

A Case Study in Rehabilitation

An interview of the employee on sick leave and her employer

A project in Occupational Health Physicians course, Sahlgrenska Academy, University of Guthenburg, 2002/03.

Rachel Beloso, Occupational Health Physician, Feelgood*
Tutor: Associate Prof. Björn Karlsson
Occupational Medicine Clinic,
University of Lund

***Feelgood, Malmö**
Djåkenatan 12
211 35 Malmö

Contents

Abstract	1
Introduction	1
Aims	3
Material and Method	3
Interview results	
Employee	4
Employer	6
Discussion and Conclusion	8
References	11
Appendix	12

A Case Study in Rehabilitation

An interview of the employee on sick leave and her employer

Abstract. Rehabilitation work is one of the many challenging tasks of occupational medicine. In the day-to-day work, the occupational physician may, however feel that rehabilitation is not going in the right direction, may even stagnate to a standstill. This case study presents some aspects of rehabilitation that are rarely mentioned in actual rehabilitation procedures but which may prove crucial in the outcome of rehabilitation namely the expectations of the employee on sick leave and her employer on the rehabilitation processes as a whole, and their expectations of one another. The object of this paper is to seek out such expectations and see if there are common grounds in rehabilitation that may lead to an acceptable resolution. An employee on sick leave and her employer/manager were chosen and interviewed. The results showed that there was a conflict of interest with very different expectations of the rehabilitation process and of each other. There were no common grounds to begin with and communication problems arose because of lack of confidence in each other. It is concluded that in failing rehabilitation work, one problem to consider and address is the problem of conflicting interests and lack of common grounds to work with. The occupational physician may bring this up to light in rehabilitation procedures but has however, not always the commission to do so.

Introduction

Over a ten-year period, 1991-2001, a strange phenomenon in the pattern of sick leave statistics is noted by the National Social Insurance Board (Riksförsäkringsverket, RFV) in Sweden. After being constantly in the decline the early half of the decade, one sees now an alarmingly steep rise in the number of sick leave cases and this statistic unfortunately keeps growing. Statistics from RFV show that by the end of 2001 the number of persons on sick leave has risen to 250,000. In December 2003, this figure has grown to 295,000 (1). Breaking down this figure into diagnostic groups, one sees that musculo-skeletal (45-47 %) and psychological dysfunctions including burn-out syndrome account for nearly 70 % of the total number (2). Explanations to this phenomenon have come from diverging perspectives – medical, political, social, economic as well as organizational/labour. These observations have in turn prompted the government to conduct its own analysis. This resulted in Johan Rydh's Analysis of Health and Work (AHA utredningen, SOU 2002:62). In this document, the function and role of occupational medicine and health care (Företagshälsovård, FHV) are emphasized and encouraged. Aside from helping in continued and systematic health promotion at work, the return of the long-term sick back to the work place, poses a great challenge to occupational medicine which plays a key role in the processes of vocational rehabilitation.

Rehabilitation is a broad concept that encompasses all efforts or plans of action, whether they be of medical, psychological, social or vocational nature, directed at helping the sick and disabled – with or without functional hinder, to recover the ability to enable him or her to resume normalcy in life the best possible way (3,4,5,6). Rehabilitation includes work-directed rehabilitation (YIR) where YIR is defined as all measures in direct relevance to

reaching a possible return to work through for example, work probation, training, guidance/counselling or labour market education.

The legal framework for rehabilitation is the Swedish law on general health insurance (AFL, lagen om allmän sjukförsäkring). This was first enforced in 1955 but it was in its 1962 version that the provisions on rehabilitation were first incorporated. From this date on, even the category employed and on long-term sick leave (more than 90 days) was included in the concept of work care (arbetsvård) as it was defined in the 1940's. (7).

In 1992, this law was further reformed to broaden the concept of rehabilitation from the then existing YIR to vocational rehabilitation (arbetslivsrehabilitering) that takes into account the many aspects of work and includes all measures that the employer and the social security agencies primarily stand for when a person is to resume or maintain a position at work. Occupational rehabilitation now includes not only the sick and disabled but everyone in the work force with existing ties to the market place, including the unemployed in search of work.

