"Excuse me, doctor, but your chargeslip is showing!"

This article highlights workers' experience of medical practice. While many of the points raised are applicable to most health professionals, this article focuses specifically on the medical practice of doctors. The author, Dr Lesley London, is currently employed by Food and Allied Workers Union (FAWU) to work in the Ray Alexander clinic.

Health services for workers

It has been estimated that 11% of South Africa's workplaces (employing 52% of South Africa's workforce) provide some form of occupational health service. Of these, an unknown proportion would employ either full-time doctors or make use of local general practitioners through part-time appointments. Most doctors involved in providing health care to workers at factory level are thus employed by management, the few exceptions being doctors employed as part of union-linked benefit funds or as part of service groups or directly in unions in non-clinical health and safety structures. Outside of the factory, workers make use of the state and private sector services. With the growing crisis in the state service workers are increasingly being forced to use the private sector, either as cash patients or as a small but growing constituent of medical aid schemes in South Africa.

Workers and the state services

Doctors and health workers in state services are frequently insensitive to workers' needs. Common complaints are that patients are often not given certification for work or are made to wait in long queues, frequently missing their shifts or transport to work. Workers may wait the entire day to be seen, only to be sent home at 5 pm when the non-emergency medical staff go home.

Assumptions are sometimes made by hospital staff about the existence of facilities

in the community or in the factory for follow-up treatment.

The racism and overcrowding experienced at state hospitals force many workers to rely on private GP's despite the extra cost involved. Nonetheless, many of the problems experienced by workers are applicable to doctors in both private and public sectors.

Workers' problems with doctors' practice

Attitudes towards sick leave

Workers frequently complain that the doctor they consult seems more concerned with minimising sick leave than with their condition. A recurring complaint is that the doctor did not book them off work when they felt really ill, or only booked them off for a short period of time. It is not unheard of for a worker with a fractured foot to be sent back to a standing job the next day. The potential savings in reducing time lost from production may constitute the prime reason for the introduction of factory-based clinical services. Doctors who are more likely to grant sick leave may easily be excluded by management and their medical certificates are often systematically queried.

Members of the FAWU medical benefit fund act out their experience of doctors' attitudes to workers.

On the other hand, workers sometimes describe doctors writing out sick certificates without examining them. This is the "how-many-days-do-you-want?" approach and is experienced by workers as equally undermining when they feel they have a genuine medical problem.

Clearly, the problem that workers are not perceived as being really sick, but rather as pretending, is common.

Management can influence doctors' attitudes

In some cases, the doctor's attitude to the patient may be directly influenced by management. Management may inform doctors in advance that a "trouble-maker" is coming to see them. The nurse at the factory is frequently the one to do this "priming" since she/he has an accepted medical role to play in assisting the doctor with relevant information. Under such circumstances, it is difficult for a busy doctor to take time to distinguish opinion from reality. At the same time, many doctors are only too willing to accept such information at face value.

Quality of care

Another problem is the poor quality of medical care. Workers often describe how they are not examined properly or are examined in a cursory and dismissive fashion. This is often due to a combination of factors ranging from racism or sexism, to fundamental language, cultural and class differences between doctor and patient.

Workers receiving treatment from private practitioners are frequently cash patients and the incentive for doctors to see as many patients a day as possible undermines concern for individual patients.

Workers who are part of medical schemes, are usually part of benefit funds which have limited scales of payment. Workers believe they may be discriminated against, either because of these limited scales or because of disputes which may arise between the doctor and the scheme itself.

"Pain tablet" for all ills

Another common grievance is that of "one-pill-cures-all-ailments". Workers frequently notice that no matter what their complaint, they receive the same treatment (usually a pain tablet). This may reflect a mismatch between the workers' expectations and the dictates of a rational drug policy on behalf of the doctor. This is reinforced by poor doctor-patient communication. However, it all too frequently reflects the true nature of many doctors' medical practice, where financial concerns for profit lead to economy at the expense of thorough care.

