

The Activity of Occupational health physicians in relation to the Task of Keeping People Affected by MSD in Employment: a Gender Effect?

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Abstract. As part of research into occupational doctors' practices in the field of MSD prevention, the objective is to explore the differences between occupational health physicians in practices between men and women employees' ability to return to work. Diagnosis is based on what they are able to do or not do in their day-to-day life. The way the employees are questioned is often stereotypical depending on family roles and gender-related characteristics: housework for women, doing DIY or gardening for men. A part from this stereotypical style of questioning, the occupation health physician' actions when writing out ability restrictions for men and women are often linked to the employees' work context. Indeed, employees can be exposed unequally to MSDs, and this sometimes leads to real job issues. Yet, underlying these common practices, the way the back-to-work medical visit with a female or male employee is organised differs according to the occupational doctor's gender. One of the main differences is the way the doctors manage their relationship with the employees.

Keywords: gender, MSD, occupational health physician, activity

1. Introduction

For over two decades, the prevention of MSD has been a subject of international concern with research being carried out in several disciplines (biomechanics, physiology, epidemiology, ergonomics, etc.). Although knowledge with respect to the etiology of this phenomenon (notably the link between physical and psychological aspects), and how to prevent it, is improving all the time, the number of cases of MSD is nevertheless growing. Today, research needs to focus on the need to produce knowledge about action and intervention [1, 2, 3] as illustrated by the papers presented at the last PREMUS 2010 conference. As part of research on the MSD prevention practices of occupational health physicians, financed by the French National Research Agency, we have tried to better understand the activity of these key actors in order to explore the kind of room for manoeuvre they have to set up effective and lasting MSD prevention.

Our focus is on the production of knowledge about the diversity of physicians' practices in relation to their own characteristics (age, seniority, gender, professional careers, etc.) and their work context (work organisation, collective, instruments, etc.) as these can broaden the scope of possible actions in terms of prevention. Recognising and debating this diversity through discussion work on the rules of this profession is one means of enhancing the skills of occupational health physicians and providing them with resources for action.

2. Theoretical Framework and Objective

In this theoretical framework of links between the diversity of physicians' practices and the effectiveness of MSD prevention, the question of gender and work in an ergonomic approach to activity would appear to be especially important to understand. For many years, approaches in sociology of work distinguish between (biological) sex and (social) gender [4, 5]. The aim is to underline the importance of social construction in the way stereotypes are attributed to men and women and the ways work is divided according to gender (for example, women can be found more in service jobs while men are more building construction or industrial blue collars workers). [6] More recently, ergonomic studies with a gender-sensitive approach have tended to revise the initial

approach of sociologists by underlining the differences in the way a job is performed, not only because of different biological characteristics, but because of a different relationship to the task in hand, the possibilities for individual and collective action [7], notably with the notion of regulation [8] and the amount of room for manoeuvre in work situations, including the situation outside of paid work.

Thus, our hypothesis is that by analysing the differences in practices of male and female occupational health physicians when exploring their activity, we will be able to explore new possibilities for effective MSD prevention. Such prevention could become lasting but only on condition that it is requested by the physicians themselves, is debated among them and internally thought through by each and every one.

In a special edition of *Work* (to be published in 2012), a group of ergonomists show that the strategies employed to reconcile life at work and life at home are to be found in the work situation. Indeed, several studies criticise approaches that presume a dichotomy between professional and personal life. Activity carried out in the professional sphere aimed at balancing work and family depends on individual regulation (e.g. varying workloads, anticipating unexpected events, managing work-related constraints, etc.), as well as collective regulation (e.g. mutual aid, sharing of workload and effort, etc.), which are only possible in certain forms of work organisation. The question is: if occupational health physicians include these work-activity-based methods of work-family balancing when performing diagnostic and preventive actions, would this not facilitate the way MSD are managed? We shall explore how male and female occupational health physicians understand the way in which male and female employees build up compromises in the working environment to preserve their health when faced with the multiple requirements and demands of their work situations.