According to the rehabilitation reform of 1992, its implementation rested mainly on two actors: firstly the employers who were given an increased and explicit responsibility not only in the rehabilitation of their own employees but also in improving their working environment, and secondly the local social insurance offices who were given the overall responsibility of coordinating the activities of rehabilitation. A central role was given the employers because of their competence in the rehabilitation process on an individual basis. With an enhanced work environment legislation and directives involving internal control, the employers were to obtain the tools necessary for regulatory schemes over the employees' work environment and rehabilitation (AFS 1992:6). To help them implement this, the employers had the support of occupational medicine and health care and work foundations (arbetsfonderna), the latter was however dissolved in July, 1995.

There are other actors with parallel responsibilities in rehabilitation. They include private (FHV) and public sectors; health care (county), social services (municipality), and employment agencies (Appendix 1)(8). Cooperation among these actors is considered paramount if successful rehabilitation of the long-term sick is to be attained. As the table shows, the aims of rehabilitation differ from organization to organization and the absence on this list of the patient/employee who has the central role in the processes of rehabilitation suggests the difficulty in establishing what successful rehabilitation means. Some of the studies analysed by Kerz and associates show that this difficulty is closely related to the question of whose is the problem of rehabilitation and in the very definition of rehabilitation itself. Upon analysis, the success of rehabilitation is measured in terms of the differing organizations' perspectives. Thus, most of the studies on rehabilitation touched on very different measures of success: happiness, life satisfaction, work and profitability, for example.

Larsson(2) suggests a central role for the patient/employee in the process of rehabilitation. He has therefore motivated a need for a new reform in occupational rehabilitation among which he maintains that successful rehabilitation should rest on the individual's commitment and cooperation. He considers it necessary that the individual be given a sizable influence by giving him or her certain legal rights against the other actors in rehabilitation (2). In SOU 2000:28 and National Social Welfare Board (Socialstyrelsen) 2000:5 the individual's own motivation and desire are given emphasis as important in the final resolution of rehabilitation. In this perspective, it is emphasized that the contribution of authorities be coordinated so that

society's intentions of rendering social service in a humanistic way can meet and respond to the demands and wishes of the individual undergoing rehabilitation.

Given this background, it is of interest for occupational medicine and health care to gain knowledge of the different aspects of rehabilitation and apply this knowledge to every rehabilitation situation on an individual level. Because of the afore-mentioned diverging perspectives from different actors the task of occupational medicine in the author's view, is to put an understanding as to how these perspectives can focus on the individual who finds him-/herself in a certain stage of a medical condition, to define his or her own position at that stage so that the other active partners in the task of rehabilitation may, in turn, plan a course of action intended to help the individual from their own organizational perspective.

It is the interest of the author to see what happens in a given rehabilitation situation. What is expected of the meeting? What forces can lead to failure or success? What can one learn from an individual case of prolonged rehabilitation?

Aims

The aims of this project are:

1. to find out from an individual case what the employee and employer expect of the rehabilitation process,
2. to find out what they expect of one another in the context of the rehabilitation procedures,
3. to explore if there are common grounds for both parties to facilitate an acceptable resolution in rehabilitation,
4. to find out in what way both parties consider occupational medicine to be of help in the rehabilitation of the long-term sick.

Material and Method

Subjects. An employee, female and her manager, male, were selected because of their current contact with Feelgood where rehabilitation procedures have started because of the employee's sick leave period of over 90 days.

Data sampling. By means of prepared and open questions concerning the subjects' backgrounds in the context of their present positions in the company, their expectations of the rehabilitation processes, their expectations of one another, their views and feelings as the rehabilitation proceeded and their expectations of the role of occupational medicine, a semi-structured interview was conducted.

Procedure. The subjects were interviewed on two separate occasions but on the same day at their work place. For reasons of convenience, the employer was interviewed first. Both were informed again of the purpose of the interview, that it would be conducted with a tape recorder on and that the interviewer would take down notes as the interview proceeds. Both were informed that their identities will not be revealed in the report. The interviews took about more than an hour each.