Workers' right-to-know

Few doctors treat the workers' right to know of the hazards to which they are exposed with any serious concern. The current system of occupational health care maintains a patronising and top-down system of information control, excluding workers from effective participation in matters affecting their health. While workers in many foreign countries have won this right by law, South Africa continues to assume that management and the medical profession can be trusted to safeguard workers' health. This misconception is borne out by the tragic experience of South Africa's asbestos workers who now suffer the legacy of the highest rates of asbestos-related cancers in the world as a result of exposure to asbestos dust at the workplace some 20 to 30 years ago.

The nightmare of Workmen's Compensation

A particular problem with compensation for injuries is the practice of sending workers to the "company doctor". Management may choose a doctor for the worker whom they know will be more sympathetic to management's concern for production. This has major implications for the compensation claim as the worker may not change once he or she has started at one doctor. Furthermore, the area of rehabilitation and assessment of disability arising from injuries at work is notoriously poorly handled by doctors who are frequently unaware of the functional disability experienced by the worker. In addition, facilities for rehabilitation in the community are grossly neglected and many workers sustaining permanent disability are left without on-going support.

Another source of immense hardships for workers is the delay in payments to the worker arising from failure or tardiness on the part of the doctor concerned to submit documentation needed by the WCA Commissioner. Often injured workers may be off work for long periods with no income, causing huge financial difficulties.

The limits of conventional models of medicine

The World Health Organisation (WHO) recognises a range of syndromes of occupational illness, from specific disease entities caused by production (eg: silicosis) to illness acquired outside the workplace and simply aggravated by the work situation. The majority of doctors today, however, are largely ignorant of occupational causes of illness. Doctors frequently fail to recognise that relatively minor problems such as varicose veins can become an unbearable problem in the context of prolonged standing at work, or that production schedules may directly interfere with treatments (for example, workers treated with diuretics for hypertension may not take their tablets because they are not allowed out to the toilet during work periods).

"If you can't measure it, you can't be sick!"

Another failing of the "medical profession" is the inability of doctors to deal with ill-defined entities such as backache and musculo-skeletal disorders. There is a growing realisation that much disability arising from the workplace takes the form of precisely such ill defined entities as repetition-strain-injuries (RSI's) and neuropsychiatric syndromes caused by chronic low level exposure to solvents at the workplace. For many years the medical profession and industry resisted the notion that repetitious movement and static body posture could cause musculo-skeletal disorders. Today RSI's are recognised as a major epidemic in Britain and Australia.

Workers often know instinctively what has made them ill at work but, because it does not fit with conventional medical wisdom, doctors will insist on knowing better (until the literature becomes too overwhelming to ignore).