The objective of this paper, therefore, is to study the differences in practices between men and women physicians and to see how these differences can help us to question MSD prevention effectiveness in the day-to-day activity of physicians as they question employees during their medical visit following a long period of sick leave. More specifically, we focus here on how physicians' questioning relating to life at home in relation to men and women's professional activity and possibility of collective activity can help to regulate the physicians' own

activity and contribute to building a certain amount of room for manoeuvre enabling more effective prevention of MSD.

3. The Context of Occupational Medicine in France

Occupational health physicians in France have two main missions:

- *Clinical activity.* In the consultation activity, they systematically see employees who have just been recruited and then again at least every two years for an occupational health check-up. During this medical visit, the physician examines the employee with the aim of making sure that he or she is fit for the job they have been assigned to and suggesting any possible adaptations required to the work station or posting to a different job.

- *Action focused on the occupational environment.* They act as advisors to company heads or their representatives, to employees and to staff and social service representatives for all occupational health-related matters. Their scope of action covers the improvement of working conditions in the company, the general hygiene of the establishment; the adaptation of workstations; the protection of employees against any physical and mental stress; and the early prevention of disorders in relation to employees' professional activity in the establishment.

In this article, we shall only address the occupational health physician's consultation activity, which is specific to our occupational health system in France.

The socio-political context of occupational medicine in France has been marked by a number of major reforms over the last twenty years. These have been due to influence of employers' orientation and a lack of staff in the profession owing to demographic changes (in 2009, over 55% of occupational health physicians were over 55 years old), a questioning of the effectiveness of occupational medicine in terms of occupational health, the emergence of new intervention professions [9,10] and the industrial context in which workloads have increased and conditions have led to new forms of stress hence increasing the incidence of occupational health disorders (MSD, mental health, etc.). Based on a real activity approach [11], our research focuses on this context where the future of occupational medicine is being questioned, and notably the value of company medical visits.

Occupational health physicians are mainly women, having opted for this specialisation owing to the limited working hours and the work/life balance they allow.

4. Methodology

Our approach is based mainly on observing occupational health physicians during their consultation activity. The analysis of results is qualitative and explores the differences observed in the way occupational health physicians consult with employees, according to whether the physicians are men or women. The material collected from the observations performed during the consultations was used during face-to-face interviews with each physician and then discussed within a collective of volunteer physicians. In all, we organised ten meetings with this physicians' collective to talk about their consultation activity.

To run these meetings, we formed a group of 8 volunteers from 3 occupational health sectors in France. The occupational health physicians are 6 women and 2 men aging mainly over 55 years old (see table 1).

	Male health physicians	Female health physicians	Total
Under 40 years old	0	1	1
From 40-55 years old	0	1	1
Over 55 years old	2	4	6

Table 1: Breakdown of occupational health physicians observed according to age and sex

Each physician was observed individually during their medical consultation with employees over the course of at least one working day according to a protocol defined by the national physicians' association and the data protection commission in France. In all, over 60 h of occupational health physicians' consulting activity were observed.

During a day of medical visits, occupational health physicians perform different types of interviews with employees: upon recruitment, during the yearly or two-yearly check-up, and following sick leave. The objective of these interviews is to give the employees a certificate authorising them to do their designated jobs, or not,

or indicating any restrictions in job performance. During these observations, we witnessed 17 interviews with employees returning to work after sick leave caused by MSD, 9 by male physicians and 8 by female physicians. In this category, the returning employees observed were more often women (13) than men (5) (see table 2).

	Male occupational health physicians		Female occupational health physicians		Total
	Visit following sick leave	Yearly check-up or recruitment visit	Visit following sick leave	Yearly check-up or recruitment visit	
Male employees	4	10	1	7	22
Female employees	5	8	7	20	40

Table 2: Breakdown of interviews according to the sex of the occupational health physician, the type of visit and the sex of the employee.

We shall now analyse in detail some of the consultation interviews between the physicians and the employees affected by MSD, notably those whose personal life is included in the examination. To be more specific, we compare the way the male and female physicians ask male and female employees about their personal lives in order to assess whether they are fit to go back to their job, in which case they receive a certificate of fitness for work.