Data analysis. The tapes were then listened to, the subjects' responses were written down almost verbatim and were gathered together with the written notes. The responses were organized into different topics including their work backgrounds and according to the themes

as defined in the aims of this report. Qualitative analysis of data was employed because of the subjective nature of the responses. The gathered data are presented as interview results separately, one concerning the employee and another concerning the employer.

Interview results

Employee

Background. The employee has been in the service of her company since 1989. In her present position as pharmacist, her functions include drug dispensing on a 60% basis and the rest in an informative capacity both internally and externally as a contact person for public medical service locally. In November 1989, she was relocated to another pharmacy. She had welcomed the move which was part of her company's reorganization.

Right from the start she had difficulties with another workmate, also a pharmacist who was then responsible for the staff's work schedule. (This pharmacist was later up-graded and moved on to another pharmacy.) A promise of project work was also taken away and her duties now became purely dispensary in reality.

Her former manager was informed about her problems then but the employee did not feel it was of interest to him and the problem continued without being resolved. She therefore lost complete trust in the manager and when the new manager, now currently serving in the same capacity, came in the fall of 2000, he was soon informed of the problems. Again, she did not feel she was being helped and this made her search for other openings in other pharmacies. Unable to get employment elsewhere, the situation aggravated and she began having symptoms of physical and mental strain. She then began relating her problems as a systematic mistreatment of her as a person and in December 2001, other actors in the company were engaged, firstly the personnel officer and finally the rehabilitation coordinator, the latter already consulted by the manager at an earlier stage. A series of dialogs with proposed solutions to the problems ensued but none that the employee could accept. Her view at the time was that her placement in this pharmacy was giving her symptoms of ill-health. Her symptoms worsened so that by the spring of 2002, she had short absences because of insomnia, general muscle pains and even swelling of the lower extremities. She consulted Feelgood, then the company's occupational health care service in August, 2002 and was put on sick leave. She has since then been on sick leave in varying degrees.

Prompted by Feelgood, a rehabilitation meeting was scheduled in the spring of 2003. This was followed by yet another meeting after a couple of months. Placements in other pharmacies were offered for purposes of rehabilitation. None of them were considered by the patient as being equivalent to the position she holds. She tried work-training in other pharmacies and because she felt well while being there, she ended her sick leave in June, 2003. Because of this, rehabilitation in principle was terminated and she went back to her work place and to her duties. The symptoms returned and she continued her search for other alternatives, this time outside of her company. Just before she was interviewed, she had obtained a promise of another job in a pharmaceutical company in an informative capacity and was later allowed a year's leave of absence by her employer.

Results.

The employee admits that she had no expectations whatsoever as to the results of rehabilitation as initiated by occupational medicine. When it started, she did not really know

what it meant . By that time she was also made exhausted by her countless contacts with management, she felt no confidence in them. In fact, a recurring reasoning during the interview was that this rehabilitation did not have to occur in the first place if management had listened to her and understood her right from the start when she, in numerous occasions told them of her problems, in her own words when she raised the warning signal. She reiterates the only solution they had to consider was another placement for her in a similar capacity somewhere else within limits of her commuting capacity. Not really understanding a need for this rehabilitation after the countless ones she has had with management, she sees no common grounds for discussion. In general she sees rehabilitation as aimed at getting her back to work but feels at the same time that in her case a promise of work as noted above or a redressing of grievances would have solved the problem.

She experienced the rehabilitation meetings as chaotic, at one time she was offered details of a new placement whilst in the corridor outside the conference room where the rehabilitation meeting had taken place. She felt no common grounds in the discussions and felt that in the early dialogs she was not given any explanations as to her perceived mistreatment which she now calls mobbing and therefore could not change any of her ways or thinking. She does not consider herself really in need of rehabilitation and that her feeling of being thrown back and forth between the manager, the personnel officer and the rehabilitation coordinator stems in their inability to listen and understand her. This has in turn strengthened her fear that a systematic mobbing at her work place at management level exists and that the only way to resolve this is to leave.