Health promotion and prevention

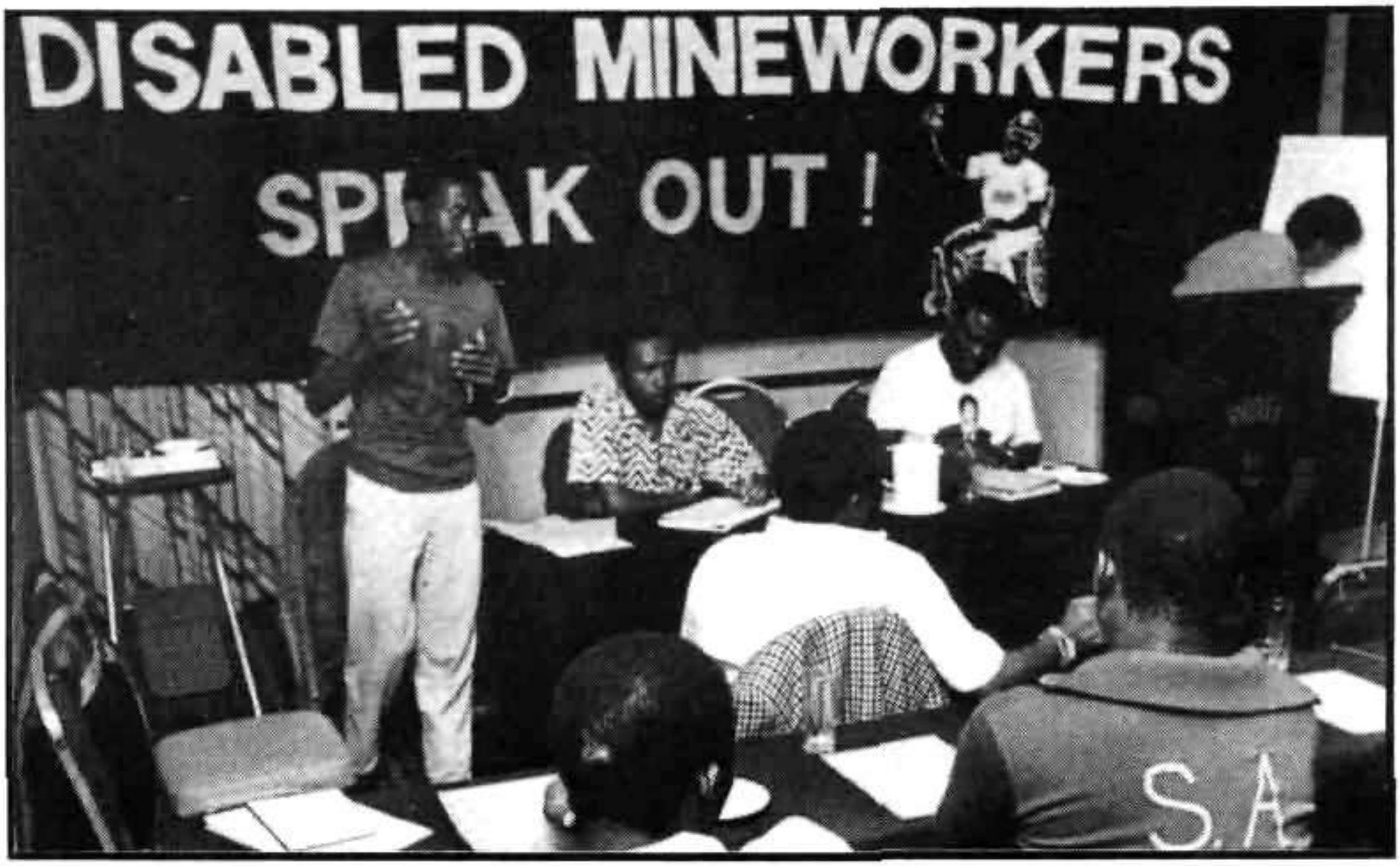
Doctors are often unable to adequately deal with health promotion, prevention of illness and injury and rehabilitation. This is largely reflective of medical training and status attached to curative medicine, both by doctor and by (worker) patient. However, it is also the direct result of the nature of private practice where doctors are rewarded per patient seen and not for disease prevention. Occupational health services (OHS) are rarely planned as part of a comprehensive primary health care service and rarely address the needs of workers' families or those of the surrounding community.

Why are doctors unable to meet the health needs of workers?

To begin with, the vastly different class backgrounds of doctors and workers can affect attitudes, values and understanding of health and disease. However, beyond the individual doctor-patient relationship, there remains a structural limitation to the ability of doctors' medical practice to meet the health needs of workers.

Historically, the role of occupational health services has been primarily to ensure a workforce healthy enough to remain productive. To meet this objective, the OHS will aim to keep the workforce in as reasonable a state of health as is financially justifiable to the company and will attempt to reduce possible areas of labour conflict around health and safety. At the same time, it enables management to comply with certain statutory requirements and to economise on statutory levies.

At all times, worker participation and satisfaction is not seen as a priority. Doctors in the factory have, in this context, been identified with management interests.



