Return to Work after Myocardial Infarction

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Myocardial infarction rehabilitation today consists of medical treatment as well as of psychosocial care. Rehabilitation is intended to compensate irreparable consequences by still present functions of the organism. Rehabilitation comprises all somatic and psychosocial endeavours to preserve for the person, afflicted with a chronic heart disease, the same position within society that he occupied before his affliction. Problems of keeping his job, of being re-employed, of modification of the work-load and, finally, of being retired and how to cope with it, are of the greatest importance for those endeavours.

What is the present situation vis-a-vis returning to work after myocardial infarction? The return to work is not only of importance from the point of view of social medicine or of national economy or of health politics, but also in terms of the patient's quality of life.

Figures relating to the number of patients returning to work after myocardial infarction vary from 40% to 90% in the national and international reports; the following factors may account for this discrepancy.

1. The kind of work: Studies in Germany (Weiss, 1982) have shown a higher rate of return to work for white-collar workers (sedentary or moderate work) than for blue-collar workers (physical work). Often, white-collar workers seem to have more chance to arrange their work with more flexibility and to adapt their job to the new health situation, Weiss (1982) showed that the percentage of patients performing heavy physical work who returned to work was smaller than among patients with moderate physical work. Studies from Israel and U.S. support this finding.

2. Medical reasons also influence the rate of return to work. In German, English and American papers there is consensus about a number of medical factors that influence reintegration into work: severe angina pectoris, ventricular dysrhythmias, extent of obstructive coronary artery disease, heart failure, aneurysms. Non-cardiac disease, e.g. diabetes, also reduce the rate of return to work.

3. The waiting time for further medical procedures is another important factor influencing return to work after myocardial infarction; this is especially so when coronary surgery is involved, Walter et al. (1983) found a reduction in return to work with increasing waiting time for coronary surgery. Hammermeister et al. (1979) showed that the most important predictor of return to work is whether the patient was employed 3 months before surgery or catheterization.

4. Individual psychosocial factors play an important role in the return to work after myocardial infarction. According to the literature the most cited factors are: level of school education, social class, family support and job position. Higher scores to these factors increase the percentage of return to work after myocardial infarction.

5. Present sociopolitical and economic trends: There is little doubt that rehabilitation and coronary surgery can alleviate symptoms and improve exercise performance. Therefore failure to return to work must often be caused by non-medical factors. Possible reasons include
the patient's fear; economic incentives to remain retired because of pension, disability insurance and social security benefits; economic disadvantages to the employer because of the workman's compensation insurance; and competition for jobs from younger, healthier people. In Germany the age of the patient plays an important role. After the age of 55 the return to work is reduced dramatically (Krasemann and Jungmann, 1979 Walter et al., 1983)

The above-mentioned factors, which influence the return to work after myocardial infarction, also influence the length of time before returning to work after myocardial infarction.

On the other hand, measures have been demonstrated during the past 10 years which increase the return to work:

1. Step-wise return to work (increasing working hours from 4 to 6 to 8 hours). Studies by Brost et al. (1982) have shown a higher rate of return to work after myocardial infarction when step-wise return was performed.

2. Comprehensive medical and psychosocial care according to the “Hamburg Model” or the concepts of Prof. Halhuber. Krasemann and Jungmann (1979) for the “Hamburg Model” and Halhuber and König (1982) for the “Höhenried Rehabilitation Clinic” reported a higher rate of return to work among patients with intensive follow-up treatment in a rehabilitation clinic than among patients without organized rehabilitation. After the establishment of coronary groups in the vicinity of the patients' homes for the continuation of therapy, the percentage of patient able to return to work increased even more (Krasemann and Jungmann, 1979). Several studies from the U.S. have also shown an increase in return to work after myocardial infarction when a rehabilitation centre was visited.

3. Co-operation and dialogue with general practitioner. A study by Stein and Krasemann (1981) showed the importance of good co-operation between the physician of the rehabilitation clinic and the general practitioner. If there is good co-operation, then the percentage of patients who return to work is greater and also the time before return to work is shorter. The same authors also showed that a precise patient/physician dialogue as to the patient's prospects and the exact date of return to work upon discharge from the rehabilitation clinic has positive effects on the percentage returning to work and on the time before return to work. The recommendation of the physician of the rehabilitation clinic as well as that of the general practitioner is of much importance for the patient. Positive motivation increases the number of patients returning to work, while anxiety and uncertainty on the part of the physician decrease the return to work.

To improve the return to work in the future and for further follow-up, the occupational health services should play a bigger role, because their doctors know their patients suffering from myocardial infarction and also the patient's working conditions. The prognosis of coronary heart disease is not negatively influenced by an early return to work (Stein and Krasemann 1981). In addition, it is necessary to establish general criteria to answer the question of whether coronary patients should return to work. Furthermore, it is important to carry out more research in the psychosocial field to learn more about its influence on return to work.

References

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