She has no misgivings towards her co-workers and feels she has received helpful support from them and occupational medicine (doctor and psychologist.) Her feelings about being on sick leave were however ambivalent. In one way, she resented being on sick leave, she found it psychologically trying but found it unbearable being at work.

The somatic symptoms she endured were hard for her to understand in the beginning. The coping strategy of being on short absences saved her in the beginning but when the signs and symptoms worsened, she felt it was beyond herself to find relief and that was when she contacted Feelgood. As her sick leave continued, she came to realize more and more that her symptoms were related to her feelings about her work place. It was also during this time that she came to realize that the unfair treatment has become one of mobbing, not only at her pharmacy but by other managers in other pharmacies as well.

Her views of rehabilitation are two-fold. She felt in one way that it was successful in that it gave her more insight and a stronger ground to base her feeling of unfair treatment on. It was unsuccessful in that she failed to convince her manager in this respect. It was also unsuccessful in that it had cost her a lot of energy and strength. It failed to give management insight as to how they should handle personnel problems at work, that they cannot just blame reorganizations and that they should show responsibility for their staff instead. Asked about how this can possibly be resolved, she thought that management would be interested in silencing the problem down and that she felt they would be pleased if they could arrange for her to leave the company quietly. By interview time, she revealed her intentions of asking management for a leave of absence to try working in another capacity in a pharmaceutical company. She felt it was only in this way that she could regain health and build herself up again.

Employer/manager

Background. The manager joined this company in 1981. In November, 2000 he took his present position as district manager for three pharmacies. In his present capacity, he has the operational responsibility over three pharmacies in his district and is chief over 60 personnel among which six are pharmacists. His duties include management of economy, personnel and work environment among others. At the time the interview took place, he had 4 personnel on sick leave, 2 pharmacists and 2 pharmacy technicians. He admits current problems of lack of personnel and is still recruiting for the position of pharmacists (2), and a pharmacy technician. To help with this problem, he has engaged the services of personnel from an internal pool system to cope with the demands of his district.

Soon after starting in his current position, he initiated meetings with the staff on individual bases for the purpose of evaluating personal improvement schemes and it was in the first meeting with the actual employee that the subject of work-related problem was brought to his knowledge. He understood that the employee felt wrongly treated by the former manager and that the promise which was made to her prior to her placement in the district was never met. He felt this was a past history which he had not created and tried instead to lift the problem so it can be addressed to. He contacted the rehabilitation coordinator at an early stage and felt he had good advice and feed-back from her. There were a series of dialogs to find solutions to the problems but he felt his hands were tied and no positive result came out of these dialogs. As he understood it, the problem that the employee time and again repeated was unfair treatment and that his role in this was to help her accept this and get her to continue working with a changed attitude. In practical terms an attempt was made to help the employee by giving her a chance to talk with a psychologist not linked up with the company nor the occupational health care service they had at the time, Feelgood. He was present at the two rehabilitation meetings together with the company's rehabilitation coordinator.

Results

His expectations of rehabilitation were two-fold. On an individual basis, he had expected it would lead to concrete plans of what the employee's future duties should be. He was in need of her competence in internal education and development of the pharmacy but was not sure exactly how these duties would look and expected the employee to contribute to this through future dialogs. He had also an ongoing problem of lack of personnel and his ideas of new duties for the employee could not be implemented immediately.

There were placements outside their district for the purpose of rehabilitation, she tried two such placements but she cut short the period of rehabilitation to return to her own work place. He found it hard to understand that in one of the proposed placements, the prospect of being employed there on a permanent basis was good but the employee still insisted on returning to her own work place.

