International Journal Dental and Medical Sciences Research
Volume 5, Issue 5, Sep-Oct 2023 pp 409-412 www.ijdmsrjournal.com ISSN: 2582-6018

Proposals for organizing the assessment of incapacity for work in cancer patients

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Date of Submission: 05-10-2023 Date of Acceptance: 15-10-2023

SUMMARY
Medical certification is, next to diagnosis, treatment and control, one of the parts of a doctor's work. The doctor's task is to determine the right to leave from work, the right to disability benefits or inability to live independently, or the right to determine health damage. This diagnosis must be based not on the name of the disease, but on the anatomical and functional effects that the disease and treatment have on the patient. In Poland, the patient has the right to obtain the right to temporary incapacity for work (180 days), and then he or she can apply for the right to temporary or permanent inability to work (the right to a pension). People who are unable to live independently may apply for a care allowance. This work is based on many years of experience of the author, who has been working in medical jurisprudence in Poland since 1991. Despite the fact that in most countries of the world the issue of disability insurance for cancer patients has been solved differently (depending on local customs), it seems that it is possible to outline some common solutions. These considerations omitted commercial insurance and focused solely on the right to disability benefits obtained under social insurance. Cancer is a disease that is so burdensome to health that it is justified to discuss this topic.

Keywords: medical certification, incapacity for work, sickness benefit

As we know, the degree of incapacity for work is determined not by the diagnosis itself or the treatment method used, but by the effect that the disease and its treatment have on a given patient, limiting his or her ability to work. The doctor must also remember that the only criterion for assessing the health condition are substantive criteria. Therefore, non-substantive factors should not be taken into account (e.g. age of the examined person, number of children, whether the patient is unemployed or not, etc.). Making the recognition of a disability benefit dependent on the above factors would indicate that the medical examiner is acting as a social welfare officer, not as a doctor. When adjudicating on oncological matters, it should be remembered that the doctor's task is not to comment and verify the correctness of treatment, but to assess the effects of the current course of the disease and its treatment on the patient's body. The doctor has no right to inform the patient about his health condition, methods of treatment, prognosis, prescribe prescriptions, etc. The interview should be carried out in three phases: in the first phase, contact with the patient should be established to gain his trust; secondly, allow the patient to freely express his or her comments, complaints and conclusions about his or her health condition; and only in the third stage – you should ask questions verifying what the patient has just told us. This approach to the petitioner allows you to avoid demanding attitudes, even despite the refusal to grant the benefit. For these reasons, judicial work cannot be carried out in a hurry, in a way that does not allow the examinee to express his or her own opinion. The doctor's inappropriate attitude causes or intensifies demanding attitudes.

Questions asked to petitioners must be formulated in an appropriate manner – they cannot suggest answers. Therefore, you cannot ask questions such as: "How many meters will you walk before pain appears behind the sternum?" – the necessary information can be obtained from the patient by asking him "Are you going to the store?" Church? Friends? Why not? What happens then?" or "How did you come for today's examination?", etc. Similarly, you cannot ask: "Did you feel pain when bending your knee?" but "What did you feel when you bent your knee? In what place?" etc.When collecting interviews, patients very often mention the names of diseases and the names of organs, instead of talking about the ailments in their own words. You should then correct the patient's statement by saying, for example: "please speak in your own words about what you feel,

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without calling it hypertension" or "how do you know that the cause of these symptoms is coronary artery disease?" Did the doctor say? And if he didn't say it, how would you know it?", etc. Diagnoses made by patients themselves should be approached critically unless they are verified by qualified physicians in appropriate medical records.

The clinical examination begins with the patient's first eye contact with the doctor. On the one hand, the patient evaluates the doctor, who must give the patient the impression of a competent person who is interested in conducting the examination properly and impartially. On the other hand, for the doctor, the first moments of the patient's stay in the examination room are an opportunity to observe the general impression of the patient: whether he is independent, how he walks, what his facial expression is, his body structure, etc. Therefore, during the examination, the doctor should pay attention to: (1) his appearance, facial expressions, intonation of voice, gesticulation, way of speaking, sitting or moving around the room, (2) the style of conducting the examination – without unnecessary haste, carefully, methodically and in such a way that the patient is convinced that he was treated competently.

