How are things going on the job?’ There is a brief period of silence, followed by a low-pitched ‘Oh, that son of mine’, or ‘Things are not so hot at home.’ The door is open, thereafter, to exploration of the true problem troubling the individual and to professional guidance for the rectification of the current dysfunction at home or at the workplace.

An employee was shown his X-ray films as part of a survey of personnel exposed to asbestos, past or present. The findings were explained and reassurance was given as to the minimal changes encountered. On completion of the clinical aspects of the visit, the query was placed regarding conditions at home and the response of ‘Oh, my daughter . . .’ was given. Further questioning revealed that the late teenager had not spoken to her family for many months. It was arranged that she visit the occupational health service for an interview.

It was anticipated that the young woman would be an angry, mute, non-communicative person, with whom interaction would be difficult. To the contrary, on entry, the daughter was bubbling with smiles and energy, talked freely, and welcomed any expressed concerns by her parents. She played guitar, composed music, was highly articulate and willing to have the family situation rectified. Counseling was initiated and communication reinstalled within the family.

On another occasion, on completion of the clinical aspects of the visit, the same question was put to the employee concerning events other than those at the workplace setting. An extremely concerned response was given regarding a 15-year-old daughter who had a presumably uncontrollable, spasmodic, persistent, non-productive cough (48 coughs per min) and who communicated solely by written notes. She had been studied by 14 specialists at a variety of hospitals without change in the condition. Following the obtainment of records, appropriate referral was made to a university medical center and with indicated clinical tests and psychotherapy, all difficulties cleared. Subsequently, the young woman became a physician.

In all comparable instances the employed parent(s) were extremely grateful for the directive care given and for the lifting of the heavy emotional burdens occasioned by difficult situations away from work.

These examples are offered to lend credence to the belief that a few moments of concern about the real problems perplexing workers can be totally rewarding to the
occupational health service, the distraught employees’ families and to the involved persons themselves.

In a recent ‘Piece of my mind’ in the Journal of the American Medical Association, the author wrote, ‘[We] physicians are still incredibly blind to a critical area of professional skill—our ability to listen to and talk with our patient. [The] number one complaint from the patients was always the same—they said that far too often we medical colleagues don’t take the time to really understand how they feel’ [1].

In parallel with this observation is the late Arthur Ashe’s comment in his autobiography, that while serving on hospital boards he had ‘seen studies of patients’ complaints that list at the absolute top the doctors’ chronic unwillingness to listen to them’ [2].

Practitioners of occupational medicine can readily alter this public view by utilizing those extra moments to seek the true problem behind the patient’s need for help. Many a clinical visit is made without the employee’s ability to, or being given the opportunity to, express the true underlying quandary that is affecting his or her home and family life and job.

May those few extra moments be used to change some seriously damaged lives and restore well-being to troubled employees and their loved ones.

References