Of the rehabilitation process itself, it was not clear to him if he could expect it to be of help in shortening the employee's sick leave. He admits difficulty in evaluating the results of rehabilitation even if the aim of rehabilitation, that is to get the employee back to work on full-time, is clear to him. In his view, the difficulty arose partly because of the non-somatic nature of the illness (he compared clear cut rehabilitation procedures for somatic illness) and partly because the employee failed to give him information well ahead of time as to when she

would go back to work and in what degree. He was asked not to say anything to her co-workers and this made it impossible for him to have the overview that was necessary for his operational plans. He describes the work of rehabilitation in this case as very difficult and cumbersome. He felt it took much of his time and that he tried to address the issue at hand even if the conflicts occurred long before he came to his new post. There was a recurring grievance of unfair treatment by a former manager and even if he understood her situation, he felt he was not in a position to take sides or judge if her health problems and symptoms were due to the problems perceived by the employee. His interest was to make it possible for her to return to work and outline future tasks he thought she was very competent in doing through dialogs which indeed transpired in formal and "ad hoc" manner, with or without the personnel or rehabilitation officers on hand. He felt frustrated however because suggestions made to improve her situation were not accepted by the employee and he mentioned he felt his hands were tied.

When a rehabilitation meeting was suggested through Feelgood, he felt it came too late. At that time, the series of dialogs has already been underway and he thought this problem was past beyond the rules of rehabilitation. It was positive in that it gave an opportunity for all interested parties to meet together. It felt like a start and he felt that the exchange of information at this meeting was positive. Because previous internal dialogs had already presented suggestions on how to solve the problem and because they were not accepted by the employee, he was not surprised at the dismal outcome of the meetings. He however, learned something of the formal rehabilitation initiated by occupational medicine, like giving structure to the rehabilitation process by documenting plans, describing evaluation possibilities. It even led to stricter routines added to the duties of a personnel specialist.

He describes his experience of this rehabilitation as coming from his own point of view and as he perceives it from the employee's. Here he raises relevant questions as to who has the right of interpretation in cases like this. Who decides over the processes of rehabilitation? He mentions that as the employer's representative, he felt his hands were tied and that his attempts at solving the problems the most practical way were, according to the employee, not good enough. He felt that whereas every case should be dealt with as unique in itself, he found it difficult to assess the situation because it was based only on the employee's account and took into consideration only her terms and conditions without taking the employer's view of the work and personnel situations as well as the company's goals and operative reality. His expectation as a whole is coupled up to a lesson he says he has learned in that this process takes time and that he expects a clearer picture as it proceeds. He feels that in this case, there is plenty of room for reparative work because common grounds, he admits, if they ever existed at some time in the past, have crumbled away. He feels it is in the interest of the company to restore lost confidences from both directions and feels the challenge to respond to this.

His view of the role of occupational medicine is one of a consultative partner. It could also serve as an instance for feed-back as it sits in a central role in rehabilitation process. He felt it desirable in this case, if occupational medicine had given leads as to other contacts, other possibilities and mentions a model of sick leave procedures that are done in Holland whereby the employee has a continued role at work throughout a sick leave period.

Discussion and Conclusion

Rehabilitation is a well-established procedure in helping employees on sick leave to get back to work. There are many actors involved in rehabilitation (App. 1)(8) but in the practice of occupational medicine, the actors involved for the most part are the employee, the employer, the social insurance officer and representatives from occupational medicine itself. All of these actors have different goals and interests to keep, even to defend and many times when rehabilitation seems impeded, it is because there are conflicting goals that cannot be resolved within the rehabilitation process. As Kerz (7) maintains, rehabilitation has evolved in such a way that its contents have expanded. The target groups include more individuals, several professions are now linked up in rehabilitation and more dimensions from differing activities are expressed as competing goals. Aside from this, cooperation and coordination in different levels become problematic as communication often also fails.

In this case, the conflict of interest is between the employee and the employer. While both prescribe to the main goal of rehabilitation as the employee's return to work, there is little else that both can claim as common grounds to work on. The employee's desire is to get back to work but in another work place. She has also believed that the employer was capable of giving her this opportunity. The employer on the other hand felt that it was not up to him, in the context of rehabilitation, to boost her career in the direction she wanted. The employer was wary of a power clash that ensued in the dialogs and was worried for the employee as his conviction was that employees always lose against his/her organization represented by management. There was no common ground to explore or work on, or if ever there was one, it had now vanished. The employee wanted a redressing of grievances, the employer wanted continued dialog to discuss future tasks but had nothing to offer in the present because the lack of personnel affected his operational strategies. The confidence that the employee lost in her former manager was never won again by the present management who felt the main problem belongs to the past and could only be resolved by the employee's change of attitude.