The doctor performing the examination should have the necessary medical equipment – a stethoscope, a neurological hammer, a flashlight, a device for measuring BP, but also: a centimeter (to measure muscle atrophy or swelling) or a cotton swab and a needle (to assess superficial sensation).

Each applicant being examined for adjudication and pension purposes should undress down to his underwear before the examination. The examined person must be weighed and his/her height, blood pressure and heart rate measured. Body weight should be compared to the ideal values. Then, ask the patient to walk around the room slowly and on tiptoes and heels. During this time, we assess the body structure, the state of muscle development and their possible atrophy, the mobility of peripheral joints, and the distribution of fat tissue. Undressing the examined person down to their underwear also allows us to assess the skin and subcutaneous tissue, the presence (or not) of scars, varicose veins, pressure sores, edema and fistulas, as well as the assessment of peripheral lymph nodes. In this way, we can also assess the examinee's independence in undressing and then dressing (it happens that some subjects are better at dressing than undressing, because they have already undergone the examination).

Oncology is a multidisciplinary science in which it is difficult to find a common denominator. In the case of ophthalmology, objective measures are: acuity and field of view; in orthopedics it is the range of motion in joints or muscle atrophy; in cardiology, ECHO, ECG or stress test assessment. In oncology, it is difficult to find such objective measures, even though there are extensive scales for assessing treatment toxicity.

This results in a tendency to individualize adjudication – however, if two patients of the same age, treated in a similar way for the same disease entity with a similar advancement, with the coexistence of similar diseases, receive two different decisions from two different doctors, this may raise questions among the adjudicators. about the influence of non-substantive factors. Hence the need for some standardization of views.

It should also be remembered that oncological patients usually do not aggregate and do not "force" benefits. However, they assess all signals very carefully, including those contained in the extract from the judgment. It sometimes happens that a patient with, for example, gastric cancer in the stage of dissemination, when he receives permanent benefits, interprets them as an irreversibly bad prognosis. It remains to be considered whether in some situations it is better to grant periodic benefits for a long period, even longer than the prognosis based on medical knowledge (a decision with a pro psyche value).

It should also be remembered that the decision cannot be a form of compensation for the diagnosis, i.e. – one should not, guided by compassion or one's own experience with oncological diseases in loved ones, grant benefits to a greater extent than medical knowledge provides.

When making a decision in the field of oncology, five basic factors should be taken into account:
•Diagnosis
• Nature of treatment undertaken
• Progress of the disease
•Way of treatment
• Time since completion of treatment

The medical examination of oncological patients should be carried out by analogy to the clinical examination used in oncology. There are three elements to evaluate here:
• what kind of cancer am I dealing with?
• how advanced is the process?
• with what burdens due to other diseases, injuries, age, allergies, medications taken, etc. I'm dealing with?

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These issues translate into thinking and judicial behavior:
• if I can cure the patient, radical treatment means a chance for permanent recovery
• if I cannot cure someone, palliative treatment means no chance of permanent cure, but with no chance of independent existence
• if I have no grounds for implementing any causal treatment, symptomatic treatment means no chance of returning to work and independent living

When assessing the medical history of an oncological patient in terms of judicial decisions, the following questions should be answered:
• Do I have a clearly defined name of the disease (result of microscopic examination!)?
• Can I determine the advancement of the disease?
• What is the nature of the treatment: radical / palliative / symptomatic?
• can comorbidities and history of previous injuries, diseases or consequences of medications taken for other reasons significantly change my assessment of the consequences of oncological treatment?
Only the above premises will be the basis for drawing further conclusions.

Stage of the disease – usually the better the prognosis, the lower the stage of the disease. With each advancement level "up", the chances of recovery decrease by 25%. The exception is bladder cancer in situ, which often occurs multifocally, quickly becomes invasive and requires cystectomy in 30% of patients.

Time since the end of treatment – an observation period of five years is usually assumed, after which oncological patients are considered cured. However, this period is used mainly for statistical purposes and cannot be easily applied to all oncological patients. The problem in adjudicating cases of cancer is most often not the question "who should benefit from" but "when should it end?". The term "cure" also requires clarification. If cure in oncology were possible, patients would not require follow-up, which is mandatory for them for the rest of their lives. A more appropriate term is "no active disease."

JUDGMENT PROPOSALS

The proposals presented below apply to situations where the oncological problem is the only issue to be resolved and we have appropriate medical documentation. When comorbidities need to be assessed, these proposals provide general guidance.