Workers with permanent disabilities are often left without ongoing support.

In some cases, the medical personnel within companies occupy specific management positions (eg: directors of medical divisions, loss control officers) and the blurring of management and medical responsibilities is almost complete.

Doctors as "independent" professionals?

However, even where doctors are striving to maintain a semblance of "independent" professionalism, (whether as full-time employees or as GP's appointed on a part-time basis), they are still responsible for providing certain crucial services that fulfill management functions:

- Doctors are frequently responsible for performing pre-employment examinations on prospective workers, and unfit workers are excluded by management. This is unlike the situation overseas where the medical report is used to place workers in jobs appropriate to their health status (a pre-placement examination). In the context of massive unemployment in South Africa, the doctor, willingly or unwittingly, becomes drawn into the control of labour.
- In providing limited factory-based services the role of many doctors is to economise on costs and to cut back on absenteeism and to process compensation injuries with the least loss to the company.
- Much of the routine medical work is purely curative and makes no attempt to address

issues of monitoring hazards of production. Where medical monitoring programmes are offered they are usually a substitute for effective engineering controls. Under such circumstances, medical personnel tacitly accept the position of management that "it is too expensive" to affect changes to production.

The value of providing health services to workers is obviously important at an ideological level. Management can be seen to "care" for their workers. Ironically, it is precisely this credibility that is undermined by the problems experienced by workers at the hands of the "company doctor".

Ethical contradictions and the "neutrality" of doctors

Many of the dynamics of factory medical services raise ethical contradictions for medical practice, such as the lack of choice afforded to workers (eg: with Workmen's Compensation Cases and in-house doctors) akin to a closed shop and the question of confidentiality of reports.

Since doctors are employed by management they are contractually obliged to give management access to medical reports in terms of common law, yet this contradicts the ethical requirement for confidentiality in the doctor-patient relationship. Under these circumstances it is difficult to see how such doctors remain neutral. There is an unavoidable conflict in the workplace between the interests of management and labour. Health services at the factories have come to fulfill specific tasks in the context of this conflict.

What options are open to concerned doctors?

For doctors who are concerned about the imbalances and inequalities of medical practice at the workplace, there are a number of options available. Some suggestions are:

- Be sensitive to the possibility of work-related illness in patients seen at your rooms/ work.
- Make contact with unions and advice offices.
- Ask to inspect workplaces.
- Take on cases as WCA when employers refuse to acknowledge responsibility, even if this implies no guarantee of payment.
- Ensure confidentiality of records as far as possible. Draw up summary reports to management containing only the minimum pertinent information.
- Ensure workers-right-to-know of any hazards at the workplace.
- Be prepared to be accountable to the workforce. This could include meeting with the workforce or shop stewards or being elected by the workforce as the factory doctor,

Ill-defined entities such as back strain due to frequent bending are often not taken seriously by doctors.

rather than simply accepting an appointment from management.

For doctors directly employed by management the challenge of making one's medical practice sensitive to workers' needs is constrained by the structural limitations of being "the company doctor". However, it is not to say that efforts to address some of the problems raised above are not worthwhile.

Doctors' medical practice will only change fundamentally in the context of a change in the health services as a whole. This obviously implies the need for political changes on a broad scale to address the needs of all South Africans. With the unbanning of political organisations and the return of exiles, we are currently witnessing the beginning of a period of profound political transition. We also have an expanding and militant union movement. It remains to be seen if the medical profession can meet the challenge posed to us to provide medical care that meets the needs of South Africa's workers.

References

1. Sitas F, et al. *Occupational Health Services in South African Manufacturing Industries: A Pilot Study*. American Journal of Industrial Medicine, 1988: 14: pp.545-557.
2. Le Nevez C. Strange L. *Delivering Workplace Solutions in OHS: The Workers Health Centre Model*. Journal of Occupational Health and Safety of Australia and New Zealand 1989: 5(1): pp.45-52.