When a rehabilitation meeting was initiated by occupational medicine, the employer felt it came too late, the employee felt it was unnecessary as she calls all past dialogs as rehabilitation and as they all led to a perceived failure, she had difficulty in finding herself in the discussions and the suggestions of rehabilitation strategies. She was resolved in her perception that mobbing by management has taken place and that this was spreading to other pharmacies making it difficult for her to get work elsewhere. Maintaining it was her work place that made her sick, she cut short her job-training during rehabilitation in other pharmacies as she saw herself well and fit while being there. This made it difficult to evaluate the effects of rehabilitation. The employer on the other hand was frustrated by the lack of communication from the employee. They were not informed well ahead of time as to when she would be back or how many hours she would work. They were asked not to discuss her sick leave with the other employees. As such, work schedules were at the risk of being disrupted or could not be planned out properly. Even rehabilitation plans were changed by the employee and could not be evaluated accordingly.

Another area of difficulty that was specifically mentioned by the employer is that of identifying which perspective should be given priority in rehabilitation. It could be argued that the employee's predicament and medical condition be given priority but the needs of the

company have also to be met. In cases where these two needs are irreconcilable, which way should rehabilitation go? How can the other active actors help resolve the problem? Is there a mandate for them to do so? Here also lies the difficulty in determining how rehabilitation should be used. In a conflict situation, it can easily be interpreted as an extra battleground, some arena where combatants seek justification, expect redressing of grievances so that the main purpose of rehabilitation is put aside and the process remains at a standstill. But is rehabilitation at a standstill unproductive?

In this case, it maybe be argued that as rehabilitation dragged on and even if it could be viewed as strongly impeded, both parties were somehow using time to consolidate their own positions and strengthening their grounds. The employee was getting more and more convinced that she was being treated unfairly, that she was well and fit in other pharmacies. This may be interpreted as a perception that it was the work place that was sick. She could then justify that a move from her work place would solve her problems and a decision could mature based on her conviction that her efforts should be directed at seeking other employment elsewhere. The employer on the other hand was hopeful for an attitude change from the employee, was open to more dialogs and waited for a more favourable time to discuss future tasks for the employee as his personnel situation was still not fully resolved. These conditions he felt, may be met in due time. The negative effect of the stagnation of the rehabilitation process for the employer, his frustration due to a sense of lack of control and communication was however strengthened as well.

It can be argued if the timing of the interview has evoked the kind of response from the subjects. At the time of the interview, the employee had made up her mind to accept a position she had applied for in a pharmaceutical company. This information, on the other hand, had not reached her manager yet. Already determined that somehow, the bridges have already been burned, an attitude of non-reconciliation could be read from the employee's response. The manager on the other hand was still considering future dialogs and was keeping an open channel, he was still seeking a successful resolution to the problem.

The core of the matter is what measures a successful rehabilitation? Even if goals are specifically set, and even if they were arrived at, would that comprise success? In this case, both parties understood the purpose of rehabilitation, the employee's return to work on full-time basis and yet because of very different views, the employee expecting a certain measure from the employer (employment in another pharmacy), the employer a different measure from the employee (a change of attitude) resulted in continued disagreement. Is it the task of rehabilitation to thresh out these differences first? In what level? In this case, the employee felt that the key lay in the hands of the employer that is, a job. The employer felt his hands were tied and that he could not give her a position in another pharmacy. As starting points, the positions were locked and neither the social insurance officer nor occupational medicine, in the context of rehabilitation could mend this.