Temporary incapacity for work (max. 180 days) as a sufficient period for the benefit granted
• pre-invasive cancer and cervical cancer, stage IA1
• Paget's breast cancer (intraepithelial hyperplasia)
• LCIS (lobular pre-invasive breast cancer)
• DCIS (pre-invasive ductal carcinoma of the breast) when the VNPI index is up to 4
• Dukes stage A (pT1N0) and B1 (pT2N0) colorectal cancer
• pT1 prostate cancer
• stage "0" of chronic lymphocytic leukemia according to Rai
• pT1 skin and lip cancer after radical surgical treatment
• malignant melanoma after surgical treatment pT1
• hydatidiform mole with a normal decrease in HCG levels
• monoclonal gammopathies of undetermined significance (MGUS).

Two breast cancers in situ require separate mention: lobular carcinoma (LCIS) and ductal carcinoma (DCIS). LCIS requires only follow-up every 6-12 months for 5 years after surgery to remove the nodule, and treatment may take place within the framework of temporary incapacity for work. The situation is different in DCIS. Here, the procedure after removal of the nodule depends on the VNPI (Van Nuys Prognostic Index) value. If it is up to 4, the patient only requires control (temporary inability to work); if from 4 to 10 – radiotherapy is indicated (periodic inability to work); and if the value exceeds 10 – a simple mastectomy should be performed with the assessment of the so-called sentinel node (further therapeutic and judicial decisions then depend on the results of the microscopic examination).

The general rule for determining incapacity for work is that the diagnosis of malignant tumor means incapacity for work (except for the situations mentioned above). Permanent total incapacity to work may be considered in the following clinical situations:

• permanent intestinal/tracheal/urinary stoma
• permanent third or fourth degree swelling of the limb
• previous bilateral lymphadenectomy or radiotherapy of the axillary/groin areas, due to the risk of swelling of the limbs
• significant therapeutic amputations (extensive skull bone defects, removal of the entire lung/larynx/bladder, extensive limb amputations)

We can consider the inability to live independently when we state:

- disease recurrence beyond treatment options
- that the examined person's health condition constitutes a threat to the patient and his/her surroundings
- when the height acuity after correction in the better eye does not exceed 0.05or the field of view is telescopic and does not exceed 20 degrees
- that the expected state of occupancy will last more than 6 months

An independent factor in the assessment is malnutrition, especially in people who are many years after radical oncological treatment, without signs of active disease, but due to chronic and irremediable malnutrition, their ability to work or self-service may be reduced. To assess the degree of malnutrition, anthropometric parameters are used, i.e. arm circumference (>23 cm in men and >22 cm in women) and the thickness of the triceps fold (>10 mm in men and >13 mm in women) and biochemical parameters (mainly creatinine and its clearance, albumin level and nitrogen balance – a positive balance is the norm). The immunological parameter is of secondary importance, i.e. the total number of lymphocytes > 1500/mm3. A slight (reversible) degree of malnutrition occurs when the body weight is over 85% of the ideal weight and the albumin level is over 3 g%. Moderate malnutrition (which may become reversible after nutritional treatment) and which may affect the ability to work occurs when the body weight is 75 to 84% of the ideal weight and the albumin level is 2.5 to 3 g%. Severe malnutrition (difficult to reverse), which may affect the inability to live independently, occurs when the body weight is below 74% of the ideal weight and the albumin level drops below 2.5 g%.

The Zubrod or Karnofsky scales can be used to assess the degree of independence. However, we can form an approximate opinion about the patient's fitness by asking the patient a few simple questions. A patient who spends more than 50% of his waking time in a resting position during the day will be unable to work. The patient will be permanently bedridden and unable to live independently.

When can you think about returning the ability to work in oncological diseases? This decision requires taking into account not only the time that has passed since the end of treatment; the result of microscopic examination; but also the results of additional tests assessing whether local or generalized relapse occurred; results of tests monitoring side effects and damage to organs/systems during oncological treatment; functional capacity of patients (e.g. presence of limb swelling after mastectomy) and age of patients. The risk of disease recurrence generally decreases with time after completion of treatment. While it is known that cancer patients remain under medical care for the rest of their lives, adaptation to new functional conditions after treatment means that many of these patients can resume work.