5. Results

What is Said about the Activity

When the collective of physicians is asked whether there are any differences in the way they manage their questions about employees' personal lives as part of their consultation activity during a back-to-work medical visit, both male and female physicians say there are no differences and that they perform the same type of questioning of female and male patients. Questioning employees about their personal lives appears to be a means of diagnosing employees' ability to fulfil their job conditions and guides the occupational health physician's actions. Neither do the physicians believe there to be any difference in the way they question employees about their personal lives according to whether the employee is male or female.

To go beyond the preconstructed discourse of the male and female physicians when they talk about their common practices, we focused on the real activity observed in the consultation room. The aim was to study how the physicians queried male and female employees' management of their work/life balance during the back-to-work medical visit according to whether the physicians was a man or a woman.

Observations with Women Occupational Health Physicians

However, during our first observations we saw that as part of the back-to-work visit the male and female physicians do not assess employees' fitness to return to work in the same way, with their diagnoses focusing on different things that employees are able or unable to do in their private lives.

Establishing a detailed understanding of the activity helped to better identify how questioning focusing on an employee's personal life helps a physician with his or her diagnosis and allows them to act on the employee's job with the ultimate goal of preventing MSD.

With a female employee

When women physicians are assessing a female employee's fitness to return to work, the diagnosis is based mainly on the employee's ability to reconcile her professional life and her private life. For example, one woman on part-time sick leave following a shoulder problem is interviewed by female physician AM. The issues addressed during the consultation concern her new job conditions (in terms of stress, learning and relationship with colleagues) and the way the employee feels about being on part-time sick leave. The objective of the interview is to prepare the woman to return to full-time work within 3 months. The woman physician queries the employee about how she manages her time between work and home and warns her about the possible difficulties she may encounter in terms of this work/life balance should she return to full-time work (notably with respect to child care). The occupational health physician's exploration of how the employee anticipates possible future difficulties provides the physician with the means of regulating a possible failure in the woman's return to full-time work owing to these difficulties.

The actions of physicians when filing restrictions about employee fitness are often limited by the work context itself. For example, in some highly

feminised sectors of activity, such as cleaning, child care or individual care, it is very difficult to impose any restrictions with respect to the job as this may lead to employees losing that job. Indeed, such jobs are often uncertain and involve atypical working hours. This often means that occupational health physicians have very little room for manoeuvre when it comes to MSD prevention.

However, we observed that questioning about personal lives in this context could lead women occupational health physicians to find a means of regulation. For example, female physician C asks Mrs B, who is a cleaning lady with a shoulder condition and a difficult job that is not readily adapted to this condition (no help with handling equipment, works on her own with little support from a collective), whether she receives any help at home. The physician goes into detail about the help provided by the woman's children in terms of tidying their rooms according to their age and that provided by her husband in terms of cleaning the house.

Physician: And during the day? When you're at home?

Employee: ...At home

Physician: Your children still live at home, they're quite old, your children?

Employee: yeah, they're old, yeah.

Physician: But, they do their room, don't they? You don't have to do their rooms, do you?

Employee: Yes I do. I'm the one that does their rooms.

Physician: Don't they do a little bit of housework, your children?

Employee: This year my daughter got married, so she's left. The younger one's 14.

Physician: Well then, he can do his room at 14, no?

Employee: Oh, you mean clean it? Yes, he does that.

Physician: But your husband could help too. Doesn't he?

Employee: Yes, he does. He helps too.

Physician: And that helps you.

Employee: Yes it does. When I got ill, he did everything.

The female physician's objective as she asks these questions about the employee's personal life is to find out whether the woman is able to relax at home, whether she is able to recover and preserve her health ("And that helps you"). The employee doesn't have a lot of helps. The physician encourages her to think about how she can be helped at home and to continue to ask for this help. Tying

her life at home with her life at work allows the physician to establish whether she can cope with her extremely taxing working conditions so that she can fill in the certificate of fitness. Thus, her questioning focuses more on the employee's efforts to set up a work/life balance than on her return to work. The physician feels less guilty when filling in the certificate of fitness without stipulating any restrictions about the cleaning woman's ability to work, even though the woman is affected by MSD.