In conclusion, rehabilitation must be seen as a complex procedure where different actors come together with the task of helping the sick get back to work. Each actor has his own interest to keep and when problems arise in rehabilitation, the reason may be due to conflicts of interests. The question to be asked is where and when these conflicts can be addressed at. Rehabilitation procedures are well established and tend to be routinely used, there seems to be limited possibilities of diverting from these procedures to find unique solutions to problems specially suited to the sick individual. In this case, with the locked position of both parties, occupational medicine may have the key in helping both parties by bridging the gap and

extending its service not only to the employee but also the employer who sought out other links and contacts. It may well be that in rehabilitation work occupational medicine, aside from mapping out clear rehabilitation goals that are acceptable to both employee and employer be aware of the factors that impede rehabilitation from moving forward and establish this from the onset. The dilemma for occupational medicine is that this mandate is not always clear, may not even be appreciated by the company that commissions its service. In this respect, occupational medicine may at most try to hold open channels for the actors in rehabilitation through a positive attitude and good communication skills.

References

1. Statistical Yearbook for Sweden 2003.
2. Larsson G. Individens i centrum. En diskussionspromemoria om den framtida svenska arbetslivsinriktade rehabiliteringen. Utredningen om den arbetslivsinriktade rehabilitering. (S 1998:08).
3. Edling C, Nordberg G, Nordberg M. Hälsa och miljö. Lund: Studentlitteratur, 1998.
4. Svenning M. Rehabilitering – ide och verklighet. Lund: Studentlitteratur, 1998.
5. Järholm B (red.) Arbetsliv och hälsa – en kartläggning. Arbetarskyddsstyrelsen, Arbetslivsinstitutet, Rådet för arbetslivsforskning. Helsingborg: AB Boktryck.
6. Höök, O (red.) Medicinsk rehabilitering. Stockholm: Norstedts Förlag, 2002.
7. Kerz J, Werner M, Wesser E. Vad vet vi om rehabilitering? Lund: Sociologiska institutionen, Lunds universitet, 2001.
8. Järholm B, Olofsson C (red.) Försäkringsmedicin, Lund. Studentlitteratur, 2002.

Tabell 10.1 Kort sammanfattning av olika rehabiliteringsaktörer. Patienten/den försäkrade har en central roll som rehabiliteringsaktör men sätts inte in i denna tabell.

Organisation	Huvudman	Verksamhet och syfte med rehabilitering
Arbetsgivaren		Uppmärksamma rehabiliteringsbehov hos de anställda, vidta arbetsanpassningar och åtgärder som kan ske inom eller i anslutning till den egna verksamheten.
Arbetsförmedlingen	AMV*	Hjälpa den sökande att få och behålla ett arbete.
Hälsa- och sjukvården	Landsting och privat	Medicinsk vård, utredning, behandling och medicinsk rehabilitering.
Försäkringskassan		Övergripande samordningsansvar för de åtgärder som behövs för att den försäkrade ska bli arbetsför och ha möjlighet att försörja sig genom arbete.
Arbetsförmedlingen – Rehab (f.d. AMI)	AMV	Utredningar av arbetsförmåga, utbildningsbehov m.m. till personer som saknar arbete och där den medicinska rehabiliteringen är avslutad eller i det närmaste avslutad.
Socialetjänsten	Kommun	Hjälpa personer med olika former av sociala och ekonomiska problem. Kommunerna har även ansvar för hjälp till alkohol- och narkotikamissbrukare.
Företagshälsövård	Privat	Erbjuder företag hjälp med rehabilitering och kan medverka i enskilda rehabiliteringsärenden.
Samhall AB	Statligt bolag	Samhall AB tillhandahåller anpassade arbetsplatser till personer som inte kan få arbete på den reguljära arbetsmarknaden.
Arbetslivstjänster	AMV	Erbjuder mot betalning sina resurser till företag, försäkringskassan och organisationer för att förbättra arbetsförmågan. Arbetar endast med anställda och egna företagare (ej arbetssökande).
Samhall Resurs AB	Statligt bolag	Erbjuder mot betalning sina resurser till företag, försäkringskassan och organisationer för att förbättra arbetsförmågan. Arbetar endast med anställda och egna företagare (ej arbetssökande).
Privata		Erbjuder mot betalning sina resurser till företag, försäkringskassan och organisationer för att förbättra arbetsförmågan.

*): Arbetsmarknadsverket