With a Male Employee

Our analysis here is limited by insufficient observations. The only male employee returning to work whom we were able to observe being interviewed by a woman doctor was a man who had been off work with backache. The man was wearing a visible corset. He had gone back to work part-time. During the interview, the physician does not refer to his domestic life at all.

This may indicate that the focus on life/work balance seems less relevant for a woman physician with respect to a male employee.

Observations with Men Occupational Health Physicians

With a Female Employee

When male physicians assess a female employee's functional capacity, their questioning is also based on the stereotypical behaviour of men and women according to their social role in the home. For example, Mrs G is seen by male occupational health physician, J, before she is due to return to her job in a supermarket. She has been on sick leave for several months owing to a shoulder condition. She is not going to be able to return to her job stacking shelves and benefits from the assistance of a job support centre that is helping her to go back to work on the tills. The aim of the interview for the physician is to assess whether the employee is physically fit to do this new job. He asks her what domestic chores she is able to do in order to discover what her physical limitations are:

Physician: Do you make jam?

Employee: No, I don't make jam but I do make clafoutis. I picked the cherries off the cherry trees.

Physician: Do you do any household chores?

Employee: Yes, everything.

Physician: Everything?

Employee: I don't iron as much.

Physician: Less than an hour?

Employee: Even less than that.

Physician: Can you manage a quarter of an hour?
Employee: Yes, but no more than a quarter of an hour.
Physician: What else do you do?
Employee: What do I do...?
Physician: What about the windows? Do you still do them?
Employee: No, I try not to. I hang the washing out, clean the chairs, the cushions...
Physician: Have you changed the way you hang out the washing to make it easier?
Employee: When my daughter's around I ask her to do it.
Physician: You could perhaps change the way you hang the clothes out so that you don't have to ask the rest of the family.
Employee: I peel the potatoes.
Physician: Do you put any weight on your arms?
Employee: I find it more difficult to do upward movements with my shoulder.

With each interview, the physician makes a note of what the employee is able to do to assess whether her shoulder condition is improving. He even notes down the number of shirts she is able to iron and uses this information in the next sessions to check on progress. This type of questioning provides the physician with room for manoeuvre in order to manage information and improve his diagnosis as to the possibility of the employee returning to work.

When male occupational health physicians see women their questioning focuses on their everyday domestic chores. The physician's questions allow him to stipulate restrictions with respect to her job and make the employee aware of movements that are painful.

With a Male Employee

Our observations revealed that male physicians ask male employees the same type of stereotyped questions about their daily life according to a gender-based distribution of their social and family roles. For example, Mr. E works in an industrial environment and is seen by male physician, J. Mr. E. has already returned to work part-time, having benefited from the help of a job support centre to go back to a job as a forklift truck operator. He was unable to take up his old job as a production operator because of a shoulder and wrist disability. The aim of the medical visit is to assess the possibility of increasing his hours. The issues addressed during the interview concern his working hours and his gradual return to work, the location of

the pain he feels, his professional ambitions and possible changes to his job. An aspect of the employee's life at home is brought up during the interview:

Physician: Do you have a nap in the afternoon or...?
Employee: Sometimes.

This question reassures the physician as to the possibility of the employee increasing his working hours by 25% in spite of the pain he still feels. He notes on the work certificate: "Fit to take up a ¾ part-time job until end 2009."

Another employee is a nurse in a retirement home who has been off sick because of depression. By asking the employee whether he does any gardening, physician J tries to ascertain whether he is physically and psychology fit to go back to his job as a nurse.

By asking questions about male employees' life outside of work, the male physician' aim may also be to find out whether they hold a second job, which would complicate their assessment of their occupational illness and put them in a difficult position in relation to their employer and the chief medical examiner.

Physician: So what did you do this weekend? Did you go up into the mountains?

Employee: Oh no, no I helped my cousin.

Physician: Oh, that's right, you often do DIY, and what are you working on?

Employee: The electricity.

Physician: Oh, yes, that's good, the electricity, putting holes in the ceiling and all that.

Here, the physician is attempting to ascertain whether this dual activity is not causing the employee's pain. By questioning the employee about his life outside of work, he is creating room for manoeuvre in order to regulate any possible mistakes in his diagnosis without undermining the relationship of trust he has with the employee.

6. Discussion: from Stereotyped Discussions to the Collective Analysis of Activity

The discussions between the male and female occupational health physicians reveal different practices, which very quickly point to sex and gender-related stereotypes. As already shown in the sociology of work, these differences between sex and gender are socially-constructed. For example, after observing one male physician during an interview, the group of physicians is asked whether they feel it is appropriate to speak about their own

personal life with employees. This leads to an animated discussion about keeping the right distance between the physician and the employee and reveals very different feelings according to whether the physician is a woman or a man. Exercising the profession of physician does not entail the same identity-related and professional role-building challenges for men and women. With the ergonomic objective being to improve MSD prevention effectiveness and increase physicians' room for manoeuvre, this would not be a very interesting approach. The discussions that we organised within the collective of physicians based on our analysis of their activity were more aimed at making the physicians understand that this questioning technique focusing on life outside of work plays a role in their diagnostic activity. Our aim was to explore how they raised queries about employees' personal lives and what the objectives underlying this approach were in terms of how they regulate their medical activity. In short, we wanted to find out how private life questions could help to improve MSD prevention effectiveness.

These discussions provided each of the occupational health physicians with ideas to explore in terms of their activity preventing MSD. They went beyond simply focusing on gender stereotypes. For example, when the results about male physicians' activity in terms of questioning employees about their private life were presented to the collective of physicians, one male physician referred to the female supermarket employee followed by his colleague stating that *"We can also talk about domestic chores. When somebody has a handicap, what can you do? Can you use the vacuum cleaner? Can you carry a pan? Can you take the bins out?"* During this discussion the women physicians refer to other approaches, such as asking employees to mime their future job and then pointing out which movements are painful.

The objective of a gender-related activity analysis is not simply to observe these differences between women and men but to create a space for discussion about different practices according to sex in order to broaden the possible scope of activity. Although both male and female physicians say they bring up employees' private lives in the same way in order to assess their abilities (whether they are men or women), our observations revealed that they in fact do this differently. This raises a certain number of questions about the effectiveness of these investigations in terms of employees going back to work after a long period of sick leave. One of the

major questions is how much is the employee allowed to play a role in his or her successful return to work?

Male occupational health physicians seem to call on stereotypes more when assessing employees' abilities outside of work in order to then ascertain their ability to do their job. In other words, they draw a parallel between what the employee (whether male or female) is able to do at home and what they will then be able to do at work. Their private-life questioning also seems to be stereotyped according to family roles and the employee's gender-related characteristics: doing housework for women, and doing DIY or gardening for men.

Female occupational health physicians seem more focused on trying to understand how women employees can strike a balance between their life at home and their life at work. They see this balance as a possible means of regulating their workload. This creates room for manoeuvre for the physicians allowing them to deliver a work certificate in spite of working contexts that are not very suitable to MSD prevention actions.

This exploratory study is limited by the number of cases studied and should be backed up in the future with additional data. The main difficulty of such work is being able to compare observation situations in different contexts.

Our analysis of professional activity according to sex and gender takes into account the diversity of occupational health physicians' practices and aims to increase this profession's room for manoeuvre in order to produce more effective prevention actions. Highlighting the way in which occupational health physicians are able to understand the possible activity of employees by asking them about their private lives contributes to raising awareness about men and women's activities and encourages these men and women physicians to discuss different activity possibilities. The aim of this analysis was also to help these physicians to develop their activity and be able to act in the challenging field of MSD prevention.

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